NSCP Annual Report 2021/22
Safeguarding Children Arrangements for Nottinghamshire

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 a culture of high challenge and high support[1].
- 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 safe, 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 achieved over the past year, including the following:

- An update on progress in relation to the safeguarding priorities for 2020-23 and the key areas of work to take forward.
- A summary of the decisions made in relation to local case reviews and the learning and actions taken from those reviews and national reviews.

[1] The Strategic Leadership Group have amended this wording from 'constructive challenge' to reflect the ethos the partnership aspires towards.

- The effectiveness of the safeguarding arrangements in practice.
- 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.
- 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.

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[2]. They include details of the partners to the arrangements and explain how the functions of the Partnership are carried out through several different groups and led by the Strategic Leadership Group (SLG).

In the last year there have been significant changes within the partnership business unit with the Group Manager Joe Foley, Service Manager Steve Baumber and Development Manager Bob Ross all having retired in March and April 2022. The Strategic Leadership Group (SLG) and the new Group Manager (Claire Sampson) and Service Manager (Sam Harris) recognise Joe, Steve and Bob's diligent work in converting the Board to a partnership in 2018/19 and the significant impact each had on establishing the partnership in its current form, we thank them and wish them well.

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[2] Work is underway to review the safeguarding arrangements by the end of 2022.

Safeguarding partnership activities and progress

The current NSCP Business Plan covers 2020-2023, having been updated in July 2021 by the SLG in order to streamline the seven priorities considered in the previous annual report into three key priorities with key enablers. Details of these priorities, achievements against them, the impact of the work undertaken and the areas requiring further action are detailed below.

Priority 1

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

Current key enablers:

Ensure safeguarding priorities are considered in the development of the Integrated Care Partnership and the strategic plan.

The Health and Care Act was published in April 2020 and the Nottinghamshire Clinical Commissioning Groups (CCGs) have been working together since to establish an Integrated Care Board and a blueprint for establishing the whole Notts Integrated Care System in line with NHS England requirements. In March 2022 NHS England recognised that Nottinghamshire and Bassetlaw's roll out was rated as 'amber', which recognised good progress made in line with most other CCGs across the country. Rosa Waddingham has been appointed as the Director of Nursing for the Notts ICB and as she has sat on the partnership Strategic Leadership Group since 2019 this allows for continuity in the existing discussion about health's interactions within the partnership. A safeguarding implementation plan is being developed, but NHS England's safeguarding assurance framework is currently being updated and is needed before the local implementation plan can be developed. It is hoped this will be achieved within the next 6 months.

Increased coordination and working with other strategic partnerships to maximise impact.

The particular focus for this enabler over the past year has been improved working with Nottingham City's Safeguarding Children Partnership. A joint neglect strategy has been developed and launched at a partnership forum in May 2021 with 77 attendees who reflected on the strategy throughout the afternoon and have taken it back into their own organisations. A joint steering group is also in place to develop a consistent approach to risks outside of the family to children from child criminal exploitation (CCE) and child sexual exploitation (CSE). City and County partnership processes are now fully aligned for CSE and are close to full alignment for CCE as is a joint Exploitation mission statement.

Engagement with and representation on the Domestic Abuse Local Partnership Board

The Domestic Abuse Partnership Board met for the first time on 4 April 2022 at which time the Nottinghamshire tackling domestic abuse plan was agreed. The plan has three priorities:

- Prioritising Prevention
- Supporting Victims
- Pursuing Perpetrators

A children and young person's sub-group has been established and is currently undertaking a local needs assessment due for completion early next year to inform a work plan for the group. The group will be the key conduit for interaction between the domestic abuse board and the NSCP.

Key work to take forward

- Continued engagement with key initiatives such as the Integrated Care System and the Domestic Abuse Partnership Board to ensure a strategic approach for the safeguarding of children and families.
- Develop the cross-authority Neglect Steering Group to drive, monitor and evaluate the Neglect Strategy.
- Conclude the work to fully align the CCE response across City and County and develop a plan to evaluate progress.
- To consider the government's Green and White papers and recommendations in respect of how better to engage schools and academies within the NSCP.

