Nottinghamshire Safeguarding Children Partnership

Annual Report 2019/20

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 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 NSCP and its supporting groups including; reports presented to those groups; records of meetings; multi-agency audit findings; and the findings from case reviews.

The report will be published in October 2020 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 Strategic Leadership Group for the Partnership

Welcome to the 2019/20 Annual Report for the safeguarding children arrangements in Nottinghamshire. The first full year of operation for the Nottinghamshire Safeguarding Children Partnership (NSCP).

This report details the work of the NSCP over the past year and fulfils the requirement in Working Together[1] for the safeguarding partners to provide a 'Yearly Report'. It includes the Independent Scrutineers assessment of the leadership of the arrangements.

A safeguarding partner is defined under the Children Act 2004 (amended) as the local authority, clinical commissioning groups and chief officer of police. They have a statutory duty to agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. It is important to have that clarity of accountability which was a key driver behind the introduction of new safeguarding arrangements. Effective safeguarding however relies on a much wider partnership of organisations that are committed to working together to protect children and promote their welfare. We are fortunate in Nottinghamshire to have long history of partnership working across a wide range of organisations that provide services to children and families in the county. This report therefore reflects the work of the whole Partnership and recognises the contributions that all organisations have made over the past year.

The Child Death Review Partners are responsible for ensuring that all child deaths are reviewed effectively and that actions are identified to prevent future deaths. A joint Nottinghamshire/Nottingham City Child Death Overview Panel (CDOP) has been established and their report will be published separately. It is important to retain connectivity between the two arrangements, so that when safeguarding concerns arise in relation to the death of a child actions are coordinated, and this report therefore includes details of how that has been achieved.

Colin Pettigrew

Andrew Gowan

Nottinghamshire County Council

NOTTINGHAMSHIRE POLICE PROUD TO SERVE

Nicola Ryan

Rosa Waddingham

NHS Bassetlaw Clinical Commissioning Group

NHS Nottingham and Nottinghamshire Clinical Commissioning Group

[1] Working Together to Safeguard Children (2018)

Independent Scrutineer

I am delighted to add comment to the NSCP 12 monthly report, in my capacity as Independent Scrutineer for the Partnership. I came into this role in Nottinghamshire in January 2020, and it is fair to say that the impact of the pandemic has made this a very different first nine months to what I had initially anticipated!

Whilst the pandemic has certainly been a challenge, I have seen clear evidence of a strong and mature Partnership and of the creativity of professionals, especially for our most vulnerable children and young people. Evidenced for example by the response of SAIG to these unprecedented times, by the consistently high quality of Nottinghamshire's Rapid Reviews completed and importantly as a result of informed, cross party, Political engagement and involvement with safeguarding.

Who would have thought just a few months ago, that we could have become so adept in our 'virtual' communications, that they now seem so normal? Certainly, there have been unanticipated benefits, for example through attendance at key meetings has improved as busy professionals no longer need to 'factor in' travel time to attend and, perhaps more tellingly, young people telling us they often prefer digital communication and feel more at ease discussing sensitive issues that way. As a result, when things do return to (new) normal, we need to take care not to lose some of the advantages that this enforced change of practice has required.

I have been able to attend meetings virtually and to keep abreast of what is happening and, whilst I know this is no substitute to meeting people in person, what it has revealed to me about the strategic direction the Partnership has taken subsequent to the new safeguarding arrangements coming into force in September 2019 is positive and encouraging. For example, through the process of selection of clear and locally specific safeguarding priorities, and latterly the manner in which these are being driven forward. I have seen that the Senior Leadership Group (SLG) works effectively as a mechanism to 'set the tone' of safeguarding practice in a way that is genuinely reflective of equal and mature Partnership between Police, Health and the Local Authority.

As I get to know Nottinghamshire better, there will inevitably be issues of concern that come to light and challenges for our Partnership to overcome. But at the end of a rather unusual first nine months in this role, I would like to thank everyone engaged in safeguarding, from The NSCP Business Unit, all of the agencies, to each and indeed every one of you working in safeguarding at whatever level for your commitment and hard work across a unique and very challenging period.

Dr Mark Peel
Independent Scrutineer
Nottinghamshire Safeguarding Children Partnership

Nottinghamshire Safeguarding Children Partnership

Vision and values

The partnership has set out its vision *'That children and young people in Nottinghamshire grow up in a safe and stable environment and are supported to lead healthy, happy and fulfilling lives'*.

The Nottinghamshire Safeguarding Children Partnership will:

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

Safeguarding Partners

The safeguarding partners responsible for the safeguarding arrangements in Nottinghamshire are:

- Nottingham and Nottinghamshire Clinical Commissioning Group
- NHS Bassetlaw Clinical Commissioning Group
- Nottinghamshire County Council
- Nottinghamshire Police

Key features of the safeguarding arrangements: -

- Three agencies (CCGs, police and the local authority) as safeguarding partners 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 arrangements provide a framework under which organisations can work together to improve safeguarding. The Relevant Agencies are represented at each level within the framework: -
    - **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
    - **Partnership Forum** – provides a means of communication, consultation, coordination and networking with a wider range of organisations and direct connectivity with operational managers
    - **Child Safeguarding Practice Review Group** – undertakes 'Rapid Reviews', makes decisions on the need for Child Safeguarding Practice Reviews and oversees any that are undertaken
    - **Learning & Workforce Development Group** – overseeing the multi-agency training programme and cross authority interagency procedures, 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
- Five Designated Safeguarding Leads from schools and the Safeguarding Children in Education Officer, attend the Partnership Forum and provide a link to the Safeguarding in Education Focus Groups that are held twice a term
- Representatives from the safeguarding partners lead each of the groups under the arrangements and the relevant SLG member is responsible for linking in with them to ensure that the group is working effectively and to identify any issues

Listening and responding to the voices of children and families

The NSCP aims to seek the views of children and families to inform it's work and is developing ways to achieve this however there is more to do.

Each time a child safeguarding practice review is undertaken the lead reviewer and NSCP Development Manager meet the family involved to gather their views on the services they received and what could be improved to ensure that their perspective is included and responded to appropriately. At the conclusion of the review the findings are explained to the family.

A great early success for the Partnership has been the number of visits to frontline services that have been undertaken and more about these is included in the section on safeguarding assurance and improvement. The visits provide the opportunity for senior managers to visit areas of partnership work that they may not be familiar with and speak to the children and families receiving services and the staff working there.

When a multi-agency audit is undertaken every effort is made to find ways to include the views of children and families either from records already held or by actively canvassing views when appropriate.

When the Safeguarding Assurance and Improvement Group (SAIG) is scrutinising areas of safeguarding practice a key question is always to seek evidence of the children and family's views of that service, whether that is children subject of a child protection plan, looked after children or children living at the Clay fields Secure Unit for example. Many partner organisations have formal mechanisms for gathering the views of children, for example Nottinghamshire County Council's 'message in a bottle' for looked after children, and these provide valuable insights. Inspections undertaken by regulatory bodies also provide evidence of how well organisations are listening and responding to children and families.

Strategic Leadership

The senior accountable officers from the safeguarding partners have met as a Strategic Leadership Group on six occasions during the year. The group is chaired by the Corporate Director for Children and Families, Nottinghamshire County Council. The Vice-Chair is the Head of Public Protection, Nottinghamshire Police.

As part of the work to ensure that the safeguarding partnerships of Nottinghamshire and Nottingham City work effectively together on shared priorities and identify cross-cutting issues, a joint Strategic Leadership Group has been established and now meets on an annual basis.

Measures to respond to the COVID-19 pandemic were introduced by HM Government towards the end of the period covered by this annual report (March 2020). As a consequence, the SLG moved to monthly meetings to maintain strategic oversight of the implications of the pandemic for safeguarding children. The Safeguarding Assurance and

Improvement Group (SAIG) was tasked with monitoring the impact on the operational framework for responding to safeguarding concerns and introduced fortnightly meetings of senior managers.

Review of safeguarding arrangements

The SLG has reviewed the safeguarding arrangements and published a revised version in January 2020. To ensure continuity and reinforce the shared responsibility amongst the safeguarding partners for the safeguarding arrangements the SLG agreed that the Vice-Chair will take over the role of Chair from 2021 with a representative from the Clinical Commissioning Groups becoming Vice-Chair.

The schedule of Relevant Agencies has been expanded to include faith groups and work is ongoing to strengthen connectivity in this area. Nottinghamshire Women's Aid have also been included as a Relevant Agency[2] providing an important link to domestic abuse work. The relationship between the Partnership and the Office of the Policing and Crime Commissioner (OPCC) has been clarified with representation from the OPCC now attending the Safeguarding Assurance and Improvement Group (SAIG). During the course of the year the Nottingham and Nottinghamshire Violence Reduction Unit (VRU) was formed and the Partnership has established close working relations to ensure that shared priorities, including the prevention of child criminal exploitation, are taken forward collaboratively.

A new business cycle has been developed which clearly sets out how the components of the Partnership work together (see **Appendix A**). This was used as the basis for a development session, led by the SLG members, at the Partnership Forum meeting (January 2020) to share understanding of the arrangements, consult and gather feedback from across the Partnership.

