Nottinghamshire
SAFEGUARDING
CHILDREN Board

Working in Partnership to Safeguard
Children & Young People

ANNUAL REPORT

2016 – 2017

TABLE OF CONTENTS

Contents

TABLE OF CONTENTS

Essential information

This report has been compiled on behalf of the Nottinghamshire Safeguarding Children Board (NSCB) by Steve Baumber, NSCB Manager. It has been produced in consultation with members of the NSCB Executive and approved by the NSCB. The content is drawn from the work of the NSCB and its sub groups including; reports presented to those groups; records of meetings; multi-agency audit findings; s.11 self-assessments; and the findings from serious care reviews and other forms of case review.

The report will be published in October 2017 and will be a public document.

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

FOREWORD FROM THE INDEPENDENT CHAIR

Foreword from the Independent Chair

Welcome to the 2016/17 Nottinghamshire Safeguarding Children Board Annual Report.

This report sets out what we have learned about the effectiveness of safeguarding arrangements in Nottinghamshire. In the section entitled 'Learning and Improvement Framework' details can be found of the learning from reviews and audit including many positive aspects of local safeguarding practice such as improvements across all key areas of work related to child exploitation, effective management of early help cases and some good quality assessments leading to good outcomes for children in neglect cases.

Areas for development are set out in the last section within the report and include a focus on improving key elements of interagency safeguarding such as, the use of strategy discussions to coordinate multi-agency action and better use of processes to resolve professional disagreements, as well as broader objectives for the Board and measures to improve NSCB functions.

The past year has seen continued improvements to the safeguarding children arrangements in Nottinghamshire and I am satisfied that organisations are working effectively to keep our children and young people safe.

The year ahead is likely to see the development of plans to change the way safeguarding arrangements are coordinated across the county. The Children and Social Work Act 2017 has now been enacted, however provisions of the Act relevant to safeguarding children will not come into force until the Secretary of State makes appropriate regulations by statutory instrument. The Act allows greater flexibility around how safeguarding arrangements are delivered locally and new statutory guidance is expected which will provide further information. Responsibility for undertaking child death reviews will pass from Local Safeguarding Children Board (LSCB) Independent Chairs to '*child death review partners*' (local authority and clinical commissioning groups). The NSCB will be supporting the '*safeguarding partners*' (police, local authority and clinical commissioning groups) and

FOREWORD FROM THE INDEPENDENT CHAIR

'*relevant agencies*' (to be specified within regulations) to develop a plan to introduce new safeguarding arrangements based on the revised statutory guidance.

Please take a look at the NSCB website to find out more about the day to day activities of the Board, links to relevant sections of the website have been included within the report to help you find further information.

Chris Few
NSCB Independent Chair

INTRODUCTION

Introduction

The Nottinghamshire Safeguarding Children Board (NSCB) was established in accordance with the Children Act 2004 to coordinate what is done by partner organisations to safeguard children and ensure the effectiveness of that work. It operates in accordance with statutory guidance, Working Together to Safeguard Children (2015), which provides the framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

The NSCB has three strategic priorities:

- Through a comprehensive understanding of the needs of children and young people in Nottinghamshire, to ensure that the work of the NSCB is focussed on the most vulnerable, their safety and empowerment

- To provide effective scrutiny of safeguarding outcomes for children and young people; embed the NSCB learning and improvement framework and ensure that training, procedures and guidance support improvements in safeguarding children

- Strengthening the role and engagement of partner agencies in the work of the NSCB and developing a culture of open and transparent self-analysis. Improving communications with key stakeholders, in particular children and young people. Ensuring frameworks to support safeguarding are in place and that the NSCB is effective at the delivery of its core purpose (in line with Working Together 2015)

Further details about how the NSCB operates can be found in the about-the-board section of the NSCB website. In particular:-

- the constitution describes partnership relationships, roles and responsibilities and now includes further detail on the function of advisors to the Board
- the business plan 2016-18 outlines objectives for the Board under the three strategic priorities
- minutes of Board meetings provide details of the issues that have been dealt with by the Board over the past year

INTRODUCTION

- a description of the roles of the NSCB Executive and sub groups including the Child Death Overview Panel (CDOP), Serious Incident Review Sub Group (SIR), Multi Agency Audit Sub Group and Learning and Development Sub Group

The NSCB is funded by contributions from partner agencies and this enables a small team to facilitate the work of the Board, coordinate and deliver multi agency training and provide high quality safeguarding procedures and guidance. A list of NSCB members, advisors and supporting staff is attached to this report (**Appendix A**).

One of the ways safeguarding performance is monitored by the NSCB is through the provision of a quarterly Performance Information Report (PIR) to the Executive. An annual version of the PIR is available via the NSCB website under the heading NSCB Annual Report.