Priority 2

Preventing abuse and neglect

Current key enablers:

Nottingham and Nottinghamshire Child Neglect Strategy 2021 – 2024

A cross authority steering group was established in November 2021 with terms of reference for the group finalised in February 2022. The group has commissioned the development of two animations to raise awareness about neglect across City and County both of which are due for completion in summer 2022. The NSCP has invested in additional temporary part time service manager post from January 2023. One of the key tasks of this post will be to drive the Neglect Strategy forward over the next twelve months.

Nottinghamshire Early Help Strategy 2021 – 2025

The Early Help Strategy was published in April 2021 and sets out the NSCP's ambitions for Early Help for Children and Families in Nottinghamshire, the principles that guide Early Help services, and our shared development priorities.

Nottinghamshire's Early Help Executive brings together senior stakeholders from across the partnership who are committed to the delivery of the strategy. It is a subgroup of the NSCP and its membership includes local authority children's services, health providers and commissioners, district councils, police, the Department of Work and Pensions and third sector partners.

This is a multi-year strategy spanning from 2021 to 2025, with an underlying theme of "community and connectedness" which underpins three areas for development: Locality Family Hubs, community resilience and contextual approaches to working with families.

In 2021/22 progress has been made to varying degrees in all three areas.

Work undertaken by the Executive has put Nottinghamshire in a good place to respond to the Governments' move towards Family Hubs as a model of working. Three Family Hub pilot sites have been proposed, with consultation and community engagement underway in Retford (Bassetlaw), Hawtonville (Newark) and Summerhouse (Sutton in Ashfield). The vision is that each Family Hub will have a network of services for children and families of all ages, working together in a more connected way with joint allocations meetings, common ways of working, improved information sharing and shared outcomes. Each hub will have both a physical and a virtual presence where families can go to get advice, help and support. Nottinghamshire was not successful in its bid to the Family Hubs Transformation Fund and has not been named as one of the 75 Local Authorities to receive funding through the Family Hubs Start and For Life Package, which means there is no

additional resource coming into the area to accelerate the establishment of Family Hubs. Nottinghamshire County Council have funded a temporary Family Hubs Development Manager and Family Hubs Data Officer to support the work of the Early Help Executive.

Through the Community Resilience work the aim is to reduce re-referrals into statutory services through sustainable community-based support for families and to foster a culture within services that values volunteers and supports them to develop skills and move towards employment. In 2021/22 services have been upskilling residents in to deliver services such as the peer-led breastfeeding support and volunteer led parenting programmes.

Contextual Approaches to Working with Families is an extension of whole family working. It means considering children and young people not just in the contexts of their families, but families within the context of their environment – both physical and virtual. We are seeking to better understand and support families in the context of their relationships and in 2021 we have launched the relationships really matter pages on Notts Help Yourself, and have trained professionals from across children's services in Reducing Parental Conflict programmes. In 2022 the training offer will expand to a much wider range of partners including police and housing officers. We also want to ensure colleagues across the partnership know how to identify and protect children from contextual risks which is why several new learning events are now on offer through the NSCP on topics such as criminal exploitation, county lines and radicalisation. In 2022 there will be a focus on data maturity, and how information sharing and data matching can help us understand need in communities and to demonstrate the impact of non-statutory support and target resources effectively going forwards. This work closely links with the Whole Family Safeguarding approach being developed within Children's Social Care and particularly the Multi-Disciplinary Team model referred to earlier in this report.

Empowering Parents Empowering Communities (EPEC) is a volunteer lead parenting programme. In the last year 20 volunteers have been trained as parent group leaders. There has been a total of 14 'Being a Parent' courses delivered, with 8 of these delivered virtually and 6 face to face. 82 parents and carers have attended these and have shared the following feedback through course evaluations.

"I just would like to say thank you to the whole team who made me see parenting through a new set of eyes and that changing a few little things improves so much more."

"Fantastic course, fantastic leaders and resources. The course has taken pressure off me to be a perfect parent, it has allowed me to feel normal as others have some of the same issues. The course has benefited the children immensely because I am calmer so are they. Thank You."

Volunteers have also delivered three 'Being a Parent together' courses, where couples attend together and consider the impact of relational conflict on their parenting. 20 parents/carers have completed these.