SLG key facts

Coordination of the Partnership response to COVID-19

Continuity of leadership agreed

Joint SLG with Nottingham City established

Safeguarding arrangements reviewed and updated

Strengthened links to faith groups, Nottinghamshire Women's Aid, the Violence Reduction Unit and Police and Crime Commissioner's office

New business cycle developed

Funding arrangements reviewed

New Training Charges Framework developed and implemented

Funding

Arrangements for funding the Partnership have been reviewed by the SLG. During 2019/20 funding was derived through:

- contributions by a small number of partner agencies
- income generated through training and safeguarding checks
- direct funding of specific posts by Nottinghamshire County Council and Nottinghamshire County Clinical Commissioning Group

In addition, a grant was successfully applied for from the Department of Work and Pensions in order to take forward work aimed at reducing parental conflict. The Office for the Police and Crime Commissioner also funded a safeguarding conference to raise awareness of contextual safeguarding. Details of the contributions by partners and other income received along with expenditure for 2019/20 are attached as **Appendix B**. Following the review of the

[2] Relevant Agencies are determined locally by the SLG from the schedule of potential agencies set out in the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

funding arrangements, the SLG agreed that contributions from partner agencies should be maintained at the same level for 2020/21[3]. It was also agreed that the training provided through the Partnership should be fully costed and a new charging framework developed. The NSCP Training Charges Framework was subsequently developed, agreed and implemented on 1st April 2020.

Independent scrutiny

Since the implementation of our new safeguarding arrangements in January 2019 we have been fortunate to have the support of Chris Few, former Independent Chair of the Nottinghamshire Safeguarding Children Board. Chris agreed to take on the role of Independent Scrutineer during the transition phase and whilst the new arrangements were embedded, and we are extremely grateful for the contribution that Chris made to safeguarding in Nottinghamshire during his time as Chair and as the first Independent Scrutineer under the new arrangements.

Following a recruitment process in December 2019 the Lead Representatives for the safeguarding partners were pleased to appoint Dr Mark Peel as the new Independent Scrutineer. Dr Peel brings with him a wealth of experience in safeguarding children both at strategic and operational levels having been the former Independent Chair of Leeds Safeguarding Children Board, an Associate Professor of Social Work at the University of Leicester and qualified social worker. The Independent Scrutineer attends the Strategic Leadership Group and acts as a critical friend providing an assessment of the effectiveness of the safeguarding arrangements and highlighting areas for improvement. They provide assurance around key elements of the Partnership learning and improvement work; take an active role in ensuring case reviews are carried out effectively, contribute to the multi-agency audit programme and scrutinise the effectiveness of the training provided through the Partnership.

Unregulated children's homes for children under the age of 16 years

One of the first pieces of work undertaken by Dr Peel has been to review Nottinghamshire's approach to the use of unregulated children's homes for children under the age of 16 years. Dr Peel subsequently reported to the SLG that the use of unregulated placements for children under 16 occurs very infrequently and those that do are very carefully considered and comprehensively managed and reviewed within the Partnership.

Independent Inquiry into Child Sexual Abuse (IICSA)

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 looked at how public authorities responded to allegations that children were being sexually abused and sought to identify any common themes and failings. The safeguarding arrangements annual report (2018/19) detailed the extensive action taken by Nottinghamshire in response to the learning from the Inquiry as it has emerged, and the Partnership has continued to monitor progress on key areas of practice. On 31st July 2019 IICSA published their report into the Nottinghamshire Councils strand of the Inquiry and it was positive to see that the publication of the Inquiry Report in itself encouraged people to come forward and report abuse that happened to them in the past.

One recommendation in the Inquiry report related specifically to Nottinghamshire:-
Nottinghamshire County Council should assess the potential risks posed by current and former residential care staff and foster carers, which are directly provided by the council, in relation to the sexual abuse of children. They should also ensure that current and former staff in residential care provided by external agencies, and current and former foster carers

[3] Contributions from partner agencies have not increased for over ten years

provided by external agencies, are assessed by those agencies. Any concerns which arise should be referred to the appropriate body or process, including the Disclosure and Barring Service, the relevant regulatory body, the local authority designated officer (LADO), the fostering panel and the police.

The Joint SLG received assurance from the local authority regarding the detailed response to this recommendation and the governance arrangements, through the Policy Committee and the Children and Young People's Committee, to ensure appropriate action is taken. The Joint SLG also agreed that their next meeting (November 2020) will be used to reflect on all of the learning from the Inquiry and the effectiveness of the response by relevant agencies.

The Inquiry report made it clear that it will return to a number of issues which emerged during their investigation, including but not limited to: harmful sexual behaviour, the barriers to disclosure of sexual abuse by children, including those in care, and proactive steps to reduce those barriers and the approach to civil litigation, including the role of insurers. The Partnership will therefore continue to follow the progress of the Inquiry and identify opportunities to improve practice in Nottinghamshire.

LGA Peer Review and Ofsted Inspection

The Partnership has contributed to both the Local Government Association (LGA) Peer Review and Ofsted inspection of local authority children's services. Information was provided in support of both processes and the outcomes were presented to the SLG for consideration. The LGA Peer Review process does not result in a grading however Nottinghamshire children's services received an overall grading of 'Good' following the Ofsted Inspection. Some areas for improvement were identified and more detail is provided later in this report.

Interim Early Help Development Plan

A number of changes to the way early help services are provided are scheduled for 2020/21 and therefore an Interim Early Help Development Plan was presented to the SLG for approval. The plan links closely to the Pathway to Provision, which is the thresholds document for children's services. A 3-5year strategic plan will be developed in due course utilising the knowledge gained during the period of the Interim Plan.

Tackling Modern Slavery & Human Trafficking in Nottinghamshire

Modern Slavery and Human Trafficking (MSHT) is a serious human rights issue with an estimated 15,000 victims of slavery in the UK, it affects children, young people and adults. In January 2020 an overview was provided to the SLG of Nottinghamshire Police's approach to tackling Modern Slavery and Human Trafficking in the county, and specifically to update progress in delivering the recommendations of HMICFRS as set out in their report, "Stolen Freedom, The Policing Response to Modern Slavery and Human Trafficking" (2017). Assurances were received that Nottinghamshire Police have made good progress with the modern slavery agenda leading the way nationally with convictions at court which have had a strong positive impact on community confidence. Strong collaboration with local partners has allowed for a more informed understanding of the threat and provided an enhanced capability to support local investigations and prevention strategies.

Strategic links to other partnership arrangements

The NSCP has strengthened its links to other multi-agency arrangements. A Joint Strategic Leadership Group for the safeguarding children partnerships in Nottingham and Nottinghamshire ensures that work across the partnerships is coordinated where appropriate and this is supported through regular meetings of the officers for the two sets of arrangements. Opportunities for greater collaboration around training are currently being explored. In addition, the officers for the Nottinghamshire Health and Wellbeing Board, Safer Nottinghamshire Board, Nottinghamshire Safeguarding Adults Board and the NSCP

meet regularly to ensure their work is aligned, for example in relation to issues such as domestic abuse and sexual violence.

Joint Child Death Overview Panel Support Arrangements

As outlined in the introduction to this annual report the child death review arrangements are the responsibility of the Child Death Review Partners (local authority and clinical commissioning groups) and therefore a detailed annual report concerning that area of work will be provided separately. The Joint Strategic Leadership Group includes the representatives from the Child Death Review Partners and provides the mechanism for the governance of the Nottingham and Nottinghamshire Child Death Overview Panel (CDOP). Any cross-cutting issues between the two arrangements are identified at this level. Proposals were agreed by the Joint SLG for a single support function for CDOP, hosted by Nottinghamshire County Council and funded through existing safeguarding partner contributions, and this was implemented from 1st April 2020.

Safeguarding assurance and improvement

The Safeguarding Assurance and Improvement Group (SAIG) scrutinises safeguarding effectiveness and co-ordinates improvement activity by developing action plans for themed areas of work. The group is chaired by the Service Director, Commissioning and Resources, Children and Family Services.

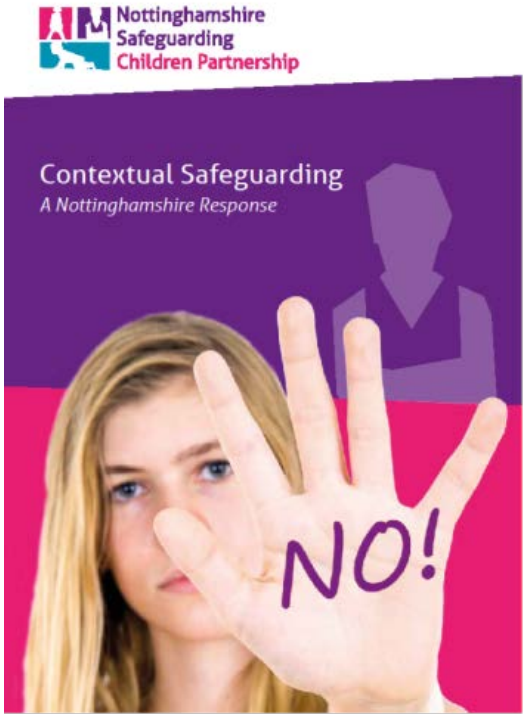
Membership of the group includes senior managers from the safeguarding partners and relevant agencies that have responsibility for safeguarding performance within their organisation, and the NSCP Independent Scrutineer. The nominee of the local authority elected member with portfolio holder responsibilities for children's services is a participant observer of the group.

This year a new Performance Management Framework was developed and introduced (**Appendix C**) by the SAIG. The framework sets out how qualitative information from case reviews, audits and inspections is used alongside performance data and business intelligence (e.g. annual reports from key areas of safeguarding practice) to inform the Partnership about the effectiveness of safeguarding. Practice improvement workstreams are then identified and action coordinated through the SAIG.

This year the Partnership has been working on the following areas of safeguarding practice with actions identified and monitored through the Practice Improvement Workstreams Plan (**Appendix D**):

- Contextual safeguarding – including child sexual exploitation and criminal exploitation
- Multi-Agency Safeguarding Hub (MASH)
- Strategy discussions
- Injuries to pre-mobile babies
- Information sharing
- S136 detentions under the Mental Health Act

Details of the work undertaken by the SAIG are set out in this section of the report.