NSCB UPDATES

NSCB updates

PROCEDURES AND GUIDANCE

The online NSCB safeguarding procedures were updated twice during the year (November 2016 and April 2017) to ensure they remain current and include learning from local and national sources

Full details of the amendments made to the content in this latest update are available in the 'Using this Manual' section of the procedures and include:

- Responding to Abuse and Neglect - an additional section concerning the responsibilities of schools and colleges and further information on the investigation of physical abuse
- Children Living Away from Home - links to further information regarding private fostering
- Children Missing Education – links to statutory guidance and advice
- Trafficked Children – links to further information about Modern Slavery Act 2015
- Safeguarding Children and Young People Against Radicalisation and Violent Extremism – clarification regarding the online reporting process and useful links
- Self-Harm and Suicidal Behaviour - information about self-harming behaviour in primary school age children

The Pathway to Provision is a handbook designed to support practitioners to identify an individual child's, young person's and/or family's level of need and to enable the most appropriate referrals to access provision. The handbook describes the thresholds for different levels of provision and is produced by Nottinghamshire County Council Children, Families and Cultural Services in consultation with partner agencies on behalf of the NSCB. A revised version of the handbook was approved by the NSCB during the year.

NSCB UPDATES

COMMUNICATIONS AND DISSEMINATING LEARNING

A new Communications and Engagement Strategy has been developed and agreed which sets out the communication aims of the NSCB, target audiences, key messages, methods of communication and approach to engaging with children, young people and families. The strategy will be used as a benchmark against which the success of the NSCB communications and engagement will be measured and actions will be identified to address any gaps.

The NSCB website continues to be the primary means of communication with NSCB stakeholders and includes resources for professionals, parents/carers and children and young people. It was recognised that children and young people are unlikely to seek out safeguarding information from the NSCB website and the Board was pleased to support financially, and through consultation with members, the work led by Nottinghamshire County Council Public Health and Nottinghamshire Healthcare NHS Foundation Trust to provide a website specifically aimed at young people. The Health for Teens website has now been launched and includes useful local information and advice on issues such as emotional health and wellbeing, sexting and self-harm.

LEARNING AND IMPROVEMENT FRAMEWORK

Learning and Improvement Framework

The NSCB Learning and Improvement Framework enables partner organisations to improve services by providing clarity about responsibilities, enabling learning from experience and particularly through the provision of insights into the way organisations work together to safeguard and protect the welfare of children.

The NSCB has a robust multi-agency audit process and ensures improvement is monitored through repeat audit in priority areas. There is a strong learning and development programme linked to national and local issues, and learning from serious case reviews helps guide the content of the programme. The lead officers for each of these areas of work meet regularly to coordinate activity and ensure that learning is embedded into practice. The Performance Information Report (PIR), reviewed by the NSCB Executive each quarter, provides an indicator of areas for further exploration, agency inspections and audits offer an additional source of learning as do the targeted visits to frontline operational sites carried out by NSCB members.

The sub groups that support the Learning and Improvement Framework are chaired by members of the NSCB representing different partner organisations. Annual reports on the effectiveness of these groups were presented to the NSCB for assurance in June 2017.

Learning and Development

The Learning and Development sub group has overseen the delivery of a multi-agency training programme focussed on the key learning from case reviews and the outcomes of case audits. Examples of training courses developed to respond to issues identified through local reviews include; *Decision Making and Disguised Compliance, Hidden Men, Information Sharing and Neglect.* Learning from multi agency audits has been incorporated into existing core training.

Training levels have been developed and introduced to further clarify which staff groups would most benefit from attending specific training events and these have been incorporated into a revised Safeguarding Children Training Pathway. A new Level 4 course, aimed at safeguarding leads, was introduced during the year and proved particularly popular with GPs.

LEARNING AND IMPROVEMENT FRAMEWORK

As ever the NSCB is extremely appreciative of the commitment shown by the members of the training pool, drawn from partner agencies, which make delivery of a comprehensive training programme possible. This year we were fortunate to welcome seven new members to the training pool providing an even more diverse range of experience and expertise to draw on. Over 2,100 staff working with children and families have been able to attend the 43 NSCB training events held during the year. It was particularly encouraging to see a significant increase (up from 292 to 363) in the numbers of school and college staff taking up the opportunity to attend multi agency NSCB training to supplement the school specific courses available through Nottinghamshire County Council

The NSCB also funded a new E learning package which expanded the subjects available through this convenient method of learning from four to 22. Over 4,100 staff completed E learning modules on safeguarding issues including; awareness of abuse and neglect, child sexual exploitation and safe sleeping for babies. The NSCB has also continued to use its links with schools to promote safeguarding awareness in the community, encouraging parents and carers to complete an E-learning module on the risks of CSE and providing information regarding Female Genital Mutilation (FGM).

Post course evaluations indicate that levels of confidence to deal with safeguarding issues show significant improvement as a result of the training provided through the NSCB and satisfaction with the quality of training provision continues to be very high.

Serious Case Reviews

Wherever possible children, young people, parents and carers are involved in reviews that affect their families. This will usually take the form of being contacted at the start of the review to inform them about the arrangements for the review and explain what it hopes to achieve. Then at an appropriate stage a meeting is arranged with the Lead Reviewer to provide an opportunity for the children and family to offer their perspective and hear what the review has found out up to that point. It is expected that SCRs are published and therefore need to be anonymised. The NSCB has used an alpha-numeric system to identify SCRs and this year we introduced an expectation that children and families are specifically asked if they wish for any particular pseudonym to be used to represent the child concerned.

LEARNING AND IMPROVEMENT FRAMEWORK

During the year four cases were referred to the Serious Incident Review (SIR) sub group for consideration.

