Nottinghamshire Safeguarding Children Board

Annual Report 2017-18

Contents

Foreword from the Independent Chair 1

Introduction 3

NSCB functions 5

- Procedures and guidance 5
- Finance 7

Learning and Improvement Framework 9

- Safeguarding Survey 9
- Learning and Development 11
- Serious Case Reviews 13
- Child Death Reviews 16
- Multi-agency audit 18
- Scrutiny and challenge 24

Moving forward 30

- Vulnerable groups 30
- Child safeguarding practice 31
- Transition to new safeguarding arrangements 31

Appendix A 33

Appendix B 37

Essential information

This report has been compiled on behalf of the Nottinghamshire Safeguarding Children Board (NSCB) by Steve Baumber, Service Manager, Partnerships and Planning. 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 2018 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 2017/18 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 as well as the action taken in response to that learning.

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 will see a considerable amount of work as we transition to new safeguarding arrangements under the revised statutory guidance that has recently been published. I have been closely involved in the planning for the new arrangements and we will be ensuring that the strengths of the current arrangements are maintained whilst using the flexibility of the new guidance to address the challenges that face coordinating safeguarding in a large county with a diverse range of needs and complex service provision. The new arrangements will ensure that all current members of the NSCB will be part of the new Nottinghamshire Safeguarding Children Partnership and allow for greater engagement with other organisations. The details around how each organisation can contribute in the best way to the new arrangements will be developed over the next few months.

This year the Board undertook a safeguarding survey with frontline practitioners, the response to the survey was very encouraging and I am grateful to those who took the time to complete it. Findings from the survey are included within relevant sections of this report and will help guide the development of future safeguarding arrangements.

FOREWORD FROM THE INDEPENDENT CHAIR

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 line with the requirements set out in the Children Act 2004 to coordinate what is done by partner organisations to safeguard children and ensure the effectiveness of that work. During the period covered by this reported the Board operated in accordance with the statutory guidance, Working Together to Safeguard Children (2015). A revised version of the statutory guidance was published on the 29th June 2018 and further details of the plan to implement new safeguarding arrangements are outlined in the future developments section later in this report.

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
- 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. The financial section of this report provides a breakdown of contributions received and expenditure incurred during the year. A list of NSCB members, advisors and supporting staff is attached to this report (**Appendix A**).

Part of the Learning and Improvement Framework operated by the Board is the review of key performance information through a quarterly Performance Information Report (PIR) presented to the NSCB Executive. An annual version of the PIR is available via the NSCB website under the heading NSCB Annual Report and can be read in conjunction with this report.

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NSCB functions

PROCEDURES AND GUIDANCE

The online NSCB safeguarding procedures were updated twice during the year (June 2017 and January 2018) to ensure they remain current and include learning from local and national sources.

Full details of the amendments made to the procedures are available in the 'Using this Manual' section of the procedures, some of the key changes made in the latest updates are as follows:

- a new chapter 'good practice supporting the voice of the child'
- extensive updates to the chapter on self-harm and suicidal behaviour
- additional guidance for health colleagues dealing with sub-conjunctival haemorrhage in infants, fabricated or induced illness, and perplexing presentations
- revised missing children guidance to reflect changes to national definitions and clarify communication channels with health colleagues
- revised guidance on dealing with neglect
- inclusion of the Brook Sexual Behaviours Traffic Light tool to help those dealing with harmful sexual behaviour
- updated guidance regarding ; online safety, honour based violence, female genital mutilation, forced marriage, domestic violence/abuse, and trafficked children

The interagency safeguarding children procedures are managed through the cross authority procedures sub group in conjunction with Nottingham City Safeguarding Children Board therefore providing common procedures for partner agencies across Nottingham City and Nottinghamshire. There have been some challenges in partners being able to contribute to procedures work during the year and we are grateful to those who have committed the time to ensure that they remain up to date and relevant.

A significant effort has been made during the year to review the procedures and make them more streamlined and easier to access. Analysis undertaken indicates positive use of the procedures with increased access to the following sections; local resources, responding to

abuse and neglect, reporting concerns, allegations against professionals and good practice at core groups. A significant proportion of users access the guidance via the NSCB website or through the link in Nottinghamshire Children's Social Care Procedures. Over 85% of respondents to the recent NSCB Safeguarding Survey were aware of the interagency procedures and almost a quarter of those had accessed the procedures within the past month. Of those that used the procedures over 84% said they were very helpful of helpful. Some of the comments included

> Excellent resources that can be accessed by all agencies for clarity and information

> Great way of quickly checking procedures and information out without spending lengthy time on the phone.

> Useful guides on what actions to take when you are faced with a safeguarding issue.

> We use them as a major component of our induction for new staff

The majority of comments were very positive and support the improvements made to the procedures, particularly around ease of access, having all the procedures in one place and the ability to search for relevant guidance to address a specific issue. There is clearly some further work to be done by the NSCB and partner organisations to further raise awareness of the procedures and develop greater use of flow charts, for example.