Contextual safeguarding

This year Nottinghamshire Safeguarding Children Partnership, as part of its ongoing work to raise awareness of risks to young people from outside the family, organised a conference which provided the opportunity for over 350 local practitioners to learn more about contextual safeguarding. With the support of the Nottinghamshire & Nottingham City Violence Reduction Unit we were able to expand the event and work with Nottingham City Safeguarding Children Partnership so that more practitioners could benefit from the inspirational presentations provided by national experts including Dr Carlene Firmin MBE, from the University of Bedfordshire and Dez Holmes, Director of Research in Practice.

Supporting materials were also developed for the conference. The partnership is particularly appreciative of the contribution made by Nottinghamshire County Council staff to the organisation of the event and the preparation of materials.

Youth Violence and Child Criminal Exploitation

Nottinghamshire (including Nottingham City) has been identified as one of 12 policing areas facing significantly high rates of violent crime. In the summer of 2019, the Office of the Policing and Crime Commissioner received funding to establish a Violence Reduction Unit. The core function of the VRU is to offer leadership and, working with all relevant agencies operating locally, strategic coordination of the local response to serious violence. VRU activity enabled by the funding must support a multi-agency "public health" approach to preventing and tackling serious violence. Current performance in reducing knife crime in Nottingham City/Nottinghamshire is positive, with good reductions being seen this year although the overall reduction is a result of a larger reduction in the City, with a small increase in the County. The reduction in knife crime is attributed to a dedicated police robbery team which has reduced weapon enabled robberies previously more of a concern in the city than elsewhere.

In May 2019 Nottinghamshire County Council approved the establishment of a number of Youth Worker posts whose work was to be targeted at young people at risk of violence. After a successful recruitment round the countywide youth work interventions project began in October 2019. The youth work intervention team is working in partnership with a variety of agencies, including housing, police, anti-social behaviour coordinators and neighbourhood wardens to gain key intelligence to ensure that the right groups and 'hotspot' locations are targeted. Youth workers are focusing their time working with young people, building relationships and trust through a range of positive activities. In a short period of time there are several good examples of young people engaging well with youth workers and getting involved in a range of diversionary activities. For instance, the Friday night football project in Arnold regularly attracts around 60 young people per week. The team has linked with the local police who also attend and engage in the programme of activities. The team has produced several case studies alongside young people to highlight the outcomes and impact this programme is having on individuals as a direct result of youth work intervention.

The NSCP has established a multi-agency steering group to develop the approach to and oversee multi-agency activity in relation to Serious Youth Violence and Child Criminal Exploitation. This includes all activity against the children's themes of the Knife Crime strategy[4]. The Multi-Agency Serious Youth Violence and Criminal Exploitation Panel made up of senior colleagues from across the NSCP, (established in January 2019) has continued to meet on a monthly basis to consider those young people in the County seen as being at the greatest level of risk. Since March 2019, to January 2020, 55 young people have been discussed at panel, of whom 51 were male and 4 females. A 'cohort approach' has been developed with young people being tracked by the Panel until agreed that the identified risks have been markedly reduced. A Serious Youth Violence and Child Criminal Exploitation Coordinator was appointed to for a 12-month period from October 2019. Although relatively

[4] Led by the Office of the Policing and Crime Commissioner

early days, the post has enabled a much-improved coordination of panel activity, focusing at present on enabling effective information sharing into and out from the Panel to improve its connectivity to case holders and so increase its overall effectiveness. A data set is currently in development to assist in judging the effectiveness of the panel.

County Lines is one example of criminal exploitation and the police are developing their resources in this area and have established a specific county lines team that became fully operational in January 2020. Intelligence is gathered at a county and regional level and linked to this the police have developed a 'vulnerability tracker' containing the names of young people at risk due to county lines. These young people are included as part of the cohort considered by the serious youth violence and criminal exploitation panel.

Early intervention work with schools is being supported through the Tackling Emerging Threats to Children Team (TECT). Youth Justice Locality teams continue to provide a programme of one to one crime prevention support tailored to the needs of the young person at risk of or becoming embroiled in youth violence and criminal exploitation, in addition to the work of the youth service described earlier.

Work with colleagues in the District and Borough Councils' is underway to further improve our place-based approach to these threats. This is aimed at coordinating these county level services alongside district-based services to improve their combined effectiveness.

Child Sexual Exploitation

A child sexual exploitation problem profile and threat assessment, prepared by Nottinghamshire Police, was presented to the SAIG in December 2019. The assessment was developed to inform the work of the Partnership to prevent CSE and protect those at risk. Whilst a reduction in recorded crime was noted, an increase in demand for police resources was positive and probably indicated evidence of earlier intervention. It was identified that further work was needed regarding perpetrators and hard to reach communities (including boys/young men), 89% of recorded victims are girls (74% white British girls). A number of recommendations were included in the assessment from which an action plan has been developed and the police are leading on the completion of the plan.

Nottinghamshire County Council also reported the findings of 12 'Learning Audits' relating to children at risk of CSE. The objective of this new type of audit is to encourage self-analysis and reflection by the parties directly involved with the case and to give an opportunity for wider discussion and learning with peers and colleagues to determine strength-based perspectives and action focused practice feedback. In light of the multi-agency nature of CSE prevention work partners were invited to take part in the audits. The Partnership also liaised with the audit lead to ensure that learning from the serious case review QN17 was taken account of within the analysis of practice.

The audit found evidence of missing from home incidents being dealt with well with good communication between the police and children's social care. Issues with participation or

timeliness of CSE strategy meetings were found in more than half of the cases and arrangements for communicating the outcome of the meetings to children/young people not in attendance at the meeting were not referenced in a number of cases. However, evidence was found of s47 child protection enquiries being considered appropriately with improved recording particularly for more recent cases. The CSE risk assessment tool was regularly utilised and referenced at strategy meetings and in the majority of cases, considerable work has been carried out to engage the child/family, recognise and reduce the risk to ensure the child is kept safe. Arrangements were made to review the response to the learning identified in 6 months' time and to follow up reports of delays with therapeutic services.

Harmful Sexual Behaviour

Improving the response to children who display harmful sexual behaviour has, and continues to be, a focus of partnership improvement activity. In June 2019 an update report was presented to the SAIG which included the findings of an audit of 10 cases that had been taken to the HSB Panel[5]. Progress was reported in relation to the identification, assessment and planning for children who display harmful sexual behaviours. New and updated policies and procedures had been introduced and the introduction of the panel was viewed positively. Children/young people considered by the panel were found to have been appropriately assessed with a balance of strengths and concerns being identified and the panel was able to make recommendations for future interventions and support. Some issues were found with the timeliness of assessments and concern that not all children/young people were being referred to the panel when they should, and further clarity is needed around when the panel should be referred to.

MASH

The Partnership has committed to supporting work led by Nottinghamshire County Council to ensure the most effective operation of the MASH. Increased demand, with more contacts being made from partner agencies, has put a strain on MASH resources. A key issue is therefore ensuring that practitioners from across the partnership are clear as to when to contact the MASH, what action they may need to take before doing so and the importance of providing as much information as possible when they do. The Pathway to Provision is the Partnerships thresholds guidance and awareness raising of the guidance, and how to apply it, has continued through NSCP Training events, newsletters and briefings. The Ofsted inspection (October 2019) reported that '*Children identified as being in need of urgent protection and considered*

SAIG – key facts

New Performance Management Framework Introduced

Contextual Safeguarding Conference held with 350+ delegates

Information sharing between children's social care and the police improved

Problems with cross border arrangements for medical assessments addressed

Audits completed of harmful sexual behaviour and child sexual exploitation and learning identified

Working group established to undertake strategy discussion improvement work

Programme of visits to frontline settings completed

[5] The HSB Panel was introduced in June 2018

to be at risk of significant harm receive a quick and effective response from the multi-agency safeguarding hub (MASH). Thresholds are well understood by partners and within the MASH.'

Next steps for 2020/21:
Further work is planned to develop alternatives to contacting the MASH, such as advice for professionals regarding children/young people that do no not meet the threshold for children's social care intervention. Specific training on early help assessments is also planned and on-line resources to guide how to make a good referral.

Strategy discussions

Strategy discussions are an important statutory requirement of multi-agency working to protect children at risk of significant harm. They are used to determine a child's welfare and to coordinate and plan any rapid future actions that may be needed. As a minimum they should include a social worker, police representative and health practitioner. The Partnership has identified through case reviews and audit that this is an area of weakness for multi-agency working and this has been verified through Ofsted inspections. The quality of strategy discussions in Nottinghamshire needs to improve so that they are timely, involve all relevant partners and are well recorded.

Although previous work has been undertaken to improve practice this has not resulted in the necessary change and therefore the Partnership agreed to establish a working group to get to the root cause of the problem. A multi-agency group has been formed, including representatives from partner agencies and colleagues from Nottingham City. The group is led by the Group Manager (Emergency Duty Team, MASH, Assessment Service & Children's Disability Service) and supported by NSCP officers and the local authority programmes and projects team.