- In two of the cases the SIR sub group recommended that the criteria for an SCR was not met, the NSCB Independent Chair agreed and following submission of relevant information to the National Panel of Independent Experts (NPIE) both decisions were endorsed by that panel.
- In a third case the SIR sub group recommended that the criteria for an SCR was met. The NSCB Independent Chair agreed with the recommendation and a SCR (PN16) was commissioned and is ongoing at this time.
- In the fourth case the SIR sub group recommended that the criteria for an SCR was not met however the NSCB Independent Chair disagreed but took the view that whilst the criteria for an SCR had been met there would be no useful purpose in conducting a local SCR. The NSCB Independent Chair concluded that learning from the circumstances of this case had already been extracted by the services involved and any potential remaining issues could only be practically explored through a national review. The NPIE were engaged in the deliberations over the appropriate course of action to take and whilst a national review was not commissioned by them they agreed that the final decision regarding a local SCR rested with the NSCB Independent Chair.

Two SCRs (LN15 and NN15) that commenced during the previous reporting period were completed and signed off by the Board. Both reports were published via the NSCB website and Learning Bulletins prepared and circulated to NSCB partners to aid the dissemination of learning.

In addition to the SCR commissioned during the year (PN16) three reviews were ongoing at the end of the reporting period. This was due to a number of factors including the complexity of the case, parallel criminal/coronial proceedings and restrictions on access to children, families and professionals involved. Two of these reviews have now been signed off by the Board and the third is very near completion. Arrangements for publication of these reports will be made once all other outstanding proceedings have been completed.

LEARNING AND IMPROVEMENT FRAMEWORK

The SIR sub group has actively monitored the action being taken in relation to competed reviews on a regular basis. During the reporting period the sub group monitored the completion of 14 out of 21 outstanding actions from serious case reviews. Of the remaining outstanding actions three are long term actions where appropriate progress has been made and four relate to a review only recently signed off by the Board.

The learning identified through SCRs has been incorporated into existing multi-agency safeguarding courses and where required bespoke training events have been devised and delivered during the year as outlined earlier in this report. The 'What's New in Safeguarding' half day events are also used to disseminate learning from case reviews. In addition two seminars were held this year pulling together the learning from recent local and national SCRs – one of the events was targeted at practitioners and the other provided an opportunity for senior managers and NSCB members to consider the issues raised from a strategic perspective.

At the conclusion of each SCR a learning and improvement bulletin has been published providing a simple tool for disseminating the learning. The review reports and learning bulletins can be found in the learning from practice section of the NSCB website.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – LN15

This was a young boy who had a long history of health involvement in connection with developmental delay. He attended mainstream school and was well supported by staff. Despite extensive investigations medical staff were not able to find a diagnosis for his condition and as he grew older mother disengaged from a number of services. A booking system was introduced at LN15's hospital which required parents to 'opt in' to appointments and this led to contact with the paediatric service coming to an end. His school attendance dropped appreciably in the weeks prior to his death. LN15 died aged 8 years as a result of pyelonephritis (kidney infection), which is normally a treatable condition.

The SCR identified the following key learning regarding the effectiveness of safeguarding practice:

- **Children with a disability or additional health needs are a particularly vulnerable group as signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.**
- **Non-compliance may be a parent's choice, but it is not the child's: 'Any non-engagement with services that are central to a child's welfare should be seen as carrying potential harm for the child.**
- **A shift away from the term DNA (did not attend) to WNB (was not brought) would help 'maintain a focus on the child's ongoing vulnerability and dependence, and the carers' responsibilities to prioritise the child's needs'.**
- **Agencies should give due regard to safeguarding children during organisational change.**
- **Specialist health services should have a mechanism for reporting back to the service which made the initial referral.**
- **There is no legal requirement to register or re-register a child with a General Practitioner. It is therefore important that health organisations make 'routine enquiries' in relation to GP registration in order to identify those children with health needs who are not registered.**

Response by the NSCB:

The NSCB has utilised an excellent video animation developed by colleagues in Nottingham City to promote the message to 'Rethink Did Not Attend' . Arrangements are in place to gain assurance from partners that safeguarding implications are considered when introducing organisational change. Single agency actions to address specific issues are also being monitored.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – NN15

'Alex', who was 15 years old at the time of her death, lived with her mother and step-father. Prior to her death there was no involvement with services other than universal services. 'Alex' took her own life by hanging although it was not possible to determine what her intention was at the time she took this action. Five to six months prior to her death three of Alex's friends had approached school staff to report that she had been self-harming. Police investigations following her death revealed that she had been a victim of abuse from a distant family member who subsequently took his own life.

The SCR identified the following key learning regarding the effectiveness of safeguarding practice:

- **Three factors now known to be associated to Alex's death; self-harm, abuse and depression, however prior to her death agencies were only aware of self-harm.**
- **Professionals need to be equipped with the knowledge to recognise self-harm and take appropriate action according to their role.**
- **Students may become aware of friends who self-harm or have suicidal thoughts and should be supported to know how to respond.**
- **If a child who is self-harming refuses an offer of support this should be viewed as something which potentially increases his/her level of risk.**
- **Parents and carers require support in recognising the risks that may be posed by individuals and have strategies available to protect children from that risk.**
- **Police Services need to be intrusive in their management of registered sex offenders and make use of dynamic risk assessment tools available to them.**

Response by the NSCB:

Nottinghamshire County Council has developed a model guidance on self-harm for Nottinghamshire schools based on the learning from this review, materials developed in response by the school concerned and good practice from elsewhere. The current multi agency guidance on self-harm is being streamlined to make it more accessible and the NSCB has focused on improving the availability of information for parents and carers to help them protect their children e.g. the use of Sarah's Law.