EPEC hub coordinators are employed to recruit, train and support volunteers. A key success of the programme is that volunteers have progressed into these roles this year with 2 volunteers now employed to coordinate the programmes.

We are ambitious to expand the scope of the programme and will be training more volunteers to lead new courses for parents of children with ASD, and Parents of Teenagers from September 2022.

Development of strengths-based approaches

Strengths based Child Protection Conferences were started in April 2021. This was developed jointly with partners and the feedback from professionals and families has been overwhelmingly positive. A similar model has now been introduced for Looked After Reviews and children and young people report feeling far more included within their reviews and in some cases are being supported to chair the meeting themselves. Strength based practice is a practice methodology that requires constant review and reflection so that practice evolves to meet need. The Independent Chair Service over the next twelve months will continue to develop practice around conferences and reviews with a particular focus on participation and inclusion. Sessions on strengths-based practice have also been delivered to around 400 practitioners in 4 safeguarding children today seminar sessions through the 2021/22 reporting period.

Faith groups, sports clubs, and the voluntary sector action plan

The introduction of new safeguarding arrangements under Working Together to Safeguard Children 2018 allowed greater flexibility for local implementation. The statutory guidance allowed safeguarding partners to identify 'relevant agencies' that must work in accordance with the arrangements. One of the objectives for the NSCP has been to expand the reach of the safeguarding arrangements and in the revised local arrangements, published in January 2020, the list of relevant agencies was extended to include Faith Groups, Active Notts (County Sports Partnership), Nottinghamshire Women's Aid and Nottinghamshire Fire and Rescue Service.

Some initial work was undertaken to build connections with the additional relevant agencies through 2020. However, it became clear that a significant amount of further work was needed to broaden the reach and influence of the safeguarding arrangements in these sectors. The NSCP commissioned a seconded service manager, Hilary Poyner, in April 2021 to develop a sustainable approach for the Partnership to engage with the voluntary sector and promote safeguarding. Mapping exercises were completed along with initial engagement work leading into two online engagement events in October 2021. There was a strong attendance at the faith event with 42 churches represented and excellent feedback:

'great idea to raise awareness amongst faith groups and encourage the sharing of ideas'

'good event, great mix of presenters, case studies and group work'

'great event and good to have something aimed specifically at faith groups'

Whilst 32 sports and voluntary organisations booked onto their event, only 24 attended with Hilary observing that there was a more noticeable challenge in achieving effective engagement with smaller organisations. All participants rated the event as good or excellent.

A final report was presented to the SAIG in January 2022 and SAIG approved an action plan. The initial action to include a representative from the safeguarding churches network in the partnership forum was completed with plans to continue the action plan through 2022-23.

Alignment of responses to child sexual exploitation and extra familial harm across the two children's safeguarding partnerships and further explore opportunities for integration of the current pathways

Along with the progress reported against the linked enabler in priority 1, a multi-agency audit was completed in November 2021 looking at Child Criminal Exploitation (CCE). The approach in Nottinghamshire to Serious Youth Violence and Child Criminal Exploitation (SYVCCE) was developed in 2019 and the audit considered the efficacy of this process and particularly the multi-agency

working. Strong practice was identified for the young people assessed as high risk with clear plans and proactive work aimed at reducing risk and safeguarding the young person's wellbeing. Where the risk identified was moderate, there were gaps in information sharing, joint working and mutual understanding of the risk along with limited engagement of the young person. The discussion day also identified that professionals had a less well-formed understanding of CCE than of Child Sexual Exploitation (CSE) with this impacting professional confidence. A pilot has also been started in Bassetlaw with schools and the police having set up a connection mapping pilot to achieve earlier recognition of and response to CCE risk and activity. The continuous practice development in respect of CCE and CSE across the partnership continues to be overseen by the steering group.

Key work to take forward

- Delivering the faith groups, sports clubs and voluntary sector action plan and embedding the recommendations to improve information sharing and offer annual engagement events in addition to the partnership forum.
- Develop our ability, through data review and auditing, to understand the impact of non-statutory support to children and families.
- Further developing the partnership response to CCE, including continued training and incorporating the learning from the audit into the cross authority steering group.