The working group has so far completed the following tasks:

- A shared understanding and vision for strategy discussions has been agreed
- A series of focus groups have been held with the teams that undertake strategy discussions to understand the challenges faced and consult on how practice could be improved
- Detailed process maps to describe current practice have been developed, this has particularly helped with understanding of the connectivity with the MASH RAG rating process
- Issues identified through the focus groups have been raised with partner agencies for action, including improving arrangements for out of hours communication between the police and children's social care
- Data gathering and analysis has been improved and shared with partners and a clear benchmark has been set to measure improvements against
- Health representatives have consulted with the wider health community to develop proposals for improving health representation at strategy discussions

Next steps for 2020/21:

- Implement proposals for the MASH Health Team to represent health at strategy discussions
- Review the impact of the new process being introduced, identify any further action needed including communications and training requirements

- Continue performance monitoring against the benchmark

Information sharing

The safeguarding partners are required to ensure that the safeguarding arrangements '*support and enable local organisations, and agencies, to work together in a system where Information is shared effectively to facilitate more accurate and timely decision making for children and families*[6]'.

One aspect of information sharing that has been identified for improvement is the availability of information about children on child protection plans. This work has involved two strands designed to share information with health practitioners and police officers.

CP-IS - The NSCP has continued to monitor the effective use of the national Child Protection Information System (CP-IS). This system alerts health practitioners when they are treating a child who is on a child protection plan, or has been in the past year, and signposts them to where they may find out further information enabling them to carry out a more complete assessment of safeguarding risks.

Police/Children's Social Care - A new system has also been introduced in Nottinghamshire which enables police officers attending an incident to be made aware when that a child is residing at that address who is on a child protection plan. This does not replace the expectation for any safeguarding concerns to be referred through the normal routes but does enable those police officers to make observations that are informed by information that may be significant when deciding what action to take. Each day brief details of incidents at addresses where children are living who are on a child protection plan are provided to children's social care and the social worker is notified. This means social workers are now being made aware much quicker of potentially significant events and in some cases of important events which they may never have found out about.

Strengths based practice

In March 2019, the Children and Young People's Committee approved a proposal to implement strengths-based practice as the consistent framework for practice within the Youth, Families and Social Work Division. Strengths-based practice is centred on working with colleagues, partners and children, rather than 'doing to', to assess, plan and manage cases.

By adopting a restorative and relational strengths-based practice framework, workers will:

- move away from a deficit and compliance culture towards practice underpinned by high challenge and high support
- identify strengths and resilience as well as needs and risks.
- build meaningful relationships
- hear the voice of the child and let that voice have an influence
- focus on the whole family their strengths and the community assets (strengths), which can support ad enable sustained change.

A task and finish group has been formed to identify priority areas for embedding strengths-based practice and work with teams to do so. Communications have taken place, including introductory briefings at team level and a full-service strengths-based practice development day. The SAIG has been provided with an update on progress and the implications for multi-agency working have been considered with proposals to support the approach across the Partnership.

Domestic abuse and violence

An integrated approach to commissioning domestic abuse services has been commissioned by Nottinghamshire County Council in partnership with the Policing and Crime

[6] Working Together to Safeguard Children (2018)

Commissioner. There is an increasing volume and complexity of demand for domestic abuse services. This demand continues to exceed service capacity which can cause delays for survivors and reduce their ability to access support. Survivors who are at high risk of harm, following the completion of the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (DASH RIC) are referred to the Multi agency Risk Assessment Conference (MARAC).

Nottinghamshire County Council commission the administration and coordination of the Multi agency Risk Assessment Conferences (MARACs) from the two domestic abuse support services. These are Notts Women's Aid Ltd in the North of the County (covering the districts of Bassetlaw, Mansfield, Newark and Sherwood) and Juno Women's Aid in the South (covering the districts of Ashfield, Broxtowe, Gedling and Rushcliffe). Within the services there are specialist support services for women, men and teenagers. There are also services to support children and young people living in families where domestic abuse takes place.

To oversee the MARACs there is a countywide MARAC Steering Group. This group is chaired by Public Health. At this meeting issues relating to the MARAC are considered including information sharing, GDPR, current referrals, partner engagement and attendance, conference developments e.g. using ECINs, challenges and training requirements. There are concerns that referrals are increasing on a year by year basis and this is most significant in the south of the County.

Assurances were sought by the SAIG regarding children being referred to the correct services and the impact of support services and these were raised with the Domestic Abuse Executive Group (responsible for domestic abuse services under the governance of the Safer Nottinghamshire Board).

Cross border medical assessments

Following concerns being raised by social workers about the effectiveness of arrangements for medical assessments in certain circumstances the Partnership requested clarification and assurances from health commissioners. It was established that Nottinghamshire and Bassetlaw CCGs commission paediatric services to assess children and young people who are registered with GP practices in their areas. This model works well when neighbouring CCGs operate on the same basis however it became apparent that Derbyshire commission their service on the basis of the local authority footprint. The difference in commissioning arrangements had resulted in some children who were registered to a Derbyshire GP but living in Nottinghamshire falling into a gap between services and consequently had led to delays in medical assessments. As a result of the Partnership identifying the issue, interim arrangements were put in place between the respective commissioners and providers to ensure that no children and young people were affected moving forwards. A broader piece of work was also initiated to look at arrangements with other neighbouring commissioners.

Self-harm

Self-harm is the term used to describe any act of self-poisoning or self-injury carried out by an individual, regardless of motive. The prevalence of self-harm across all age groups is 0.5%. Self-harm increases the likelihood that the person will die by suicide by between 50 and 100 fold above the general population in a 12-month period. A study of 15-16 year-olds cited by Nice (2011) estimated that 10% of girls and 3% of boys had self-harmed in the previous year. Self-harm has been a theme in several local and national serious case reviews where young people have taken their own lives (local serious case reviews QN17 and NN15 relate to young people who took their own lives).

A multi-agency self-harm audit was undertaken to understand the outcomes for young people who are referred to Child and Adolescent Mental Health Services and who; do not engage with CAMHS or who are not accepted by CAMHS. This was used to follow up learning from the QN17 serious case review. Further learning points were identified through

the audit and incorporated into NSCP training. The audit also reinforced the importance of consulting with children and young people, listening to what they have to say and acting upon it. This links to the strengths-based practice approach and the briefing for GPs (identified in the RN19 CSPR referred to later in this report). The findings from the audit were also used to inform ongoing work, led by public health, to develop a self-harm pathway.

Use of restraint at Clayfields House Secure Children's Home

The Partnership has monitored the use of restraint within secure children's units in the area as required. 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, when they are applied, by whom and what steps are taken prior to RPI to minimise its use.

The Centre Manager reported a 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 again from 190 (2018/19) to 217 (2019/20) with an increase in incidents related to self-harm. There was a slight increase in minor injuries to young people and a decrease in other categories of injury to young people and staff. An over-representation of black and minority ethnic groups involved in restraint incidents is being closely monitored by the Centre Manager who has measures in place, including a diverse and well-trained staff, to ensure that there are no issues of unaccountable disproportionality.

Clayfields has a 'referral criteria' for notifying the Local Authority Designated Officer of certain incidents and the Centre Manager confirmed that none of the incidents where restraint was used met the referral criteria. No concerns about the safety holds and use of restraint have been raised.

At the request of the Partnership some comparative data regarding the use of restraint in other secure units was provided this year. Whilst direct comparison is difficult due to the differing groups of residents of potentially complexity of need it was encouraging to find lower rates of restraint were evident at Clayfields.

Safeguarding pre-mobile babies

The partnership has continued its work to support practitioners to respond appropriately to bruises or suspicious marks on pre-mobile babies. The video developed by the Partnership and launched in March 2019, (https://www.nottinghamshire.gov.uk/nscp/news/babies-that-don-t-cruise-rarely-bruise) has been widely used at training events and seminars to promote the Bruising in Babies Pathway. The video and pathway help guide practitioners about the action they should take when they find a mark or bruise on a pre-mobile baby and when to make a referral to children's social care.

Sherwood Forest Hospitals Foundation Trust have also revised their child protection pro-forma to include guidance around decision making regarding a second skeletal survey. If a skeletal survey is carried out a second skeletal survey is now routinely booked as a follow up and the agreement of the senior Paediatrician/Named Doctor for Safeguarding and Paediatric Radiologist is required before cancelling a second skeletal survey.

Partnership inspections

Nottinghamshire Police received an overall 'good' rating following their HMIC PEEL inspection, an improvement from their previous assessment. Further work was identified regarding children in custody and a cross authority agreement with monthly meetings was introduced to improve police notifications to social care of children being held in custody.

Nottinghamshire Healthcare NHS Foundation Trust reported the findings of their Care Quality Commission (CQC) inspection – certain areas required improvement none of which related to safeguarding.

In December 2018 the findings of a full HMIP inspection into all aspects of the work of *Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)* were published. The overall rating was 'requires improvement' and the SAIG has monitored the action being taken to address two of the recommendations from the inspection that were particularly relevant to safeguarding. These related to the quality of assessments and the level, knowledge and skill of staff to carry out effective work to keep people safe.

Nottinghamshire County Council - following an Ofsted Inspection in September and October 2019 Nottinghamshire remains a "Good" local authority providing services to children. The inspection identifies that the impact of leaders on social work practice with children and families is good with political and corporate support being a strength. The report also recognises the increased commitment from District Councils, particularly with regard to Care Leavers. The report concludes that experience and progress of children in care and care leavers is good and that they especially receive a good service, with that offered to Care Leavers being described as having been transformed. More work is required to improve the experience of those who need help and protection, but Ofsted recognised that the local authority had accurately identified the areas for improvement and were working on them. They recognised that those children needing urgent help and protection received it in a timely and effective way, however for some children whose needs are less clear or urgent, then they may experience some delay. Social work in some parts of the county was found to be better than in others and the need to further improve our management of strategy discussions was identified. Ofsted recognise that large-scale service areas have improved since 2015, but that more needs done in smaller, discrete areas.