LEARNING AND IMPROVEMENT FRAMEWORK

Child Death Reviews

During the reporting year 39 children who were normally resident in Nottinghamshire unfortunately died (expected and unexpected deaths). This is a significant decrease from the previous year (50) and whilst numbers are too low to draw any statistical conclusions it is positive and we hope that this will become part of an overall downward trend in future years. There was a marked reduction in the proportion of expected deaths within the total number of deaths, in previous years expected deaths have accounted for approximately two thirds of the total deaths whereas this year they accounted for just over half. It may be that interventions around education, support and care have helped reduce the number of deaths of premature babies however further work and analysis is required to fully understand the significance of this.

Whilst the number of deaths during the year has fallen the CDOP was able to increase the number of reviews completed (58 compared to 35 the previous year). The CDOP reviews the death of a child after the completion of other processes (e.g. Inquests and criminal proceedings) and this sometimes results in a delay before cases are reviewed by the panel.

Identifying trends or patterns in child deaths with a relatively small population is recognised nationally as a challenge. Nottinghamshire and Nottingham City CDOPs meet twice a year to share information and consider strategic issues and this contributes to increased understanding and some shared work programmes. The Child Death Nurse from Nottingham University Hospitals, who attends both CDOPs, also chairs the regional CDOP and sits on the national CDOP working group providing invaluable connectivity and opportunities to share learning.

When reviewing the death of a child the CDOP identifies any modifiable factors and makes recommendations for actions to prevent future deaths. One area where the CDOP has focused attention is the promotion of safer sleeping for babies. The safer sleep working group, established jointly with Nottingham City CDOP, has developed a framework for action with progress being made in each of the following themes: -

- Workforce training, which focuses on the local children's and community workforce being skilled and confident to identify safe sleep risk factors and offer appropriate advice.
- Development and implementation of a risk assessment tool for use by the local community and children's workforce linked to the completion of the NSCB E learning module on safer sleeping.
- Ensuring parents and carers receive suitable resources to help them implement safer sleep environments and follow best practice advice.
- Communications – ensuring safer sleep messages are communicated broadly and regularly.
- Measuring impact – which involves undertaking sample audits of safer sleep practice and monitoring the impact of training.

The early identification and response to sepsis has been raised as an issue both locally and nationally. Partner organisations have developed action plans to improve practice and further confirm and challenge events have taken place during 2016/17 to provide assurance around the progress being made.

Learning from national case reviews

Clearly there is a great deal of value in looking at the learning identified by reviews carried out in other areas and the NSCB has used resources such as the NSPCC national case review repository to support local learning and development.

The NSCB was fortunate to have Dr Peter Sidebotham (University of Warwick) attend and deliver a seminar at the Board meeting in September 2016. The seminar included a model for understanding pathways to harm and pathways to protection for children and enabled Board members to identify the key learning points arising from the triennial review of serious case reviews. An opportunity was provided for Board members to reflect in groups how the learning from the seminar could inform their own practice and lead to improvements in their services.

LEARNING AND IMPROVEMENT FRAMEWORK

Multi-agency audit

The Multi-Agency Audit sub group developed an audit programme for 2016/17 taking into account the NSCB priorities and learning through the learning and improvement framework and was able to significantly increase the number audits undertaken. A total of six multi agency audits and three organisational audits were reported to the Board. Positive feedback from participants in multi-agency audits indicates these are learning opportunities for those involved and this has been recognised through the provision of participation certificates.

Sexual abuse referrals

This audit examined the multi-agency response to sexual abuse referrals and followed the methodology used for a similar audit in 2014.

Learning from the audit:

- Information sharing was good overall between police and social care and adequate steps were taken to ensure the immediate safety of the child.
- Need for consistent interpretation of thresholds – in some cases S47 child protection enquiries were not commenced even though a crime was being investigated by the police.
- Very little liaison found during referral and strategy discussion stage with paediatric service or school health.
- All agencies involved in strategy discussions should have a shared record of the discussion and agreed actions.

NSCB Response

Following the audit report being presented to the Board, police and children's social care senior managers undertook to immediately reinforce with operational staff the need to involve a Consultant Paediatrician in such cases and the Designated Doctor reported an immediate improvement. Further work to improve the effectiveness of strategy discussions is ongoing and being managed by a working group. The Familial Sexual Abuse Audit scheduled for 2017/18 will provide the opportunity for progress against areas for improvement to be checked.

LEARNING AND IMPROVEMENT FRAMEWORK

Children detained under section 136

This cross authority audit examined the cases of ten young people removed to a health based place of safety under the Mental Health Act.

Learning from the audit:

- Children should be transported by ambulance.
- Need for formal multi-agency review of children following use of s136.
- Discharge plans need to be put in place.
- The use of s136 could have been avoided in some of the cases through better risk assessment, de-escalation by residential staff or the availability of mental health street triage workers.
- Overall response by police was appropriate and sensitive.