NSCB FUNCTIONS

FINANCE

The work of the NSCB is funded, in part, through multi-agency contributions which have remained the same for the past eight years. The following table details partner contributions and income generated for 2017/18:-

NSCB Partner Contributions	
Nottinghamshire County Council	£147,712
National Probation Service	£1,647
DLNR CRC Ltd.	£1,765
Police	£17,612
CAFCASS	£550
NHS Bassetlaw CCG	£23,000
NHS Nottinghamshire County CCGs	£64,404
Sub total	£256,690
Additional contributions for specific support posts[1]	
Nottinghamshire County Council	£102,940
NHS Nottinghamshire County CCGs	£23,242
Income generated	
Training fees (non NSCB delegates)	£4,410
Training non-attendance charges	£4,320
SCIMT safeguarding checks (non NSCB partners)	£6,584
Total (contributions + income)	£400,186

[1] In addition to the NSCB partnership contributions, Nottinghamshire County Council fund the NSCB Development Manager and Child Death Administrator posts at a further cost of £79,698. These two roles support the serious incident review sub group and child death overview panel and ensure that serious case reviews and child death reviews are carried out efficiently and effectively. An agreement between Nottinghamshire County Council and NHS Nottinghamshire County CCGs also provides funding for the NSCB Manager post at an equally shared additional cost of £46,484 (this post was not filled full time during the year).

NSCB FUNCTIONS

NSCB Budget expenditure	
NSCB Independent Chair & administrative costs including; business support, online procedures, meeting venues, stationery, printing and subscriptions	£50,729
Training provision - Training Coordinator and Training Administrator costs, E learning provision, specialist training providers, venue and refreshment costs	£110,263
Safeguarding Children Information Management Team – agency checks, transfer of child protection cases between areas, national alerts regarding concerns about children and families	£55,293
Serious Case Reviews - Lead Reviewer costs related to KN15, MN15, ON16, PN16 & QN17 and Chronolator licence costs	£13,585
Rebate to SCR contributors (police, CCGs, NCC)	£32,000
Sub total	£261,870
NSCB Manager post (not filled full time and therefore costs reduced)	£46,484
NSCB Development Manager & Child Death Administrator	£79,698
Total	£388,052

The Board has agreed that partner contributions for 2018/19 will remain at the same level as 2017/18, with the exception of NHS Bassetlaw CCG which will contribute a reduced amount. The NSCB also holds a reserve to cover unexpected costs, for example a particularly complex serious case review, and the amount carried forward into 2018/19 from the reserve was £103,481.

Under the new safeguarding arrangements, introduced through Working Together 2018, the three safeguarding partners are required to agree the level of funding from each partner, which should be equitable and proportionate, and any contributions from each relevant agency, to support the local arrangements.

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.

SAFEGUARDING SURVEY

This year a safeguarding survey was undertaken to provide a further opportunity for the NSCB to understand the issues affecting frontline practitioners and to help focus the work of the Board during 2018/19. Over 500 responses were received and a full analysis of the feedback provided is currently being undertaken and will be presented to the NSCB and published. Initial findings from the survey have been included within relevant sections of this report and the following provides a summary of those issues not covered elsewhere:

Pathway to Provision (Nottinghamshire's thresholds for services guidance)

- Over 80% of respondents were aware of the guidance
- 64% of respondents had used the guidance
- Out of those respondents that had used the guidance over 84% said it was either helpful or very helpful

Early Help Assessment Form (EHAF)

- Good knowledge of EHAF (82%)
- 43% had used the EHAF
- Out of those respondents that had used the EHAF, 68% said it was either helpful or very helpful
- A significant amount of positive feedback regarding the new form that was introduced during the year
- To a lesser extent some concerns around the length of the form and the perceived duplication of effort

LEARNING AND IMPROVEMENT FRAMEWORK

Recognising and responding to abuse and neglect

- Most respondents indicated they were confident or very confident at dealing with a range of safeguarding concerns to a similar degree
- More respondents were unsure about dealing with sexual abuse, child sexual exploitation and self-harm compared to physical abuse, emotional abuse and neglect

Professional disagreements

- 31% of respondents had resolved a professional disagreement in relation to a safeguarding issue
- Support for resolving professional disagreements - references to the NSCB escalation procedure being helpful, the value of professional relationships, availability of right senior manager, support from within your own organisation
- Barriers to resolving disagreements - defensiveness on the part of agencies

Use of chronologies

- A high number of respondents (75%) said they had made use of a chronology when dealing with safeguarding cases
- Time was identified as the biggest barrier to completing a chronology

NSCB support

- Over 80% of respondents had accessed the NSCB website, with the policy and guidance and the training sections identified as the most useful
- Less awareness and use of the learning from practice section which contains learning bulletins and details of serious case reviews
- Positive feedback on the value of the Learning and Improvement Bulletins by those that had accessed them
- Over 86% of respondents found the NSCB newsletters either helpful or very helpful

Following a full analysis of the safeguarding survey responses an action plan will be developed targeted at areas for improvement.