Sherwood Forest Hospitals Foundation Trust - a CQC inspection undertaken at Kingsmill Hospital, Newark Hospital, Mansfield Hospital and outpatient services provided by the Trust, in January and February 2020 graded the Trust overall as 'outstanding'. The inspection found the services for children and young people were inclusive and took account of children, young people and their family's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. The inspection found that staff were knowledgeable about safeguarding and demonstrated an awareness of the trust's safeguarding processes, they understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The Trust demonstrated learning from incidents and staff were aware of these.

Visits to frontline practice

A programme of frontline visits has been undertaken by members of the SAIG during the course of the year and these have made a significant contribution towards providing assurances around safeguarding practice. The visits are an opportunity to understand how services are meeting the needs of children and young people and to connect the Partnership with frontline practitioners. Those undertaking visits are requested to address the following questions:

- Staff understanding of their role?

- Understanding of safeguarding children?
- Equality of practice?
- Is there evidence of children and young people being listened to?
- Is the work focused on improving outcomes for children?
- What is working well and what improvements could be made?
- How could the NSCP assist?

The Partnership is grateful to the members of the SAIG that undertook the visits and to the staff in those organisations for supporting the initiative. The following visits were undertaken as part of the programme and outcomes reported to the SAIG:

Private fostering

This visit was undertaken by the Named Nurse for Safeguarding Children, Doncaster and Bassetlaw Teaching Hospitals. The visit found that there was a straightforward process in place for responding to private fostering notifications with clear timescales, appropriate training for newly qualified social workers and management oversight. Concerns were identified regarding the low numbers of children identified as being in private fostering arrangements and it was agreed that partners had a responsibility to raise awareness through training, newsletters and bulletins.

Hopewood CAMHS In-patient Unit

The Service Director for Commissioning and Resources at Nottinghamshire County Council visited the unit on behalf of the Partnership. Staff working at the unit were clear about their safeguarding role, monthly safeguarding supervision was provided, and additional specialist support was available when needed. The unit provides care for young people with complex issues from a wide geographic area and this adds to the challenges of multi-agency working. A strong culture of person-centred nursing practice was evident with clear evidence of children being listened to. The visit identified that relationships between ward managers and key social work staff should be developed, that group supervision could be used to disseminate learning from case reviews and greater use could be made of NSCP training. A recommendation was also made for consideration of a multi-agency framework to respond to a group of children that are not currently served well by the partnership procedures or national guidance and this was referred on to an existing workstream under public health.

East Midlands Children and Young Peoples Sexual Assault Service (EMCYPSAS)

The Designated Doctor for Nottingham and Nottinghamshire CCG visited the service on behalf of the Partnership. The service is provided by a team of highly professional staff with a strong safeguarding background. A Crisis Support Worker (CSW) supports the child/young person throughout the process and provides them with opportunities to express their thoughts and feelings either directly or through specific feedback forms. There is also a follow-on call three days after the medical assessment to check how the child/young person is doing. Therapeutic support and the services of a Child Independent Sexual Violence Advisor are also offered. The member of the SAIG undertaking the visit raised a query regarding the lack of cultural diversity and it was established that recruiting to the unit had been a challenge. Staff at the unit requested that the Partnership raise awareness of their service with practitioners and the NSCP subsequently included additional content in training events and circulated leaflets about the unit.

Emergency Department – Queens Medical Centre (QMC)

The Head of Public Protection for Nottinghamshire Police visited the Emergency Department at the Queens Medical Centre on behalf of the Partnership, focussing particularly on the children's reception centre. A child friendly environment was evident, with separate facilities

for children attending the Emergency Department for treatment as well as for those accompanying adults in need of treatment. The visit found that staff not only dealt with the immediate treatment needs of the children but also considered the wider issues of safeguarding, longer term support and intervention with examples of good practice provided. Safeguarding training was embedded within staff training schedules and daily briefings are used to check knowledge. 'Red Thread' is well embedded within the QMC and includes child victims (indeed up to 25 years of age) who present with weapon enabled injuries, gang affiliation or child exploitation. This is the only such project outside London and provides youth workers to engage with victims of serious trauma (including stabbings and firearms discharge). Strong working relations were found with partner agencies, some frustrations were voiced with the timeliness of the response from the MASH on occasions and this was raised with the MASH Operations Manager to consider potential solutions. The need for improved information sharing by the police in some cases where there is a potential risk of retribution/violence following an admission of a patient was also identified and agreed for follow up.

Children and Family Court Advisory and Support Service (CAFCASS)

The Head of Safeguarding for Nottingham University Hospitals visited CAFCASS on behalf of the Partnership and reported back to the SAIG. The outcome of this visit was very positive particularly in relation to the way the voice of the child was listened and responded to with improving outcomes for children at the centre of their work. CAFCASS staff use of a variety of tools to gather children's views including an app to engage children and encourage them to express their wishes and the option for every child to write to the Judge concerned. Examples were provided by staff of referrals being made and the importance of safeguarding was evident.

Newark & Sherwood Healthy Families Team (0-19)

The Independent Scrutineer met with managers of the service and a group of front-line practitioners. The team provides 0-19 services (formerly health visiting and school nursing) across Newark and Sherwood and demonstrated a good understanding of the safeguarding arrangements and their role within them. There had been challenges in maintaining staff numbers as a result active recruitment of trained professionals by a neighbouring area. Within the current staff cohort, the move to a 0-19 service is generally seen as positive, allowing one practitioner to be responsible for all children within a family. A service model focussing on specific time limited programmes was also seen as positive, avoiding drift associated with long term management of cases on the threshold for more intensive intervention. The team also provides a number of specialist services, including those targeted at the gypsy /Roma community around Newark, refugee families and a continence service. The team provided very complementary feedback on the NSCP training and the opportunity for engaging with other agencies they provided. A number of concerns were raised by the team and these were reported to the SAIG for action

- The future of Children's Centres and funding - assurances were provided by the Lead Member for Children's Social Care Nominee that the partnership was changing but the service was not.
- Implications of IT systems changes – it was acknowledged that the change in IT systems would result in some information not being as readily accessible however this was countered by improved access to other sources of information and was inevitable as different organisations use different systems.
- Disparity between the county and city regarding resources for mental health services for young people – this issue had been raised with commissioners and was followed up by the Designated Nurse for Safeguarding, Nottingham and Nottinghamshire CCG.

- The recording of birth trauma to avoid false positive referrals of petechial haemorrhage – the Named Nurse for Safeguarding Children, Sherwood Hospitals NHS Foundation Trust confirmed that work was on-going with maternity ward in this regard.

NEMS

The Designated Nurse for Nottingham and Nottinghamshire CCG and Specialist Practitioner Safeguarding undertook a visit to NEMS (non-emergency medical services) and utilised a completed s.11 audit tool to guide discussions with staff. The visit provided significant assurance that NEMS is prioritising safeguarding and that frontline practitioners are aware of and proactive in fulfilling their safeguarding responsibilities. The organisation is receptive to scrutiny and proactive in identifying areas for improvement where possible. A follow up visit by the Designated Nurse was scheduled for 6 months tome to review progress in the areas identified for improvement.

Partnership Forum

The Partnership Forum provides an opportunity for all members of the Partnership to meet and focus on developing multi-agency work and improving safeguarding practice. The Forum includes Safeguarding Leads and Managers from across the Partnership and each Forum event is led by a member of the SLG. An update is provided on Partnership activities including improvement workstreams, case reviews and learning opportunities, before moving on to explore two areas of safeguarding practice that are either new or emerging areas of work or where challenges have been found locally.

The Forum met on two occasions during the year with one event postponed due to the proximity to the Contextual Safeguarding Conference. The following is a summary of activities undertaken by the Forum during 2019/20: -

- Understanding and promoting the 'bruising in babies' pathway' to ensure the right response when bruises or marks are seen on a pre-mobile baby
- Looking at the Partnership approach to contextual safeguarding, particularly County Lines criminal exploitation and serious youth violence) and improving understanding of the Independent Child Trafficking Advocacy Service (Barnardos)
- A review of how the Partnership is working – reflection on what is working and where further development is needed using the new business cycle to increase understanding of how the Partnership operates
- Strategy discussions – developing a shared understanding of when they should take place, what their purpose is, who should be involved, the role of different agencies and what we need to do to improve the effectiveness of them
- Harmful sexual behaviour – understanding what it is, the extent of HSB and the impact it has, causes and interventions. The work of the HSB Panel and an explanation of how the Brook Traffic Light Tool should be used to assess sexual harm

Learning and workforce development

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

- Developing and agreeing the Learning & Workforce Development Strategy and multi-agency training programme.
- Undertaking multi-agency training needs analysis.
- Coordinating the delivery of the multi-agency safeguarding children training including commissioning specialist training where needed.
- Ensuring that a suitably qualified training pool made up of staff from the Partnership is available to deliver the NSCP training programme.
- Evaluating and reporting on the multi-agency training provision.
- Providing a full range of e learning modules
- Maintaining the local thresholds document, the Pathway to Provision.
- Maintaining the interagency safeguarding children procedures and guidance
- Analysis and evaluation of the use of procedures and guidance.

The group meets six times a year and is chaired by the Consultant Paediatrician and Designated Doctor for Safeguarding Children, Nottinghamshire County North. The Chief Nurse, Nottingham and Nottinghamshire CCG, maintains an oversight of the group on behalf of the SLG and provides updates to the SLG on a regular basis. Two of the six L&WD meetings are held jointly with Nottingham City to specifically review and approve updates to the procedures. The NSCP Training Coordinator and Training Administrator are funded by the Partnership to support this work.