NSCB Response

An action plan was agreed by the Board and assurance provided regarding the understanding within the MASH and EDT regarding their role in safe discharge. Progress against the action plan was monitored by the Board and when difficulties in following through some of the actions were identified a specific task and finish group, as part of the Mental Health Concordat, was established. A subsequent update provided to the Board confirmed that the action plan was on track and further assurance was provided regarding the day to day monitoring of s136 cases.

Early Help

This audit looked at the threshold for referrals to the family service and the quality of interagency work in the 6 months surrounding a referral to the Early Help Unit.

Learning from the audit:

- Cases were well managed and progressed.
- Professionals worked well together to meet the child's needs.
- Conversations between professionals working with the children led to cases being managed by an appropriate lead professional in most cases.

- Need for a consistent understanding between professionals regarding provision of support while a diagnosis re developmental disorder is being considered for a child.
- Sharing of information with General Practitioners could be improved.

NSCB Response

An initial action plan was developed in response to the audit and this will be reviewed and monitored by the Multi-Agency Audit sub group. The NSCB Independent Chair has requested that the Children's Trust undertake an analysis of pre and post diagnosis support for children where developmental disorder is suspected and the commissioning of services.

Neglect

This audit looked at the response to neglect and the quality of the assessment process and planned intervention.

Learning from the audit:

- Some good quality assessments leading to good outcomes for children.
- Examples of good multiagency working, effective engagement with children and young people and good management oversight.
- Child Protection Coordinators effectively raised practice issues with organisations using a formal process, which resulted in effective management input and improved case progression.
- NSCB escalation not used to resolve professional disagreements.
- Better use should be made of the assessment tools that are available.

NSCB Response

The Board received an update on the action taken following the audit findings being reported. A significant amount of multi-agency training had been delivered in relation to the learning from the audit (see learning and development section) and other aspects of practice improvement (i.e. strategy discussions) had been incorporated into existing work streams.

LEARNING AND IMPROVEMENT FRAMEWORK

Child sexual exploitation (CSE)

This audit used the same methodology as one undertaken in 2015 and was used to compare performance.

Learning from the audit:

- Found improvements in practice across all key areas of identification, response, intervention, engagement and reduction in levels of risk.
- Holding a multi-agency strategy meeting strongly linked to positive outcomes - focus on risks and outcomes for the child.
- Engagement with GPs and sexual health services needs to be strengthened.
- NSCB escalation procedure not used although there were professional disagreements regarding roles and responsibilities in a small number of the cases examined.

NSCB Response

Awareness raising activity regarding the risk of CSE and the role of GPs through training and newsletters, has been undertaken. NSCB Level 4 training has included case studies around resolving professional disagreements and a follow up audit is scheduled for 2017/18.

Strategy discussions

A random sample of 11 strategy meetings were audited from those held in a four week period November/December 2016.

Learning from the audit:

- More than two thirds of the strategy discussions took place within the required timescale.
- Further work is required to ensure that all strategy discussions are compliant with procedural expectations such as appropriate recording.
- Health professionals were only involved in 2 of the 11 cases audited and more generally strategy discussions tended to just involve children's social care and the police.

LEARNING AND IMPROVEMENT FRAMEWORK

NSCB response

The outcome of this audit supported the findings of previous reviews and audits. Considerable efforts have been made in terms of training and guidance however the NSCB concluded that a working group was required to coordinate work to drive forward and embed further improvements and put this in place. Strategy discussions are identified as an area for improvement during 2017/18 and progress will be monitored by the Board.

Organisational audits

Three organisational audit were undertaken during the year. The section 11 is a self-assessment against a set of standards designed to assess compliance with organisational responsibilities under s.11 Children Act to discharge their functions having regard to the need to safeguard and promote the welfare of children. Organisations engaged critically with the audit and persistent improvements were noted across all the standards. The Safeguarding Children in Education Audit (previously known as the Governor Compliance Checklist) fulfills a similar function for educational establishments, the NSCB have worked closely with colleagues in education and the past year has seen enhanced completion rates and actions to achieve further improvement. The harmful sexual behaviour audit involved organisations checking their practice using the NSPCC Harmful Sexual Behaviour Audit Tool and the need for better data and a needs assessment was identified. As a result it was agreed that Brook Sexual Harm Traffic Light tool should be promoted. This has been included in the Pathway to Provision update and also in the programme for 'What's New in Safeguarding' over the next year.

The audit programme for 2017/18

- Missing children
- S11 – organisational self-assessment of safeguarding arrangements (review)
- Familial sexual abuse audit
- S136 (repeat audit)
- Child Sexual Exploitation (repeat audit)

LEARNING AND IMPROVEMENT FRAMEWORK

SCRUTINY AND CHALLENGE

In addition to case reviews, programmed audit work and the analysis of performance information routinely provided, the NSCB has further scrutinized and challenged a range of issues. The following section provides examples:-

Medical assessments and the commissioning of a sexual abuse referral centre

Arrangements for the provision of medical assessments for children suspected of being subject to sexual abuse have been reported to the Board. The NSCB has supported the effective use of current arrangements and has sought assurances that the service will continue whilst commissioning processes for a sexual abuse referral centre (SARC) are underway and until the new service has become operational. The NSCB Independent Chair has also communicated to NHS England the Board's view that the SARC should provide medical assessments for children who may have suffered female genital mutilation (FGM).