LEARNING AND IMPROVEMENT FRAMEWORK

LEARNING AND DEVELOPMENT

The Learning and Development sub-group, Chaired by Lisa Nixon (Named Nurse for Safeguarding Children and Young People), has overseen the development and delivery of the NSCB annual training programme. During the year 44 face to face training events were held with a total of 1995 practitioners attending.

Course evaluations are undertaken after each event and these continue to evidence high levels of satisfaction with, and the quality of, NSCB training. Participants report increased levels of confidence and improved practice as a result of attending NSCB courses.

NSCB TRAINING EVENTS PROGRAMME 2017/18

The NSCB Training programme is informed by the Learning and Improvement Framework. Learning from case reviews, audit and performance management has been incorporated into existing courses and where necessary specific training events have been commissioned. The training programme has included core training events and seminars such as 'Working Together' and 'What's New in Safeguarding' and the following additional events:

- neglect,
- child sexual exploitation
- safeguarding babies
- responding to sexual abuse
- young people impacted by domestic violence and abuse
- disguised compliance
- intimidation, resistance & avoidance
- fabricated or induced illness
- unexpected childhood deaths

A level 4 course was also delivered for safeguarding leads and managers that included key practice issues such as; professional challenge and escalation, managing allegations against professionals & child protection reviews.

LEARNING AND IMPROVEMENT FRAMEWORK

NSCB E LEARNING MODULES

In addition to the NSCB training programme a comprehensive range of E learning modules have been made available to partners providing an introduction to a subject or a means of updating /refreshing personal knowledge.

NSCB members are utilising the standard E learning modules as part of their staff induction programmes and this year specific modules have been promoted to coincide with relevant national awareness weeks.

The following E learning modules have been particularly popular this year:

- Introduction to Safeguarding Children
- Awareness of Child Abuse and Neglect
- Understanding Pathways to Extremism & the Prevent Programme
- Safer Sleep for Babies
- Working with Children with Disabilities
- Self-harm
- Trafficking, Exploitation and Modern Slavery

As a result of concerted efforts by the NSCB Training Team and members of the Learning and Development sub group, over 6300 E learning course have been completed this year compared to 4151 the previous year.

LEARNING AND IMPROVEMENT FRAMEWORK

SERIOUS CASE REVIEWS

The NSCB has an effective system in place to ensure that when a child comes to serious harm consideration is given as to whether a review should be undertaken to identify any learning and practice improvement. Any member of the Board can refer a case to the Serious Incident Review (SIR) Sub Group which undertakes an initial collation of information and makes a recommendation to the Independent Chair as to whether a review should be undertaken. The Independent Chair makes the final decision as to whether a review should be carried out.

- **Five cases were referred to the SIR for consideration**.
  - The SIR sub group recommended that the criteria for SCR was not met in four of the cases that were referred. The NSCB independent chair agreed with the recommendations, and summaries of the cases were submitted to the National Panel of Independent Experts (NPIE) for their consideration. The NPIE endorsed the decision of the chair on each occasion.
  - In a fifth case the SIR sub group recommended that the criteria for SCR was met. The NSCB independent chair agreed with the recommendation and SCR QN17 was commissioned and commenced on 4th December 2017.

- **Four serious case reviews were finalised during the year**
  - SCR ON16 - signed off by NSCB on 15th May 2017 and published on 2nd November 2017. Publication of this review was delayed due to issues involving other legal processes.
  - SCR KN15 -signed off by NSCB on 7th June 2017. Publication has been delayed until the inquest has taken place.
  - SCR MN15 - signed off by NSCB on 2nd August 2017 and published on 2nd November 2017.
  - SCR PN16 - signed off by NSCB 25th January 2018. Publication of the review has been delayed to allow for effective feedback to the young person involved.

- **Ongoing reviews (at the end of the reporting period)**
  - SCR QN17 - this review commenced on 4th December 2018 and was signed off by the NSCB in July 2018. Publication has been delayed until the inquest has taken place.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – MN15

This case involved 'Perry' and three siblings who had extensive agency involvement over a number of years in relation to poor home conditions and neglect. Three of the four children in the family had mild learning difficulties. They were described at various times as lacking in personal hygiene, unkempt with constant head lice leading to social isolation. They showed evidence of developmental delay, lacked important social and emotional skills and were often hungry. There was a cyclical pattern of agency attention followed by minor improvement which relapsed once agencies reduced their level of scrutiny. Escalating concerns in relation to Perry's physical health which emerged in 2015 were not responded to in a timely manner and Perry was admitted to hospital with significant injuries resulting from an untreated infection.