NSCP Training Programme

The NSCP Multi-Agency Training Programme is a rolling programme of events informed by the learning needs identified through the NSCP Learning & Improvement Framework which includes:

- ❖ Child Safeguarding Practice Reviews
- ❖ Child Death Reviews
- ❖ Audits
- ❖ Annual Training Needs Analysis
- ❖ Feedback from partner agencies through the L&WD group

This year 57 face to face training events took place (compared with 45 the previous year) including core safeguarding training, specialist subject events and seminars. Overall attendance at our face to face training has increased from 2,197 practitioners in 2018-19 to 2,346 in 2019-20 (an increase of 149). A new programme of Reducing Parental Conflict was

NSCP Training – key facts

57 training events

21 different courses

2,346 attendees

Over **38** different organisations accessed training

Over **92%** of attendees rated the course as good or very good

21 different E learning modules

8,060 E Learning course completions

10,406 workforce training opportunities

Implementation of new on-line booking system

Over **5,000** learner accounts set up (excluding local authority staff)

A partnership approach to delivering training

delivered which included train the trainer events to equip organisations to take forward training in future years. Unfortunately, 4 events were postponed due to COVID-19 pandemic restrictions. Take up of training opportunities by organisations remained similar to the previous year however there has been a noticeable increase in attendance by the local authority family service, youth services, children's social care and children centre staff and also staff from Nottingham University Hospitals Trust.

We have seen a significant increase in the use of our e learning over the last year: this year there were 8,060 course completions compared to 5,518 in 2018/19. Again, nearly half of the course completions relate to our two core courses: Introduction to Safeguarding Children (1,557 completions) and Awareness of Child Abuse and Neglect (1,772 completions). These statistics support what L & WD group members have reported, in that organisations are using these courses as part of their staff's induction and view them as a very valuable source of training at this introductory level. The next most popular courses were Trauma, Toxic Stress and Adverse Childhood Experiences, Social Media & Safeguarding, Child Sexual Exploitation and Radicalisation.

The Trauma, Toxic Stress and Adverse Childhood Experiences (ACEs) is a new bespoke course that we authored and introduced this year, as we continued to work in partnership with Public Health in relation to the ACEs agenda. It proved to be popular with 676 course completions, so our third most popular course.

Evaluation of training

Course evaluations evidence that the training provided is of high quality and clear examples are given by practitioners that training has improved their practice. A robust system 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. Last year we delivered 15 courses and when asked to rate delegates overall satisfaction with the courses 92.75 % (92% - 2018-19) rated their satisfaction levels as good or very good. Also, when asked about their levels of knowledge and skills relating to working together effectively – prior to the course 32.46% rated themselves as good/very good, which then improved to 91.88 % after completing the course. This clearly is a positive measurement of the impact of the course. Some comments included:

- *"I enjoyed the diversity of the training and being made more aware of other agency practices. It was extremely well delivered"*
- *"It was great to meet people from different sectors and gain an understanding of their perspective on things. It certainly was a good idea mixing the seating up so that you were not sitting with your own colleagues*
- *"I thoroughly enjoyed the training and it was informatively and professionally facilitated"*

Some examples of other qualitative feedback we have received include:

- "*I thoroughly enjoyed the training, it was informative, interactive and well presented" (CSE course)*
- *"Excellent training" (Safer Sleep for Babies)*
- *"The variety of speakers helped to keep me interested, the cases described gave it authenticity and relevance. concise and factual - what was expected and required.*
  It was a really useful update with a lot of information packed into the morning" (Safeguarding Children Today Seminar)
- *"Although the course was fairly short, it contained a wide range of areas and issues which children can potentially face. The information was specific and precise" (Awareness of child abuse & neglect e learning)*

Interagency safeguarding children procedures

Cross partnership safeguarding procedures are maintained in conjunction with colleagues from Nottingham City to provide clear guidance for effective safeguarding practice. The content of the procedures is reviewed twice a year and proposed updates and amendments are considered and approved through the L&WD group.

Training developments

This year we successfully implemented a new on- line course booking system, so delegates no longer had to complete application forms to book onto face to face events. The same learning management system – Learning Pool – is used to access both our e learning and face to face events. Benefits of the new system for users include the ability to:

- Create their own account
- Cancel their place if they are unable to attend and re-book a place
- After an event – complete a short evaluation, print off their certificate and download copy of the PowerPoint and any resources
- View their individual training log which includes all NSCP events accessed

In April 2019 3,017 accounts (not including local authority staff) were set up, and by the end of March 2020 this has increased to just under 5,000.

We have worked closely with the Department for Work & Pensions, and our regional coordinator, to implement the Reducing Parental Conflict (RPC) training programme. Seventeen courses throughout the year have been offered including a variety of modules tailored to suit the

Interagency safeguarding procedures updates

July 2019 amendments:

- Responding to Abuse and Neglect
- Disabled Children
- Female Genital Mutilation
- Harmful Sexual Behaviour
- Online Safety

October 2019

A new chapter on Child Sexual Exploitation was added replacing the previous practice guidance

January 2020 amendments:

- Responding to Abuse and Neglect
- Organised and Complex Abuse
- Guidance for Safe Recruitment, Selection and Retention for Staff and Volunteers
- Child Sexual Exploitation
- Harmful Sexual Behaviour
- Neglect
- Online Safety
- Parents that Misuse Substances

A new chapter on child sexual abuse has been added replacing the previous practice guidance.

For all the details go to: https://nottinghamshirescb.proceduresonline.com/amendments.html

individual's need. Train the trainer 2-day events have been delivered and delegates have been provided with a range of resources to support them delivering the programme to their staff. Nottinghamshire has been at the forefront of this initiative, developing bespoke training materials which have been adopted by the East Midlands region. A targeted event was also provided for staff from educational settings and resources have been adapted and designed for use with parents and carers. The local authority is planning to embed RPC training within Children Centres and the Family Service, and the partnership aims to develop our own e learning to help support and sustain this programme in the future.

In addition to the 15 training pool members (who deliver our working together course throughout the year) a significant amount of the NSCP training is supported and/or delivered by practitioners from partner organisations with specialisms in particular areas of practice. Their support and local expertise is greatly appreciated and enables delegates to benefit from inputs by highly skilled front-line practitioners with current local knowledge of policies and procedures. Over the last year 45 colleagues, from a variety of organisations, have supported us to deliver our annual training programme and it would not be possible without their assistance.

Learning & Workforce Development – Key Priorities

- Following on from the establishment of the new safeguarding arrangements, the Strategic Leadership Group reviewed the financial contributions made by all partners which support, amongst other things, the NSCP training programme. The outcome is that as from 1st April 2020 we implemented a revised charging policy. For most partners there will be no change as their organisations contribute financially to the Partnership, but for others this will mean paying directly for training and e learning. Our priority is to ensure that high quality multi-agency safeguarding training is available for those that need it and we will be working to ensure that the revised charging arrangements do not adversely impact on this.
- The restrictions arising as a result of the COVID-19 pandemic were being implemented towards the end of this reporting period and we are currently working on providing multi-agency training through alternative means using video conferencing and online learning.
- The Learning & Workforce Development Group will continue to take on responsibility for maintaining the cross authority inter-agency procedures, ensuring clearer links and references regarding the procedures are incorporated within the face to face and e learning courses.
- Developing new training courses as the need arises including; Child Criminal Exploitation, Early Help Assessments and How to Make Effective Referrals.
- Develop a rolling programme list of courses offered, to ensure the Partnership offers core safeguarding children training on a regular basis – to allow for new staff and refreshers in subjects.

Case reviews

The purpose of the Child Safeguarding Practice Review (CSPR) group is to lead on the following areas on behalf of the Nottinghamshire Safeguarding Children Partnership (NSCP):

- Undertaking a 'Rapid Review' of cases in accordance with NSCP procedures.
- Making decisions about whether to undertake a Child Safeguarding Practice Review and agreeing Rapid Review Reports on behalf of the safeguarding partners.
- Receive details of cases which have undergone a Rapid Review and undertake further analysis when requested by the safeguarding partners.
- Undertake learning reviews.
- Draft Terms of Reference for Child Safeguarding Practice Reviews.
- Oversee the conduct of Child Safeguarding Practice Reviews.
- Report to the Safeguarding Assurance and Improvement Group with review findings and recommendations.
- Dissemination of learning via the Learning and Workforce and Development group.
- Informing the Safeguarding Assurance and Improvement Group of any emerging issues and risks.

The full CSPR group meets quarterly, is chaired by the Detective Chief Inspector, Quality and Compliance, Nottinghamshire Police. The Head of Public Protection, Nottinghamshire Police, maintains an oversight of the group on behalf of the SLG and provides regular updates to the SLG. Members of the CSPR Group and include representatives from: -

- Nottinghamshire Police
- Nottinghamshire County Council (NCC)
    - Children's Social Care
    - Education Learning and Skills
    - Public Health
- Nottingham and Nottinghamshire Clinical Commissioning Group
- NHS Bassetlaw Clinical Commissioning Group
- Nottinghamshire Healthcare NHS Foundation Trust
- Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
- Nottingham University Hospital NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust

Child Safeguarding Practice Review Group – key facts

Rapid Reviews – 7 undertaken in total: -

- ❖ 5 Rapid Reviews – learning identified no further review needed.
- ❖ 1 Rapid Review – initial learning identified and CSPR (RN19) commissioned to further explore issues.
- ❖ 1 Rapid Review – initial learning identified, CSPR recommended to further explore issues.
- ❖ The National CSPR Panel has agreed with all the decisions made as a result of our local Rapid Reviews.

6 of the 13 recommendations arising from Rapid Reviews have been completed – the remaining actions are in progress.