Priority 3

Improving safeguarding practice

Rapid Review thematic analysis

A triennial analysis of rapid reviews was completed in November 2021. This considered 25 rapid reviews completed by the NSCP since July 2018 and 5 Local Child Safeguarding Practice Reviews (LSCPR). The national Child Safeguarding Practice Review Panel agreed with the decisions of all 25 rapid reviews about whether to progress to an LSCPR. The themes identified were:

- 6 related to injuries to babies under 1 year old
- 2 concerned Sudden Unexpected Death in Infancy (SUDI) – note that there were other SUDI deaths which were not subject to Rapid Review as abuse/neglect was not identified
- 4 concerned child criminal exploitation
- In 6 of the reviews, males connected to the child were not engaged – agencies were either not aware of the men or they were known but not sufficiently assessed
- 6 of the children were in local authority care at the time of the incident

The following safeguarding practice issues featured most frequently across the range of reviews undertaken:-

- Gaps in information sharing
- Quality of assessments
- Joint working
- Understanding what the child's daily life is like

These practice issues had been identified as the individual reviews were progressed and the NSCP learning and improvement framework has allowed us to move forward through other enablers identified in this plan (for example the safer sleep working group and the cross partnership criminal exploitation work). The learning and workforce development report also evidences some of the training delivered following the above reviews. It is unsurprising that learning from local reviews reflects some of the issues that have been identified through a number of thematic reviews

commissioned by the National Child Safeguarding Practice Review Panel. The learning from these reviews is aligned to the learning from NSCP reviews.

Developing understanding of diversity when working with Black, Asian and minority ethnic children and families in a safeguarding context

The partnership learning co-ordinator, Trish Jordan, worked with partners to create a training offer with the first session to be offered on 27/04/22 and then regularly within the training offer ongoing. Attendance and feedback will be considered by the learning and workforce development group in late 2022. The newly seconded service manager will be working on expanding this enabler through 2022.

Safer Sleeping working group action plan

Sudden Unexpected Death in Infancy – the Joint Nottingham/Nottinghamshire Child Death Overview Panel has been overseeing a number of actions in this regard and linking with the Cross Authority Safer Sleep Working Group. The message that everyone can play a role in reinforcing safer sleeping practices is being promoted and supported by a Risk Assessment Tool, training programme and new E learning module. References to safer sleeping have also been included in the Pathway to Provision and the Discharge Planning Template. In Nottingham and Nottinghamshire, the multi-agency safer sleep steering group meets quarterly. The main purpose of the group is to work collaboratively to ensure that practitioners working with families understand and are supported to implement safer sleeping advice. The steering group developed an action plan based on the national 'Out of Routine' report; a review of Sudden Unexpected Death in Infancy (SUDI) where children are considered at risk of significant harm. The report was published in July 2020 by the national Child Safeguarding Practice Review Panel. The action plan developed by the Nottingham and Nottinghamshire group focused on four key areas:

- Strategic response: Reviewing and updating policies and procedures to embed SUDI prevention in a wider safeguarding context.
- Workforce development: Taking a multi-agency approach to equipping practitioners with the knowledge and understanding appropriate to their role to promote safer sleeping, with a particular focus on where children are considered at risk of significant harm.
- Information, Interventions and Tools: Establishing and delivering a suite of safer sleep interventions appropriate to individual families and the level of risk identified.
- Working with families: Understanding the views of parents about Safer Sleep information

Key achievements in the reporting period include:

Safer Sleep messaging and associated risks included in:

- Neglect strategies (city and county)
- Pathway documents (city and county)-identifying levels of need for children and families and responding appropriately
- Joint inter-agency procedures-safeguarding

A Safer Sleep steering group has been established as a sub-group of the Best Start partnership (Nottinghamshire County) and safer sleep has been embedded in Children's Services practice improvement workstreams (city and county). A Nottinghamshire wide annual report on deaths

related to unsafe sleep environments has been produced by the child death review nurses. The report was reviewed by the Safer Sleep Steering Group to help inform practice.