KEY LEARNING:

1. Several people from different services tried hard to provide support with good relationships between the siblings and particular professionals (for example youth workers)
2. Schools provided good pastoral care and were active in making contact with other professionals
3. Efforts were made to provide support to the father on several occasions
4. Practitioners should be aware that neglect has the potential to cause severe physical injury as well as emotional and psychological damage
2. Neglected children are likely to have lower self-esteem and be socially isolated and this may be compounded by learning difficulties and/or disability.
3. Practitioners need to have a clear and shared understanding with Children's Social Care as to how information provided by them is to be viewed and acted upon, for example, is an enquiry being accepted as a child protection referral.
4. Where there is a disagreement on whether concerns amount to a referral or whether there are delays in responding to information provided, professionals should understand the procedures for resolving professional disagreements and make use of them.
5. Effective joint working needs clarity around roles and responsibilities particularly in relation to child protection and criminal investigations. Strategy discussions are a key component in this and should have been used.
6. Professional guidance and tools were available but not always used.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – ON16

Baby ON16, aged 16 weeks, was admitted to hospital in early 2016 after her mother noticed she had a swollen arm. This followed at least 15 previous contacts with health professionals, some routine appointments, and some where mother raised concerns about various marks, bruises and skin lesions. After medical investigations at the hospital it was concluded that the injuries, which included bruising, swelling and multiple fractures, were non-accidental and had occurred over a period of time. The household of baby ON16 included a 2yr old sibling and 10yr old half-sibling of ON16's father.

KEY LEARNING:

1. The appearance of unexplained marks and bruises on very young children who are not mobile are not likely to have been caused by themselves or another young infant. The possibility of NAI should be part of any assessment of a non-mobile baby presenting in these circumstances.
2. Good internal agency communication by teaching staff, support staff, special education in the school where the older child attended to provide support
3. Repeated returns to Initial Child Protection Conferences should be carefully examined.
3. Practitioners need to be clear on the legal status of children and where children are placed with extended family members the quality of assessment required must be as high as that for children taken into the care of the Local Authority.
4. The strategy of placing a child with extended family members should consider the impact on the welfare of any other children in the household and be subject to regular reviews.
5. Practitioners need to have the skills and confidence to challenge and escalate problems that arise in practice.
6. Assessments should not be regarded as complete without consideration of all relevant information from partner agencies.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Reviews – Action updates

The SIR sub group is responsible for monitoring the progress of action plans arising from SCRs and then signing them off when completed. Often work falls into existing developmental work and this is referenced at other points within this report. The following provides a summary of some of the actions taken in response to serious case reviews

- neglect audit undertaken
- analysis of the use of neglect practice guidance
- safeguarding survey included questions related to responding to neglect and resolving professional disagreements
- neglect guidance reviewed and streamlined
- research to identify suitable neglect tool and work nearing completion to amend for local use
- focus on the importance of strategy meetings and coordination of the work to improve timeliness and effectiveness

In addition agency actions were completed relating to; the transfer of cases between areas, updated and strengthened training, promotion of escalation processes, awareness raising of assessment tools and use of chronologies, greater scrutiny of care plans, improvements to record keeping and inter-disciplinary information sharing.

CHILD DEATH REVIEWS

The role of the Child Death Overview Panel (CDOP) is to ensure the NSCB understands how and why children in Nottinghamshire die and to use the collective findings to take action to prevent deaths and improve the health and safety of all children in our communities.

The CDOP reviews the deaths of all children normally resident in Nottinghamshire regardless of the cause. It is chaired by Cathy Burke, Deputy Chief Nurse (Interim), NHS Bassetlaw Clinical Commissioning Group.

During 2017/18 unfortunately 53 children died in Nottinghamshire and of those, 36 were classified as ‘expected’ deaths and 17 as ‘unexpected’ deaths. For a number of reasons, including Coroner’s Inquests and the complexity of the case, it is not always possible to complete the review a death during the year in which it occurred therefore the number of deaths does not directly relate to the reviews undertaken. In 2017/18 the CDOP undertook 46 reviews and a summary of the outcome of those reviews will be reported to the

Department of Health as part of the annual data submission. The CDOP also referred three cases to the SIR sub group for consideration of a SCR.

Some of the achievements of the CDOP towards preventing future deaths are:

- Contributing to the development of the pregnancy liaison meetings initiative led by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and Doncaster Children's Services Trust which has received an award from the Royal College of Midwifery for partnership working. Details of the initiative are included in the July NSCB newsletter and similar arrangements are being established in other areas of the county.
- Taking forward through a safer sleeping working group various measures aimed at reducing the number of baby deaths caused by unsafe sleeping practices including; workforce training, development of a risk assessment tool, ensuring that parents and carers receive appropriate advice and resources, and communications (particularly during 'safer sleep week')
- Receiving assurances from acute hospital trusts in relation to British Thoracic Society (BTS) standards for the management of asthma in children.
- Improving communications with families whose first language is not English to ensure they know how to contact emergency services
- Implementation by Acute Trusts of a process to gather feedback from families following the death of a baby based on NHS London Clinical Networks guidance.