Child Safeguarding Practice Reviews (CSPR)

1 CSPR (RN19) completed and is pending publication once a Coroner's inquest has been completed.

Monitored the completion of all outstanding recommendations and actions from QN17 Serious Case Review

Support for the group is provided by the NSCP Development Manager and NSCP Development Administrator, funded by Nottinghamshire County Council.

There is a statutory requirement on the Local Authority to identify 'Serious Child Safeguarding' cases and to refer them to the National Child Safeguarding Practice Review Panel (NCSPRP), Ofsted and the Child Safeguarding Partners for the area within 5 days of becoming aware of the case. The mechanism for this is through the submission of a Serious Incident Notification (SIN). Once a SIN is received by the Safeguarding Partners, they must conduct a 'rapid review' within 15 working days and provide a report to the NCSPRP.

In order to meet this requirement, the CSPR group also meets on an ad hoc basis, as and when required, to complete a Rapid Review. When undertaking such reviews, the CSPR Group consists of representation from the three 'Safeguarding Partners', that is Police, Local Authority and CCG for the area where the incident occurred as a minimum with other organisations being invited if necessary.

The NSCP undertook seven Rapid Reviews and one Child Safeguarding Practice Review (referred to as RN19) during 2019/20. Details of the learning from these reviews, and the action taken, is set out in the learning from case review section below.

In addition to reviews undertaken locally the NSCP also supports reviews commissioned in other areas that may have involved services from Nottinghamshire. One such review was commissioned by Waltham Forest Safeguarding Children Board in relation to 'Child C'. This child lived in Nottinghamshire before moving with his family in the early spring of 2018 to live in Waltham Forest. On 1st April 2019 NSCP coordinated a practitioner workshop, facilitated by the Lead Reviewer, John Drew, to consider events and any learning from Nottinghamshire. The Serious Case Review was published on 26th May 2020 and on 12th June 2020 the findings from the review were presented by John Drew at a Nottinghamshire and Nottingham City Partnership Forum.

In December 2017 Leicester City Safeguarding Children Board commissioned a Serious Case Review following the death of a 1-month old baby as a result of non-accidental injury. The child's mother, previous partner and 3 children had lived in Nottinghamshire prior to mother moving to Leicester. In 2018 Nottinghamshire agencies contributed to the SCR and a final overview report was signed off by the Leicester City Safeguarding Children Board on 22nd July 2019. Publication of the overview report is pending the completion of the criminal process.

Learning from case reviews

Child Safeguarding Practice Review RN19

Child R (age 15) was found on the settee in the living room unresponsive. Emergency services were called, and the child sadly died later in hospital. The child's death was due to anorexia nervosa (AN) which had not been recognised as a potential problem in the child's life.

The learning from this CSPR can be grouped into three main areas

- eating disorders in adolescence
- engaging adolescents in their own health care
- promoting child health welfare in the school and elective home education settings

The CSPR found the following features of eating disorder to be present in this case

- Restrictive eating.
- Excessive exercise.
- Difficulty in the sufferer recognising that they have a problem.
- AN is very complex and children need specialist services to support them.
- AN is a disease which often causes sufferers to act in a very secretive and manipulative way, including hiding their poor eating habits, wearing baggy clothes or covering their face with hair, often effectively hiding the extent of their problem from loved ones and professionals.
- Sufferers can continue to function at a deceptively high physical level even when severely malnourished.
- Professional curiosity is important in all areas of practice.
- Parents and professionals need to be aware of the warning signs and seek early help

Practice learning - engaging adolescents in their own health care

- Was not brought (previously known as 'did not attend') – need to ensure each missed appointment is reviewed including missed investigations such as blood tests. Monitor via scheduled tasks on electronic patient record.
- Continuity of care – children should see the same clinician to promote communication and trust.
- Faltering weight in children – when weighing children remember to compare the result with any other previous weight and trends recorded, using a growth chart.
- Opportunity to see adolescents on their own - give the child chance to speak with a professional confidentially.
- Use of HEADSSS – a psychosocial tool for interviewing adolescents about issues affecting their life.

Practice learning - promoting child health & welfare in the school and elective home education settings

- Professionals should flag children on their system records to highlight their EHE status.
- There is no legal regulation for children receiving EHE to be seen.
- EHE advisors are only legally regulated to inspect an EHE child education programme annually.
- EHE children may not have their homes visited – education programmes must be seen but seeing the child at home is not required.
- EHE children can be socially isolated and this increases vulnerability

Action being taken

Health

- Further briefings, communications and showing of the 'Was Not Brought' (WNB) animation to raise awareness of the issue amongst GPs
- Development of a local health systems pathway to complement the faltering growth NICE guidance
- Development of an 'alert' process so that GPs are aware of children who miss their blood tests (and other tests) so that they have the opportunity to review the case and make a decision on next steps.

Education

- Actions in relation to the effective transfer of information from School to the Local Authority when a child becomes subject to elective home education (EHE)
- Provision of safeguarding training for EHE advisors
- Review of children who are EHE who are awaiting a place at another school
- Specific actions for individual schools involved in the review in relation to the sharing of information and information provided to parents

NSCP

- Awareness raising of the learning from the review
- To receive assurances via audit and other means from the Local Authority in relation to the effective functioning of the EHE system
- Through links with the National Child Safeguarding Practice Review Panel to request a national review of EHE non-statutory guidance

Rapid Reviews

The rapid reviews undertaken have shown clear evidence of agencies working together, sharing information, and effective planning.

When children have been reported missing from home procedures being followed with return interviews being completed and children appropriately being referred to the multiple missing/ hotspots meeting.

Some issues however have been identified and the following action is being taken: -

- Children's social care are working with health colleagues to improve the commissioning of placements for children that are intent on serious self-harm
- Police are promoting the concept of 'contextual safeguarding' within the Public Protection Unit and the wider Police Service
- The police are exploring ways that they can extend existing information sharing arrangements with schools to include other violence within families
- Further promotion of the bruising in babies pathway to guide practitioners as to what action to take when they become aware of an unexplained mark or bruise
- Work to standardise GP safeguarding 'red card' meetings – these meetings are used to raise safeguarding issues within GP practices
- In early 2019 Nottinghamshire introduced the Child Protection – Information Sharing (CP-IS) service which is an NHS England sponsored work programme which delivers a higher level of protection to children who visit NHS unscheduled care settings such as: accident and emergency; maternity; minor injury units; out of hours; paediatric wards and walk-in centres. Our rapid reviews identified some good practice in the use of the CP – IS system however a need to further promote the use of CP-IS was identified
- Audit work involving children's social care and health colleagues to consider record keeping and the sharing of minutes
- Police are taking action to improve consultation and information sharing with the Youth Justice Service
- Police to convene multi-agency meetings, known as Neighbourhood Safeguarding Disruption (NSD) meetings, following incidents of serious violent crime to map out the peer group of young people involved in the violent incidents and to identify and put in place measures to protect others at risk of reprisals, retribution and further violence

Safeguarding Partnership Priorities – 2020/23

The following priorities have been identified by the Partnership and will be the focus for improving safeguarding work over the next 3 years. The SAIG will regularly review progress and identify any emerging issues that require action.

Preventing neglect

Neglect continues to be the most common cause for concern about significant harm to children in Nottinghamshire. At the end of 2019/20 out of a total of 798 children who were subject to a child protection plan 488 were under the category of neglect, 349 for emotional abuse, 100 for physical abuse and 52 for sexual abuse (a child may have more than one category of registration).

The Triennial Analysis of Serious Case Reviews[7] (https://seriouscasereviews.rip.org.uk/) highlights the prevalence of neglect in the most serious child safeguarding cases. It recognises that poverty leads to additional complexity, stress and anxiety and can heighten the risk of neglect. Whilst most children living in poverty do not experience neglect the co-existence of poverty and neglect can escalate adverse outcomes. The national analysis found recognition of poverty and its impact on parenting was often missing. If recognised, poverty was often perceived as an outcome not a cause of a family's needs and difficulties. Professionals working in deprived communities can become desensitised when working with families in poverty and accept lower standards or care'.

The Partnership acknowledges that tackling neglect is a long-term challenge and that COVID-19 is likely to have increased the risk. The Partnership will therefore develop a new strategy to define and guide our approach. Whilst there are factors which are outside the control or influence of the Partnership the new strategy will set out the Partnership's contribution to preventing neglect.

COVID-19

Ensuring that we understand and respond to the impact that COVID-19 has had, and continues to have, on children and young people has been a priority for the Partnership from March 2020. In particular concerns around increased domestic abuse and children and young people's mental health have emerged as the effect of the pandemic has increased. The pandemic has also affected how services are delivered and, in some cases, led to services being suspended.

The Partnership has put in place measures to ensure that the multi-agency framework for safeguarding children continues to operate effectively. This has included monitoring demand on services, considering any new working practices and assessing their impact on children and for partnership working

Risks during the recovery period have been identified and mitigation put in place along with arrangements to monitor progress.

New ways of working have been developed ranging from using technology to keep in contact with children and families, online child protection conferences and virtual seminars and training events. The Partnership will review the benefits that these have offered and look towards retaining good practice.

Improving the initial multi-agency response to safeguarding concerns

Having completed a significant amount of work to understand how to improve strategy discussions the next steps for 2020/21 will be to implement a new pathway for engaging health professionals in the process. This should lead to a significant improvement in compliance with the requirements set out in statutory guidance. There will be three stages to this work:

[7] Complexity and challenge: a triennial analysis of SCRs 2014-17 (Department for Education March 2020)

- Implement proposals for the MASH Health Team to represent health at strategy discussions
- Review the impact of the new process being introduced, identify any further action needed including communications and training requirements
- Continue performance monitoring against the benchmark

Contextual safeguarding

This area of safeguarding practice is still relatively new, to date the Partnership has focused on reviewing current arrangements for responding to risks from outside the family, reinforcing existing pathways and raising awareness. A new Serious Youth Violence and Child Criminal Exploitation Panel has also been introduced to support practitioners to protect those at high risk.