Safer Sleep tools and development opportunities are shared regularly with a wide range of practitioners in different settings. E learning/self directed learning is available to all partner agencies through city and county Safeguarding Children Partnerships (Level One). Sudden Infant Death Syndrome (SIDS) training is provided virtually through city and county Safeguarding Children Partnerships to a wide range of practitioners (Level Two). Some 'in house' training delivered, for example Nottinghamshire Healthcare NHS Foundation Trust, Small Steps Big Changes/CityCare and Early Years (Nottingham City). The risk assessment tool and guidance has been refreshed and widely circulated. A survey 'Your Baby's Sleep' was refreshed in consultation with parents. Parents were encouraged to complete it using a digital platform and responses were anonymous. 152 responses were received and the findings from the survey are helping shape safer sleep messaging to parents.

Harmful Sexual Behaviour (HSB) Steering Group

The multi-agency arrangements for assessment and intervention continue to be overseen by the Nottinghamshire Safeguarding Children Partnership (NSCP). The HSB steering group with senior representatives from the involved organisations continues to provide the direct oversight of the HSB panel, procedures, tools, and training. The panel ensures that there are sufficient trained staff to complete both specialist assessments and interventions as well as commissioned services where required. Progress is regularly monitored by reporting to the NSCP Safeguarding, Assurance and Improvement Group (SAIG). In August the annual report to SAIG evidenced that despite the increase in demand continued progress has been made in terms of developing specialist knowledge and the quality of assessments and interventions provided to children and young people and panel members continue to report that the panel is effective and that they regularly see pieces of good work and intervention plans. The key priorities for the forthcoming year are to continue to develop practice across the partnership but with a particular focus on early intervention and incorporating the voice of the child and families.

Front door services – long term review of approach to explore needs led model and short-term MASH demand management

2021/22 saw continued pressure in terms of high levels of safeguarding enquiries being made to the Multi-Agency Safeguarding Hub (MASH), including a significant number that lead to no further action. Individual agencies within the MASH worked proactively to ensure that enquiries could continue to be triaged effectively, with additional staff being deployed to work in the MASH and new models of working being developed, such as a "pod" model within children's social care. Consideration was also given to how partners could be more effectively supported in understanding thresholds, with the introduction of a pilot through the What Works Centre for Children's Social Care to provide safeguarding supervision to designated safeguarding leads within half of the county's secondary schools.

It was recognised by the NSCP that a review was needed of the model for receiving safeguarding enquiries, and as part of this the partnership held workshops exploring the concept of what a "needs-led" front door might look like. Aligned to this, the County Council initiated a project as part of its Improving Resident's Access programme to develop a needs-led front door approach and designing this new approach will be a key priority in 2022/23.

Key work to take forward

- Expanding work around understanding diversity in safeguarding contexts.
- Continued work on safer sleep, thinking in particular about the cost of living difficulties and implications for safer sleep through the coming winter. Continuing to ensure this learning is across all safeguarding professionals.
- Focussing on early intervention in the harmful sexual behaviour context along with better incorporation of the voices of children and families in this area.
- Continued work towards a finalised review and recommendations for the MASH and continued partnership work to manage short-term demand.

Review of use of restraint within Clayfields

Clayfields House provides secure accommodation for up to 20 children and young people 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 Clayfields Service Manager and Independent Trainer providing details of the legal framework for Restrictive Physical Interventions (RPI), data on the use of restraint, quality assurance governance and staff support. It was noted that that statistics for RPI over the last year shows more RPI for young people of dual ethnicity, however this is accounted for by one young person of dual ethnicity being involved in a high number of RPIs. The SAIG agreed with the conclusions that:

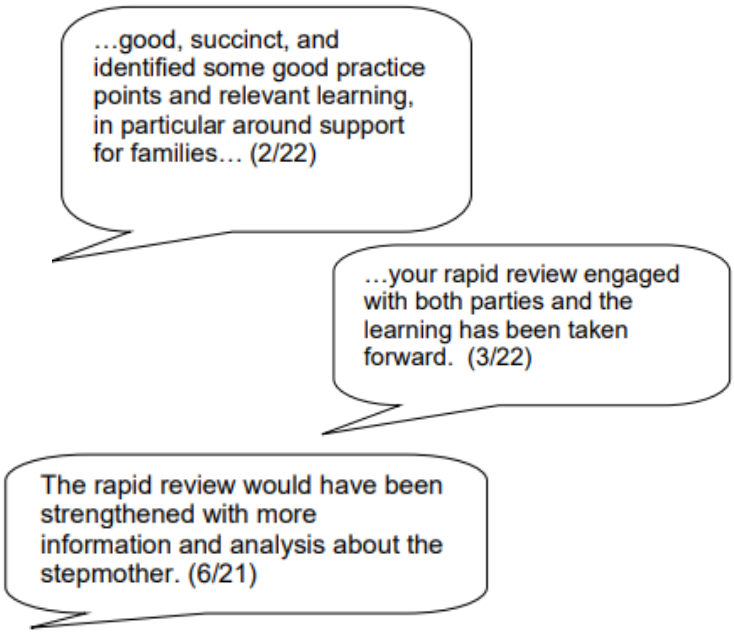
- Staff are trained to a high standard using the Safety Intervention (CPI) form of physical intervention. This replaced the previously used MAPA system with an increased emphasis on the safety of all involved in an RIP.
- Internal and external monitoring of physical interventions are thorough, and the internal quality assurance regime is robust.
- In addition, young people have the space to debrief after an incident and for any feedback to be incorporated into their safety planning (e.g. if a young person may feel calmer with a female member of staff).

It should also be noted here that in the most recent two Ofsted Inspections Clayfields House was judged overall as being good – including their health and protection arrangements. The team will continue to build on the good practice recognised and report back to the Partnership in the coming year with oversight from the Clayfields Governance Board.

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).

The NSCP remains committed to gathering as much learning as possible during the rapid review process and to only progressing to a Local Child Safeguarding Practice Review (LSCPR) where necessary. Feedback from the NCSPRP during the reporting period has been good with some learning identified – here are some examples:



There were **7 rapid reviews** completed in the reporting period.

3 reviews related to death or physical harm by suspected non-accidental injury to young babies (under 3 months). 1 was the death of a newborn whose mother had learning disabilities and was unaware she was pregnant and did not seek medical help in time after the birth.

2 reviews were for teenage boys, 1 who was looked after and died by self-hanging the other was 17 and was badly injured by stabbing in a child criminal exploitation context, he had recently ceased being looked after.

1 was for a 3-year-old boy with additional needs who died from a brain injury believed to be non-accidental.

In addition, the panel very carefully considered the impact that Covid 19 may have had in each situation reviewed during the reporting period. There was impact noted in all 7 reviews of the reduction in face-to-face contact with professionals. There has been an increased focus on returning to face-to-face working across the partnership whilst retaining some of the benefits of remote working for professionals. There is a partnership focus to reintroduce face-to face child protection conferences and looked after reviews in some capacity over the coming months and although this is not a direct consequence of the learning from the reviews it is a contributing factor.

At the conclusion of this reporting period there were 4 ongoing LCSPRs, but for completeness one was published in May 2022 just after the reporting period ended and is therefore considered in detail on the next page.

SN20 – "Jean"

This review was for a seventeen-month-old baby girl "Jean" who was scalded at her home address in March 2020 and died from her injuries. Her mother was subsequently convicted of murder in November 2020. There were substantial delays in undertaking this review due to the criminal and coronial processes. The coronial process concluded in November 2021 however publication was further delayed as further correspondence was awaited from the coroner.

The focus of concern was Jean's mother's vulnerability due to mental health and substance misuse problems and the impact these might have on Jean's care. Jean's mother made 8 repeated non-specific threats to harm strangers although at no time did she give any indication that she would deliberately cause harm to her child. The review concluded that Jean's death could not have been anticipated or predicted.