Suicide and self-harm

During the course of the year a learning review was undertaken in response to five deaths by apparent suicide. Each of the deaths would, in due course, be subject to a review under the child death review process and in one case a serious case review was commissioned (referred to earlier). However, it was agreed that a multi-agency group should meet to consider if there were any common features, identify any immediate action to prevent future deaths and consider an overview of what was known about each of the deaths. As part of the review analysis was undertaken by Public Health, advice was sought from a specialist academic at University of Nottingham and CAMHS services reviewed their contact with several young people.

LEARNING AND IMPROVEMENT FRAMEWORK

The review established that there was no connection or link between the deaths and the circumstances of each individual case were consistent with the research into findings of similar deaths. In overall service terms no significant service shortfalls were identified in relation to CAMHS. Analysis undertaken by Public Health concluded that the recent cluster of deaths did not indicate a statistically significant upward trend at this stage and that in 2016 Nottinghamshire had a lower than national rate of suicides in the 10-17 age bracket. A number of actions were identified as a result of the review and these are being monitored by the CDOP.

MULTI-AGENCY AUDIT

The NSCB has a proven multi-agency audit process and ensures that improvement is monitored through repeat audit in priority areas. The audit programme has been overseen by the Multi-Agency Audit Sub Group chaired by Colin Pettigrew, Corporate Director, Children Families and Cultural Services, Nottinghamshire County Council. Partners have committed a significant amount of resource to enable the completion of the audits and in turn very positive feedback has been received regarding the learning opportunity that audit days provide for practitioners.

NSCB AUDIT PROGRAMME 2017/18

Five multi-agency audits have been reported on during the year, two of which were jointly carried out with Nottingham City Safeguarding Children Board

- Familial sexual abuse
- Missing children
- S.136 Mental Health Act 1983
- Harmful sexual behaviour
- Child sexual exploitation

A review of the self-assessments carried out as part of the s.11 audit was also undertaken and noted a very positive improvement in compliance with the standards

A single agency audit was also undertaken by Early Help Services and the findings were reported to the subgroup.

LEARNING AND IMPROVEMENT FRAMEWORK

Familial sexual abuse

This cross authority audit considered how agencies work together to achieve the best outcomes for children and young people following a referral regarding interfamilial sexual abuse. The audit examined 10 cases and considered 12 areas of practice using an audit tool developed for the purpose. Findings from the audit were limited due to the small number of county cases (5).

Learning from the audit:

- Strategy discussions took place in all cases and apart from one instance were timely - however they tended to involve only police and children's social care and wider engagement with other agencies is needed
- Good management oversight and supervision by Children's Social Care
- Capacity issues within the police led to delay in progressing some investigations and providing information – in one case escalation processes should have been used to challenge the delay in interviewing a child but were not
- Recording the rational for decisions that are made needs to be improved
- A need for reflective, child focused decision making rather than procedural and process led

NSCB Response

The findings from the audit were used to inform the development of new supervision guidance for Children's Social Care. The Multi Agency Audit Sub Group also considered the audit report and concluded that a further action plan would not be developed as the issues raised were covered by existing work streams including; training, resolving professional disagreements and improving strategy discussions. The police had also made some changes to staffing levels since the audit was undertaken.

Missing children

The missing children audit examined the case files held by partner agencies in relation to 12 children who had gone missing. In addition Nottinghamshire County Coucil Quality and Improvement Service sought the views of the children concerned about the quality of services they had received. A feedback day was subsequently convened to collate the findings and discuss the learning.

LEARNING AND IMPROVEMENT FRAMEWORK

Learning from the audit

The methodology used for this audit and the varying levels of involvement of the agencies concerned resulted in findings for each of the agencies concerned rather than an overall assessment of the effectiveness of the multi-agency response. A detailed report outlining the findings for each agency was presented to the Multi-Agency Audit subgroup. Much of the work undertaken by agencies was graded as good however the audit did identify some development work.

NSCB Response

The interagency practice guidance was revised to take account of new terminology in national guidance and the opportunity was taken to clarify communication routes with between children's social care and health organisations when a child is reported missing. The NSCB coordinated the delivery of further missing children training events. Learning about multi-agency audit methodology was taken forward into subsequent audits coordinated through the NSCB.

Children detained under section 136

This audit examined the experience of 13 young people who were detained under s.136 of the Mental Health Act 1983[2] over a six month period in Nottingham City and Nottinghamshire. It followed on from a similar audit undertaken in 2016 and was also used to assess the implications of new legislation being implemented later in the year.

Learning from the audit:

- There was an improvement in the way such cases were dealt with compared to the 2016 audit findings
- As in 2016, recording around the events leading up to the use of s.136 and the s.136 event itself were often inconsistent or partial
- Some examples of coordinated multi-agency planning but further improvement needed particularly following discharge from the s.136 suite

[2] If a person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control, the police officer may, if they think it is necessary to do so in the interests of that person or for the protection of other persons, remove the person to a place of safety.