Elective home education

Nottinghamshire County Councils Elective Home Education (EHE) Team provided an overview to the Board of the work carried out by the team to ensure the safeguarding of electively home educated children.

Concerns had been identified in the s136 audit report presented to an earlier Board meeting that a lack of professional involvement when children are subject to elective home education can mean that vulnerabilities are not recognised or acted upon until there is a crisis. Although this related to one specific instance of concern it did highlight risks that may apply when children are removed from a school role. An issue that has been identified in serious case reviews across the country.

The EHE Team outlined the measures in place to ensure that the local authority intervenes where it appears a child is not receiving suitable education and how it acts where it appears that the safety and welfare of a home educated child may be at risk. The legal status of elective home education voluntary registration was identified as a concern and this was followed up through the regional LSCB Chairs.

LEARNING AND IMPROVEMENT FRAMEWORK

Domestic violence and abuse

Nottinghamshire Domestic and Sexual Abuse Executive, part of the Safer Nottinghamshire Board, leads on the coordination of the response by services to domestic violence and abuse (DVA) in Nottinghamshire. Domestic violence and abuse continues to feature significantly in the lives of children that become subject to child protection plans and the NSCB has sought assurance around the support services offered to all those experiencing or affected by DVA. Details concerning the effective operation of Multi Agency Risk Assessment Conferences (MARAC) have also been provided to the Board. A summary of the key themes from national research into Domestic Homicide Reviews (DHRs) has been provided to the Board along with details of the work being carried out locally to address those themes, which are broadly in line with the findings from local DHRs.

Care Quality Commission (CQC) review of services for looked after children and safeguarding

The CQC undertook an inspection of a wide range of services provided by health organisations in October 2015 and details were reported in the NSCB Annual Report 2015/16. An update was provided to the Board which outlined the action taken by Clinical Commissioning Groups (CCGs) in response to the review and the monitoring of progress against recommendations. This included details of a 'Confirm and Challenge' event attended by the NSCB Independent Chair and other members of the Board which provided a useful opportunity for multi-organisational scrutiny against the proposed actions. Details of site visits undertaken by CCG Designated Safeguarding leads and lead commissioners were also provided.

Part of the assurance process included a frontline visit to Kings Mill Hospital Emergency Department and Newark Hospital Minor Injuries Unit by the NSCB Independent Chair and Designated Health Professionals. The visit included meetings with staff and patients and a review of the s11 self-assessment for Sherwood Forest Hospitals Foundation Trust. Strengths and good practice were identified along with areas under development.

Preventing radicalisation

The Prevent Duty came into force in July 2015 and requires schools, colleges, early years' providers and a range of other public bodies to demonstrate that they are discharging their responsibilities in relation to protecting people from being drawn into radicalised or extremist

activities. Whilst the Safer Nottinghamshire Board takes the lead for coordinating and monitoring action in this regard there are clear safeguarding implications and the NSCB has received a report providing an update on progress against the Prevent Action Plan. In addition the NSCB has included content on 'Prevent' within the 'What's New in Safeguarding' seminars and the interagency safeguarding children procedures include a section on Safeguarding Children and Young People Against Radicalisation and Violent Extremism.

Organisational and service developments

NSCB members are requested to update the Board on changes to the way their organisation operates to enable consideration of any impact on safeguarding children. During the year briefings have been provided from; the police regarding the public protection department restructure, Nottinghamshire Healthcare NHS Foundation Trust regarding the development of a 0 -19 Family Service (replacing the previous school nurse and health visitor arrangements), and Bassetlaw CCG concerning paediatric service provision at Bassetlaw Hospital.

Clayfields House Secure Children's Home

Clayfields House is a secure children's home provided by Nottinghamshire County Council. In March 2016 it was reported to the Board that an Ofsted Inspection graded Clayfields House as outstanding.

In November 2016, DCI Mel Bowden, a member of the NSCB Executive, visited Clayfields House as part of the programme of frontline visits by Board members. A report on the visit was provided to the Board which confirmed that staff at the home displayed a thorough knowledge of safeguarding children. The visit was also used to obtain a first-hand explanation the restraint training and recording processes at Clayfields and DCI Bowden noted the commitment to ensuring that any restraints were using approved techniques, appropriately documented and accountable.

A report prepared by Clayfields is presented to the NSCB Executive each year to enable the Board to scrutinize the use of restraint within the unit. The most recent report was presented in August 2017 and provided details of the Restraint Minimisation Strategy and its application along with analysis on the use of restraint and injuries to young persons and staff in the preceding year.

AREAS FOR DEVELOPMENT

Areas for Development

The NSCB Business Plan has guided the work of the Board and provided the means by which the NSCB Executive has reviewed progress against key objectives. The plan has also been reviewed at the six weekly communications meetings held between the NSCB Independent Chair, Vice Chair, Safeguarding and Independent Review Group Manager and NSCB Business Manager.

The NSCB Business Plan follows a two year cycle (in line with the Children and Young People's Plan). A great deal has been achieved during the course of the past year, details of which are provided earlier within this report, and thanks must go to members of the Board whose support has made this possible.

The following section provides an overview of work within the plan that is ongoing or where new objectives have been included in the work programme following the end of year review.