The review highlighted issues in how children and adult health and social care work together and a need for better joint working to improve access to the expertise held within each service, to improve the quality of assessments of adults with parental responsibilities. It argued that improved assessment will help the implications of adult issues to be fully considered in relation to an adult's parental responsibilities and for appropriate help provided. The review also highlighted the negative impact of long waiting lists for services in adult mental health service. The NSCP has begun work to explore models of integration or ways to develop closer working between adult and children's health and social care services so that the services can undertake joint assessments of adults with parental responsibilities who have adult issues such as mental health problems, substance misuse, or being a victim or perpetrator of domestic abuse. This has included the development of a multi-disciplinary team in Newark and Sherwood which includes adult workers with specialisms in the areas identified above working within a child protection team.

The response from the national Child Safeguarding Practice Review Panel (CSPRP) was received on the 9th of June 2022 and included the following feedback:

We thought the review was clear and included helpful descriptions of practice and analysis of decision making at key points.

The themes were explored in a thorough and meaningful manner, helpfully drawing on relevant research, policy, and other reviews to inform the analysis and learning. The analysis was thoughtful and grounded in the realities of everyday practice and of family life. However, while it gave a sense of Jean's life, we noted that the report seemed more focused on the impact of mental health problems on her mother's ability to parent, rather than on Jean's own lived experience.

The actions from the review were progressed throughout the reporting year and at the end of the reporting period three out of the four had been completed. The fourth action relates to the multi-disciplinary team pilot referenced above. The CSPRP feedback noted their particular interest in this recommendation and asked to be kept informed of how the implementation of this recommendation worked out.

Area of note: Delays in completion of LSCPRs and RRs

Jean's LCSPR was significantly delayed due to the conclusion of the criminal and then coronial process. Similar delays are noted for the remaining three LSCPRs. The NCSPRP was critical of the delay for Jean's review, reminding the partnership of the relevant guidance containing a 6 month requirement unless in specific circumstances. In light of this the partnership review subgroup has considered the remaining three LSCPRs and were able to publish one in July with the other two due for publication in December and there is now a standing agenda item for the sub-group to ensure robust oversight of the timescales and improved communication with the panel should there be unavoidable delay.

The sub-group has also noted that whilst the quality of rapid reviews has remained very high during the reporting period, as evidenced by the NSCPRP's 100% agreement to the recommendation regarding not progressing to LSCPR, there has been difficulty with the 15 day timescale in several of the reviews. The sub-group is therefore reviewing the current rapid review process to incorporate a second panel meeting at which final sign off is achieved, rather than a reliance on emails which it is felt has been the cause of delay that the new system will ameliorate. The new system for rapid review will be closely monitored through a transitional period to evaluate if these changes reduce delay by the NSCP Development Manager in combination with the SAIG and the independent scrutineer (Dr Mark Peel).

Dissemination of learning from rapid reviews and LCSPRs

The learning from case reviews continues to be presented at the regular NSCP "Safeguarding Children Today" training events, and to influence the content of core safeguarding training. In addition, a triennial analysis of rapid reviews from the first three years of the new arrangements was completed and shared at the Nottinghamshire Safeguarding Children Partnership wider partnership forum in November 2021. The report included analysis of themes and the learning identified in the twenty-five rapid reviews completed between July 2018 and October 2021. A subsequent report was provided to the SAIG in February 2022 to provide assurance around the rapid review process and learning and improvement framework. Connectivity with learning from national reviews published in 2020 and 2021 was noted, namely

- It was hard to escape: Safeguarding children at risk from criminal exploitation
- 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 Myth of Invisible Men - Safeguarding Children under 1 from non-accidental injury caused by male carers.

Impact of Rapid Reviews and LCSPR's on practice

The progress of recommendations from rapid reviews has been driven by the CSPR sub-group throughout the reporting year and reviewed at each quarterly meeting. Some issues identified by the work of the group are already known to organisations with existing work in place to improve practice and the impact of the reviews has been to highlight continuing challenges and emphasise the importance of making and maintaining improvements to practice.

3 key areas of impact have been:

• Improved the identification of electively home educated children (following RN19, an LSCPR detailed in the previous annual report)
• Ensured information regarding anorexia and eating disorders is readily available to families on partner's websites (following RN19)
• Nottinghamshire Healthcare Foundation Trust established a safeguarding single point of contact where staff can access safeguarding advice from a safeguarding lead (following one of the rapid reviews).