- A need to improve the effectiveness of agencies responses to young people in significant psychological distress
- Availability of beds in the commissioned health based place of safety was a problem in some of the cases
- Availability/responsiveness of a CAMHS Psychiatrist caused a delay with the assessment of some of the young people
- The protocol for using an ambulance to transport the young person was not being applied

NSCB Response

A report on the audit findings was presented to the Board in December 2017 and it was agreed that the recommendations and action plan be over seen and driven forward by the Task and Finish Group. An interim update to be provided to the NSCB Executive.

Harmful Sexual Behaviour (HSB)

This audit followed an organisational audit completed by Nottinghamshire County Council in November 2016 using the NSPCC self-assessment tool. A multi-agency case audit was subsequently undertaken which examined the circumstances surrounding 10 cases of suspected HSB. A moderation day was used to discuss the individual findings of agencies and arrive at an overall assessment of how each case was dealt with.

Learning from the audit

- Evidence of very good work by schools, identifying and referring cases to children's social care and then making efforts to keep the child in their current school
- Delay in cases being responded to due to a lack of understanding by non-specialist staff
- Improvements needed in multi-agency work; police and children's social care work not sufficiently joined up and contact with health practitioners not timely
- Challenges around AIM[3] assessments and decisions around the criminal investigation being conflated

[3] AIM (Assessment Intervention Moving on) – a common inter-agency and holistic model for the initial assessment of young people who display sexually harmful behaviour.

- A need to integrate with work being carried out under a number of processes (e.g. Child in Need plans)
- Good evidence of the use of escalation processes between agencies and within organisations

Response by the NSCB

The NSCB has supported the introduction of a multi-agency HSB Panel based on good practice in other areas. The panel has now been formed and promotes early information exchange, improved safety planning, and is intended to lead to more consistent assessment and intervention decisions. Progress with the HSB Panel and other recommendations arising from the audit is being monitored by the Board.

Child Sexual Exploitation

This audit followed up on two previous CSE audits that were undertaken in 2014/15 and 2015/16. The audit looked at a sample of 12 cases and gave particular focus to those where a CSE strategy meeting had not been held. A moderation day was again used to discuss the individual findings of agencies and arrive at an overall assessment of how each case was dealt with.

Learning from the audit

- Awareness and identification of CSE was good across all the agencies involved with good use being made of agency specific assessment tools and to a lesser extent the multi-agency risk assessment tool
- Response to CSE could be strengthened by considering step-down to the Family Service as an option and by greater use of CSE strategy meetings
- Participation/engagement by agencies in work to manage the risks of CSE was also very positive

NSCB response

The CSE procedures are being revised to provide further clarity around the use of strategy meetings and the connectivity with other processes. A particular focus is also being given to the work led by the cross authority CSE group around transitions between services and young people accessing CSE support services.

LEARNING AND IMPROVEMENT FRAMEWORK

Early Help

Following a serious case review recommendation (KN15), a specific audit was undertaken into a sample of cases where a referral was made to the MASH that was passed to the Early Help Unit and resulted in advice to undertake an Early Help Assessment (EHAF). The focus of the audit was; the quality of interagency work on the lead up to the MASH referral, the decision making within the MASH and the period following the advice to undertake an EHAF at Tier 2 of the Pathway to Provision.

Learning from the audit

- In general cases were well managed and families made progress, without the requirement for re-referral to MASH or EHU.
- The links between children's social care and early help have significantly improved since the SCR which raise the question so that now if the MASH advise a referrer to complete an EHAF they will also be able to pass the referral directly onto a team who will offer guidance and support the referrer to follow the advice of the MASH
- Good practice was identified; universal services were seeking the voice of the child and appropriate consent from families prior to referral, threshold judgements in the MASH and EHU were generally sound, a variety of services were available to children and families at tier 2 including School Counselling Services and Healthy Families Teams, involvement of a Level Two development Worker improved the quality of planning and assessment and the use of EHAFs at Tier 2 has been proportionate
- Developmental areas; delays in processing referrals can lead to multiple referrals being open at the same time, contact with the MASH was only deemed appropriate in one case and advice could have been accessed more quickly if the referrer had contacted the EHU or CAMHS Single Point of Access, escalation processes should have been used in some cases to move them forward, the quality of assessments and the analysis of underlying causes for behaviour could be improved, lack of understanding around the distinct roles of the EHU and the Family Service

NSCB Response

The Multi-Agency Audit subgroup noted the progress that had been made since the period covered by the sample of cases subject to the audit. In particular there is no longer a

significant backlog of cases in the MASH and EHU, work has also been undertaken to improve the understanding of MASH thresholds and the use of escalation processes. A new EHAF was also launched in January 2018.

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:-

Historical/non recent abuse

Operation Equinox was established by Nottinghamshire Police as an overarching framework for coordinating a number of investigations into allegations of non-recent child abuse in establishments within Nottinghamshire and Nottingham City, including residential children's homes. A dedicated team of social workers from Nottinghamshire County Council is co-located with the police to undertake the social care safeguarding response to allegations of abuse made by former Looked After Children.