VULNERABLE CHILDREN

The following groups of children have been identified as being particularly vulnerable and will be used to provide a focus for the work of the NSCB:

- Children at risk of sexual exploitation
- Children missing from home or care
- Children subject to sexual abuse
- Children who are neglected
- Children who are privately fostered
- Children exposed to domestic abuse
- Children who have Special Guardianship Orders
- Children living with parents/carers who misuse alcohol or who have mental health issues
- Looked after children
- Children who are described as self-harming
- Electively home educated children

Specific actions related to these groups are identified within the business plan. For example, the NSCB will scrutinise the effectiveness of the response to child sexual abuse and the

AREAS FOR DEVELOPMENT

support available to those that have suffered as a consequence. Further work to check the effective use of Special Guardianship Orders (based on the Department for Education Review, December 2015) is scheduled and progress against the neglect audit action plan will be monitored.

PERFORMANCE MANAGEMENT FRAMEWORK

The NSCB Performance Management Framework was introduced during the past year to provide a clear explanation of how performance is monitored by the Board through subject specific reports and the Performance Information Report (PIR). The PIR has been significantly improved during 2016/17 however further work is needed in particular the inclusion of indicators related to:-

- Child and Adolescent Mental Health Services (CAMHS)
- Children living with parents/carers who misuse alcohol or who have mental health issues
- Strategy Discussion performance

EFFECTIVE INTERAGENCY SAFEGUARDING

The NSCB will continue to challenge key elements of child protection enquiry work and seek to support improved practice. In particular work will focus on improving practice in the following areas:-

Strategy discussions

Strategy discussions are a key mechanism for coordinating multi-agency work when there are child protection concerns. Reviews and audit work has identified the need for improved practice in this area, the police and children's social care have reinforced the need to engage appropriately with a Consultant Paediatrician when considering the need for a medical assessment and there are indications that this has had a positive effect. The NSCB has instigated the setting up of a working group to drive forward further improvements particularly around ensuring that Strategy Discussions involve the right individuals and do not take the form of a series of one to one conversations which limit their effectiveness.

AREAS FOR DEVELOPMENT

Child protection conferences

The Board will continue to monitor the effectiveness of improved arrangements of invitations to child protection conferences and support measures to enable partners to engage in child protection conferences, including telephone and video conferencing where available.

Resolving professional disagreements

Problem resolution is an integral part of interagency working to safeguard children and professional disagreement is only dysfunctional if not resolved in a constructive and timely fashion. Reviews and audit work has identified examples where difficulties have not been resolved at practitioner level and disagreements have not been escalated to achieve a resolution. The NSCB is continuing its work to understand and address barriers to effective escalation and gain assurances that escalation processes are being used appropriately.

Information sharing

Effective information-sharing underpins integrated working and is a vital element of both early intervention and safeguarding. The NSCB has sought to build confidence in the workforce to share information appropriately and has held multi-agency briefing sessions with an extremely valuable input from Nottinghamshire County Council Legal Services. The NSCB will continue this work and support the development of technical solutions to aid information sharing including the Child Protection Information System (CPIS)[1].

OTHER ONGOING OBJECTIVES

- Support for NSCB members and senior managers to carry out their roles, including a training needs assessment and provision of further specific training events
- Ensuring that agencies and partnerships have safeguarding children as a central element of their planning, business and commissioning activity, scrutinising organisational restructures and the impact of financial constraints
- Strengthen cross authority working arrangements and increase the visibility of this work

[1] CPIS is an NHS England sponsored programme to develop an information sharing solution that identifies children at risk, or in care of the Local Authority, who visit NHS unscheduled care settings such as; accident and emergency departments, ambulance service, maternity, minor injury units, out of hours, paediatric wards and walk-in centres.

AREAS FOR DEVELOPMENT

- Consider the implications of the Children and Social Work Act 2017 and new statutory guidance when available
- Develop analysis of use of the NSCB procedures and website to guide future work
- Maintain an oversight of the work of the historical abuse Strategic Management Group
- Continue the programme of frontline visits by NSCB members
- Benchmarking against the new NSCB Communications and Engagement Strategy to identify any gaps that require addressing.

LEARNING AND IMPROVEMENT

Case reviews

The terms of reference for the SIR sub group will be amended to improve the effectiveness of the way information is gathered and decisions made regarding recommendations for serious case reviews. The amendments will give greater clarity around the decision making process and reduce the demand on partner agencies. In particular account will be taken of the relevant sections in the Children and Social Work Act 2017 and the new responsibilities of 'Safeguarding Partners'.

Child death reviews

The CDOP will strengthen its role in publicising national campaigns to support local priorities and will use the Nottinghamshire Children's Trust 'Children, Young People and Families Awareness Campaign Calendar' to identify appropriate campaigns to coordinate local action with.

The commissioning of child death bereavement services will be monitored by the CDOP following the identification of gaps in provision.

The CDOP will complete the benchmarking of local practice against the Royal College of Pathologists multi-agency guidance for the investigation of child deaths and any gaps identified will form part of a revised action plan.

Local procedures will be amended to take account of the revised national guidance scheduled for publication in autumn 2017.

AREAS FOR DEVELOPMENT

Learning and development

With the availability of an increased range of e learning modules, the L & D sub group will take the opportunity to provide further clarity on how this source of learning will complement other training opportunities and promote the use of the new modules with partner organisations.