Multi-agency training, guidance and procedures

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

This was the second year of offering training during the difficult times of the Covid 19 pandemic with the virus remaining a very present part of our lives. Despite this, partnership training has continued and further developed with a comprehensive offering of eLearning and virtual live training sessions.

Training provided through the partnership is informed by the learning needs identified through the NSCP Learning and Improvement Framework. The following provides some examples from the training programme delivered during 2021/22 along with impact evaluations:

- In response to the NSCP Business Priority 3 – *Improving Safeguarding Practice (Strategy Discussions),* multi-agency training needs were analysed in relation to strategy discussions, joint investigations and child protection medicals and a training package was developed. Three events were delivered, offering places to 131 practitioners. The events were targeted at those most likely to be involved in strategy discussions with an emphasis on clear expectations on individual roles and responsibilities, recording and thresholds. Course evaluations evidenced that 37.8% of delegates rated themselves as having good/very good knowledge prior to attending the training which then improved to 93.6%, which is a positive measurement of the impact of the course. Feedback included: *"Very good training". "The multi-agency training was excellent as often you don't get the opportunity to network with other agencies, particularly paediatricians."*
- As part of the ongoing work via the Safer Sleep working group, two training events were delivered called Sudden Unexpected Death in Infancy and Safer Sleep for Babies to 200 practitioners. The training highlighted that SUDI prevention should be seen as safeguarding work for all professionals (not just midwives and health visitors). 81.5% of attendees were not from health so there was a good multi-agency level of attendance which would suggest that many partners will have further developed their understanding around this area and be able to use this knowledge to ensure safer sleep messages are shared with families across Nottinghamshire and help prevent further SUDI deaths.
- As part of our rolling programme, a new updated course to raise awareness of Perplexing Presentations including Fabricated or Induced Illness has been developed and delivered to 264 practitioners. The training included the new guidance from the Royal College of Paediatrics and Child Health. We have been delivering this course since 2014 and

KEY ACHIEVEMENTS

Expanded multi-agency training pool. 38 partners delivered training in this period, with 4 external experts also commissioned.

Further creativity in online course design, enhanced interactivity and consistently positive evaluation feedback from this.

Continued ability to offer courses in response to changing safeguarding concerns; for example courses on young people impacted by self-harm and suicide and mental health awareness in relation to parents and carers.

10,364 training opportunities accessed across the partnership this reporting year.

since then we have seen a steady increase in the number of enquires/referrals to our child protection services. The training has raised awareness of this form of abuse and given practitioners confidence in raising their concerns. The outcomes for children have been very positive as earlier intervention has meant fewer children have needed a child protection plan or been subject to legal proceedings. An example of feedback included: *"The course provided me with the knowledge of the topic and an understanding of how this can present. I will implement these skills in my daily practice with families."*

- Working Together to Safeguard Children is our core training course to develop multi-agency safeguarding work. It has continued to be successfully delivered in two parts: Part 1- E Learning, Part 2 is a 3-hour virtual event, now incorporating break out rooms. Delegates on the 11 courses that were held during the year were asked about their levels of knowledge and skills relating to working together effectively – prior to the course 37.8% rated themselves as good/very good, which then improved to 93.3 % after completing the course. Feedback included: *"The training was really good and it was nice to hear from other professionals who work in different settings, it helped me to gain a bigger understanding and perspective on the whole picture when dealing with a safeguarding issue." "I am new to safeguarding and this training has enhanced my knowledge to enable me to fulfil my role."*

Priorities for 2022/23

- L & WD Group members to continue to monitor and review the decision of when to start offering a blended approach of face-to-face classroom and virtual training events.
- The L & W D Group will continue to reflect and review how training is progressing, including attendance at events and support from partners regarding delivery of events.
- The L & W D Group will continue to oversee the cross authority inter-agency procedures, ensuring clearer links and references regarding the procedures are incorporated within the face to face/virtual and e learning courses.
- Further promote eLearning as an alternative option for learning and development and author any bespoke courses where a need is identified.
- Developing the training offer and procedures in line with the implementation of national reviews published this year (including the Independent Review of Children's Social Care, the education white and green papers, national panel reviews and the independent review into child sexual abuse) and reviews undertaken by the partnership.