A Strategic Management Group (SMG) for Operation Equinox, established in accordance with NSCB/NCSCB procedures for responding to complex abuse, meets every two months. It has reported regularly to the NSCB and NCSCB during 2017/18 on the investigations into allegations of non-recent abuse in children's residential homes, the work of the SMG and the Independent Inquiry into Child Sexual Abuse (IICSA), including published findings from the Inquiry.

In September 2017 the SMG appointed a Sexual Violence and Engagement Manager to commission:

- A Connecting/Outreach service to bring together survivors with services.
- A Survivors Support and Advocacy Service.
- Additional Counselling Support through Rape Crisis.

The Victim and Survivor Advocacy Group for Operation Equinox meets quarterly and is jointly chaired by the Service Directors for Nottingham City and Nottinghamshire Adult Social Services. Representatives from the Independent Inquiry into Child Sexual Abuse (IICSA) attended the meeting in June 2018 to listen to feedback from victims and survivors. A victim

and survivor focused leaflet for people who have experienced sexual abuse in childhood has also been developed providing details of local accredited services.

The SMG has highlighted the importance of front line staff across all organisations of responding sensitively and appropriately to survivors asking or talking about non-recent abuse. The Safeguarding Adults Boards have been asked to establish a joint Task and Finish Group to consider the issues related to developing a practice of Routine Enquiry and the provision of information to staff to support sensitive practice and responding to non-recent abuse.

The IICSA Public Hearing for the 'Nottinghamshire Councils' investigation (relating to non-recent sexual abuse of children in local authority care) has been scheduled to commence on 1st October 2018. The Independent Chairs for the NSCB and NCSCB have agreed that a joint Learning Review should be commissioned if at the end of the IICSA Inquiry there are areas that still need examination locally.

Domestic violence and abuse

Domestic violence and abuse continues to feature significantly in the lives of children that become subject to child protection plans. 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 and a report was requested by the NSCB to provide assurance around the work undertaken to protect children living in households where DVA is present.

Action has also been taken to improve the connectivity between Community Safety Partnerships, which commission Domestic Homicide Reviews (DHR), and the NSCB. Awareness of the need to consider child protection implications within such reviews has been raised and an agreement to notify NSCB officers when a review is being considered has been re-introduced to enable appropriate involvement and advice at an early stage.

Safeguarding children in education

The NSCB has sought assurance regarding the quality of safeguarding in schools and comprehensive update was presented to the Board which included details of the safeguarding children in education audit undertaken by schools in the area. A significant amount of work has been undertaken by NCC Education Standards and Inclusion Service supporting schools

to deal effectively with self-harm through the provision of guidance and the delivery of an extensive training programme. The work undertaken by the local authority to help schools recognise children missing education and advice on appropriate action was also noted as being good practice.

Private fostering

Updates have been provided to the Board, and the NSCB Executive, regarding the identification of private fostering arrangements and compliance with requirements to assess the suitability of such arrangements and undertake periodic visits. Concerns remain about the low number of known privately fostered children. Those that come to the attention of children's social care are often not notified to them by parents/carers but more likely identified as a result of contact for other purposes. The priority has therefore continued to be awareness raising with partner agencies, in particular schools and GPs, to help identify potential private fostering arrangements. Further information is available in the NSCB children living away from home guidance.

Allegations against people that work with children

Details of the arrangements for managing allegations against those that work with children have been reported to the Board. Assurance was sought regarding the notification to professional bodies and the Disclosure and Barring Service when staff resign as an alternative to dismissal and confirmation was provided that in all such cases appropriate alerts had been made.

Sexual abuse referral centre (SARC – now referred to as EMCYPSAS)

During the year the NSCB continued to scrutinise the effectiveness of the response to child sexual abuse and the support available to those that have suffered as a consequence. In particular the commissioning by NHS England of a Paediatric Sexual Assault Referral Centre (SARC) provision across the East Midlands.

In May 2017 the NSCB was advised that the NHS England SARC commissioning process had been unsuccessful. Further, that in anticipation of the new service being introduced CCGs across the East Midlands had been instructed to decommission existing acute health services for child victims of sexual abuse with effect from July 2017. On behalf of the NSCB the Independent Chair made representations to NHS England and local health

commissioners on a number of occasions over the following months, stressing the unacceptability of having no commissioned acute health provision for sexually abused children in Nottinghamshire. Nottinghamshire County Council and the Chairs of other Safeguarding Boards in the East Midlands Region made similar representations. NHS England initially provided an outline of interim arrangements and in September 2017 a firm assurance was provided from NHS England and the Nottinghamshire CCGs that the service provision which had formerly been commissioned would continue until the SARC arrangements had gone live.

In March 2018 details of the new service, now referred to as East Midlands Children and Young People Sexual Assault Service (EMCYPSAS), were provided to the NSCB. The service went live on 1st April 2018 and importantly includes support by Crisis Support Workers and an option for therapeutic support sessions.