The recent National Child Safeguarding Practice Review: Safeguarding Children at Risk of Criminal Exploitation[8] , identified that further action is needed to protect adolescents from criminal exploitation. The review included a recommendation to review statutory guidance, Working Together to Safeguard Children 2018, as well as questions and challenges for local partnerships. Nottingham and Nottinghamshire Safeguarding Children Partnerships have agreed to establish a Contextual Safeguarding Strategic Group to coordinate developments in this area of practice. A key task for the new group will be to develop a Contextual Safeguarding Strategy and work plan on behalf of both partnerships. The group will monitor national developments with the statutory guidance and proposed practice framework and address the local challenges posed by the national review under the following headings:

- Problem identification
- Supporting staff
- Service design and practice development
- Quality assurance

Areas of work previously identified including; development of place-based intelligence sharing and interventions, ensuring exploitation work is connected, raising awareness, developing a cultural shift, and multi-agency training will be taken forward and coordinated through the new group.

Information sharing

Local and national reviews continue to highlight the importance of information sharing and the need for safeguarding partnerships to ensure that information is shared effectively to facilitate more accurate and timely decision making for children and families. The Partnership will continue its work in this area.

- Identify what information sharing systems need to be in place to support a multi-agency approach to child criminal exploitation
- Monitor CP-IS and police child protection plan flag/alert system to ensure they continue to operate effectively and
- Review the basis for checks to be undertaken by the Safeguarding Children Information Management Team (SCIMT).

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

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

Practitioners should tailor support around the needs of individual children and local organisations and agencies need to have a clear understanding of the collective needs of children locally when commissioning effective services. Details of how the Partnership seeks the views of children and families about their needs, and the services provided to them, are set out at the beginning of this report. With the new arrangements now fully operational and embedded we would like to develop this further.

- Review and update the communications and engagement strategy, particularly in relation to children, young people and their families, and strengthen arrangements for gathering their views
- Use the Joint Strategic Needs Assessment (JSNA) prepared by the Director of Public Health to help understand the prevalence and contexts of need, including specific needs relating to children with disabilities and those relating to abuse and neglect, to help shape services

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

Partner agencies under the arrangements should provide services to children and families that are inclusive and accessible to everyone when needed. The following areas of work have been identified for assurance:

- The experience of black families and implications for approach/practice are understood and responded to (black meaning black and Asian)
- The experience of other minority ethnic families and implications for approach/practice are understood and responded to
- Review the availability and sufficiency of specific training in working with children and families from abroad, FGM, forced marriage, honour -based violence, religious and ritualistic abuse and unconscious bias training

Nottinghamshire Safeguarding Children Partnership

NSCP Business Cycle v0.1

	January	February	March	April	May	June	July	August	September	October	November	December
SLG	Interim budget Agree Business Plan Emerging issues and current reviews Partnership Forum planning NSCP groups exception reporting			Emerging issues and current reviews Partnership Forum planning NSCP groups exception reporting			Emerging issues and current reviews End of year budget NSCP Annual report Partnership Forum planning NSCP groups exception reporting				Emerging issues and current reviews Review Business Plan Set priorities for safeguarding improvement NSCP groups exception reporting	
Partnership Forum		Partnership update Focus on safeguarding practice x 2 Networking Consultation			Partnership update Focus on safeguarding practice x 2 Networking Consultation						Partnership update Focus on safeguarding practice x 2 Networking Consultation	
SAIG		Agree audit programme Improvement workstreams Business intelligence reports Frontline visits		Q3 PPM Improvement Workstreams Business intelligence reports Frontline visits		NSCP Annual report Annual PIR Q4 PPM Improvement Workstreams Business intelligence reports Frontline visits		S.11 self assessment Improvement Workstreams Business intelligence reports Frontline visits		Q1 PPM Review audit programme Improvement Workstreams Business intelligence reports Frontline visits		Q2 PPM Improvement Workstreams Business intelligence reports Frontline visits
L & WD	Training analysis feedback Training programme Course evaluations NSCP update		Training programme Course evaluations NSCP update		Procedures update		L & WD Annual Report Course evaluations NSCP update			Training analysis review Course evaluations NSCP update	Procedures update	
CSPR	Review of action plans Update on CPSRs SIN/Rapid Reviews TOR for new Reviews Impact log Emerging issues/risks			Review of action plans Update on CPSRs SIN/Rapid Reviews TOR for new Reviews Impact log Emerging issues/risks			CSPR annual report Review of action plans Update on CPSRs SIN/Rapid Reviews TOR for new Reviews Impact log Emerging issues/risks			Review of action plans Update on CPSRs SIN/Rapid Reviews TOR for new Reviews Impact log Emerging issues/risks		

Appendix B- Finance

Income

Partner Contributions	
Nottinghamshire County Council	£142,848
NHS Nottinghamshire County CCGs:	£64,404
NHS Bassetlaw CCG	£19,253
Police	£17,612
DLNR CRC Ltd	£2,000
National Probation Service	£1,647
CAFCASS	£550
	£248,314

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

Income generated	
Training Fees & non-attendance charges	£9,104
Safeguarding Information Management Team (SCIMT) safeguarding checks (for external bodies)	£11,006
	£20,110

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

Grants/other contributions	
Office of the Police & Crime Commissioner (VRU)	£11,130
Department for Works and Pensions	£45,100
	£56,230

Directly funded posts	Cost (including on costs and expenses)	Funding source
Service Manager Partnerships & Planning	£65,750	Funded 50/50 by Nottinghamshire County Council and NHS Nottingham and Nottinghamshire CCG
NSCP Development Manager	£59,335	Funded by Nottinghamshire County Council
Child Death Administrator	£24,463	
Total	**£149,548**	

Expenditure

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

Expenditure	End of year	Explanation/notes
Administration • **NSCP Administrator** • **Online procedures** • **ECDOP system** • **Communications** • **Printing**	£41,507	The NSCP SLG, SAIG and Partnership Forum are supported by the NSCP Administrator. Online procedures are provided through TriX and jointly funded with Nottingham City. ECDOP is the software used for the child death review work and is funded through the NSCP. A significant amount of new material was developed during the year to promote safeguarding including booklets, leaflets and other awareness raising materials.
Case Reviews • **Lead Reviewer**	£3,425	Increased use of effective in-house Rapid Reviews has resulted in reduced costs for Child Safeguarding Practice Reviews.
SCIMT • **3 x FTE posts**	£72,621	The SCIMT undertake checks for partner agencies and outside organisations to aid safeguarding decision making and safer recruitment.
Independent Scrutineer • **(inc. DBS, computer equipment)**	£13,572	The transition to the new arrangements and appointment of a new Independent Scrutineer led to reduced costs this year.
Training • **Training Coordinator** • **Training Administrator** • **Venue costs** • **External training providers** • **RPC Coordinator** • **RPC E learning** • **Learning Management System, including E learning**	£127,052	A Training Coordinator and Administrator develop and coordinate the delivery of a full multi-agency safeguarding training programme. Reducing Parental Conflict (RPC) training has been rolled out across the partnership. Two postponed courses will be re-scheduled during 2020/21. The partnership uses a learning management system to support its face to face and E learning delivery.
Contextual Safeguarding Conference	£9,982	A joint conference with 350+ attendees
Total	**£268,159**	

Appendix C – Performance Management

Quality Management

- Child Safeguarding Practice Reviews
- Multi-agency learning audits
- Single agency audits
- Inspections & Frontline Visits

Performance Data Management

Performance Priority Areas (each quarter)

- S.136 Mental Health Act
- Child Sexual Exploitation
- Contextual Safeguarding
- Child protection multi-agency frameworks
- Safeguarding non-mobile babies
- Information sharing

Performance Information Report (annually)

- Early Help - EHU referrals, Family Service Case Management
- MASH – no. of enquiries, repeat enquiries, outcomes
- Children's social care assessments – referrals, child & family assessments
- Child protection enquiries – strategy discussions, s47 enquiries
- Child Protection Conferences & outcomes
- Participation in child protection conferences
- Managing allegations re people who work with children
- Particularly vulnerable children – LAC, children affected by domestic abuse, Special Guardianship Orders, children described as 'self-harming', FII, Elective Home Education, young people's mental health, children suffering neglect, missing from home or care, children at risk of CSE

Business Intelligence Management

Annual Reports from Key Business Areas

Health of Looked After Children	Clayfields – use of restraint
Rampton Hospital – visits by children	Parental Mental Health/Substance Misuse
FGM Steering Group	Historical/Non-recent abuse
Missing children	Private Fostering
Prevent Strategy & Channel Panel	Allegations Against Staff or Volunteers
Child Protection Coordinators	Independent Reviewing Officers
Safeguarding Children in Education	Domestic abuse

Monitoring & Coordination by SAIG

- Quality Management
- Performance Data Management
- Business Intelligence Management
- Practice Improvement

Practice Improvement

Practice Improvement Workstreams

- CSE
- Contextual safeguarding
- MASH
- Strategy discussions
- Suicide/self harm
- Injuries to non-mobile babies
- Information sharing

Learning & Workforce Development

- Annual TNA
- Training Programme
- Seminars
- Workshops
- E Learning

Procedures & Guidance
6 monthly updates

Performance Management Framework

Nottinghamshire Safeguarding Children Partnership

V0.4