Revised statutory guidance is anticipated following the implementation of the Children and Social Work Act 2017 and the implications on multi-agency safeguarding training will be considered by the group. A review of the quality assurance scheme will be undertaken in consultation with colleagues in children and adults safeguarding across the city and county. The NSCB training pool will also continue to be monitored to ensure appropriate representation from partner organisations.

Multi-agency audit

The Multi-Agency Audit sub group will oversee the delivery of the NSCB audit programme for 2017/18 and coordinate activity with the Nottingham City Safeguarding Children Board.

Progress against actions arising from audit work will be monitored by the NSCB Business Manager and members of the sub group will be responsible for reporting back on their own organisations work in this regard. Learning from audits will continue to be disseminated through the NSCB Learning and Improvement Framework.

APPENDIX A

Appendix A

NSCB Membership List (at 1/10/17)

NAME	ORGANISATION
Chris Few **Independent Chair**	
Julie Gardner **Vice Chair**	Associate Director for Safeguarding and Social Care, Nottinghamshire Healthcare NHS Foundation Trust
NCC Representatives	
Colin Pettigrew	Corporate Director, Children's Families and Cultural Services, Nottinghamshire County Council
Derek Higton	Service Director, Commissioning Resources & Cultural Services, Nottinghamshire County Council
Steve Edwards	Service Director, Youth Families & Social Work, Children, Families & Cultural Services, Nottinghamshire County Council
Marion Clay	Director, Education, Learning & Skills (Interim), - Education Standards and Inclusion, Children, Families & Cultural Services, Nottinghamshire County Council
Laurence Jones	Group Manager, Early Help Services, Nottinghamshire County Council
Joe Foley	Group Manager, Safeguarding and Independent Review, Children's Families and Cultural Services, Nottinghamshire County Council
Paul McKay	Service Director, Personal Care and Support, South Nottinghamshire, Adult Social Care, Health and Public Protection, Nottinghamshire County Council

APPENDIX A

Kate Allen	Consultant in Public Health, Adult Social Care, Health and Public Protection,
Health - commissioners	
Nicola Ryan	Interim Chief Nurse, Executive Lead, Quality and Patients Safety, Chief Nurse, NHS Bassetlaw
Elaine Moss	Chief Nurse and Director of Quality and Governance, Newark and Sherwood and Mansfield/Ashfield, Clinical Commissioning Groups
Nichola Bramhall	Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe, Clinical Commissioning Groups
Health - providers	
Rick Dickinson	Acting Deputy Director of Nursing, Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Mandie Sunderland	Chief Nurse (Executive Lead for Safeguarding), Nottingham University Hospital NHS Trust
Maria Stanley	Ambulance Operations Manager for Quality and Compliance, East Midlands Ambulance Service NHS Trust
Tina Hymas-Taylor	Head of Safeguarding for Sherwood Forest Hospitals NHS Foundation Trust
Other agency representatives	
Bob Bearne	Assistant Chief Executive, Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company
Nigel Hill	Head of Nottinghamshire, National Probation Service
Robert Griffin	Detective Superintendent, Head of Public Protection, Nottinghamshire Police

APPENDIX A

Clare Mayne	Senior Service Manager, A11 Early Intervention Team, CAFCASS
Leanne Monger	Business Manager, Housing & Safeguarding, Newark & Sherwood District Council – District and Borough Councils representative
Sue Fenton	Manager, Home Start Nottingham (Voluntary Sector Representative).
Donna Trusler	Principal, Manor Academy, Mansfield Woodhouse.
Participant observer	
Councilor Tracey Taylor	Lead responsibility for Children's Social Care, Nottinghamshire County Council
Advisors to the Board – Designated health professionals	
Cathy Burke	Nurse Consultant, Safeguarding, NHS Bassetlaw CCG and representative for NHS England (Yorkshire & Humberside)
Jane Brady	Associate Designated Nurse Safeguarding Children, (Nottinghamshire) 5 CCGs,
Dr Fiona Straw Dr Nadya James	Designated Doctors for Safeguarding, NHS (Nottinghamshire) 5 CCGs.
Dr Bushra Ismaiel	Consultant Community Paediatrician, Designated Doctor for Safeguarding, Lead Clinician for Community Services, Doncaster & Bassetlaw Hospitals
Advisors to the Board - NSCB officers	
Trish Jordan	NSCB Training Coordinator
Bob Ross	NSCB Development Manager
Steve Baumber	NSCB Business Manager (P/T)
Hilary Turner	NSCB Business Manager (P/T)

APPENDIX A

NSCB Business support	
Michelle Elliott	NSCB Administrator
Carol Fowler	Child Death Administrator

APPENDIX B

Appendix B

Glossary

ADCS	Association of Directors of Children's Services
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CSECAG	Child Sexual Exploitation Cross Authority Group
EHU	Early Help Unit
FGM	Female Genital Mutilation
FII	Fabricated or Induced Illness
HMIC	Her Majesty's Inspector of Constabularies
ICPC	Initial Child Protection Conference
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
MASH	Multi-Agency Safeguarding Hub
NSCB	Nottinghamshire Safeguarding Children Board
PIR	Performance Information Report
RCPC	Review Child Protection Conference
SARC	Sexual Abuse Referral Centre
SCIMT	Safeguarding Children Information Management Team
SCR	Serious Case Review
SIR	Serious Incident Review (Sub Group)
YJS	Youth Justice Service