Female genital mutilation

The work of the cross authority FGM Steering Group is reported annually to the Board and specific issues around; representation of agencies, inclusion of FGM in the Sexual Abuse Referral Centre (SARC) specification and continuity of specialist midwife services, have been followed up as a result.

Children in custody

East Midlands Criminal Justice Services (EMCJS) provided details on the detention of children and young people a small proportion of which are remanded. Assurance was provided regarding the audit of cases where a young person is remanded and the steps taken to ensure policies and procedures are followed. The extent to which drug and alcohol use was a factor in young people being detained was also raised and work is ongoing to provide further analysis around this issue.

Unaccompanied asylum seeking children/child migration

The Board received details of the application of the National Transfer Scheme within the County and analysis of the measures in place to ensure that this vulnerable group of children are protected.

LEARNING AND IMPROVEMENT FRAMEWORK

Special Guardianship Orders (SGOs)

The NSCB requested that the CAFCASS representative provide a report on the use of SGOs within the county. Details of the work undertaken by CAFCASS in conjunction with the Local Family Justice Board and the local authority were provided to ensure that practice regarding SGOs reflects current thinking on the use of these orders.

Preventing radicalisation

The Prevent Duty 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. The Safer Nottinghamshire Board takes the lead for coordinating and monitoring action in this regard however there are clear safeguarding implications and the NSCB has maintained an oversight of this work, ensuring for example that representation from health organisations is appropriate.

Clayfields House Secure Children's Home

Clayfields House is a secure children's home provided by Nottinghamshire County Council.

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 July 2018 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.

Looked after children's health pathway

The NSCB Executive has been monitoring the timeliness and quality of health assessments for looked after children and has requested regular updates and performance data in this regard. The quality of health assessments has been very good however timescales for completing such assessments have proved to be challenging for the resources available and this resulted in the issue being escalated to the Board and continues to be a focus of attention.

LEARNING AND IMPROVEMENT FRAMEWORK

Closure of Home-Start Ashfield

It was reported to the Board in December 2017 that Home-Start Ashfield was likely to close due to one of the funding partners withdrawing and despite the ongoing support of Nottinghamshire County Council the closure was confirmed on 31st March 2018. Home-Start have been providing much needed services for families in need in that area and arrangements were put in place to allow ongoing support for 20-25 families by staff based at another office whilst alternative sources of funding were sought.

Transitions

A member of the Transitions Team provided details to Board members of the work undertaken to provide planning, assessment, advice and support services for young people preparing for adulthood. The recently launched 'Transitions Pathway' was promoted amongst the partnership.

Workshop sessions

A number of workshop sessions were held throughout the year to allow members to consider key areas of safeguarding practice. These includes a session on the response to child sexual abuse during which issues around strategy discussions, the Sexual Abuse Referral Centre, and emerging findings from the familial sexual abuse audit were explored. Another session was used to look at the increasing demands on the Multi-Agency Safeguarding Hub (MASH), and as a consequence partners were supported to communicate with staff options for accessing the correct service for the level of need. Further work to understand the reasons behind the significant proportion of contacts with the MASH that result in no further action is ongoing and will hopefully result in multi-agency agreed strategies to manage demand on the MASH.

Moving forward

The next year will see the introduction of new 'safeguarding arrangements' following the implementation of measures contained in the Children and Social Work Act 2017 which abolish local safeguarding children boards and place a duty on 'safeguarding partners' to make arrangements to safeguard and promote the welfare of children in the area.

The safeguarding partners (the local authority, police and clinical commissioning groups for Nottinghamshire) have been working on options for the new arrangements. The NSCB Independent Chair has been closely involved with this work and provided scrutiny of the emerging plans. Members of the NSCB have received regularly briefings on the implications of the new legislation through the Board and Executive and have been consulted on the preferred option being developed. The new arrangements will provide the opportunity to retain the excellent cooperation with existing NSCB member organisations, all of which will be identified as 'Relevant Agencies', as well as expanding engagement with other organisations which under the current structure are less involved. Independent scrutiny will be retained through the appointment of an Independent Scrutineer who will directly lead the safeguarding assurance and improvement functions. A Strategic Leadership Group, comprising of the safeguarding partners, will ensure that there is equal and joint responsibility for local safeguarding arrangements.

The NSCB Business Plan 2018/19 (available on the NSCB website) is an interim plan which details the priorities for the Board and ensures that the transition to the new arrangements is carefully planned whilst ensuring that improvement work identified through the learning and improvement framework is progressed.

Vulnerable groups

The following vulnerable groups have been identified and will provide a focus for the work of the Board.

- 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

The service provided to children in these situations will receive particular attention by the Board through the Performance Management Framework, multi-agency audit and learning reviews. In addition the Board will seek assurance that the front door arrangements, delivered through the MASH, effectively respond to vulnerable groups.

Child safeguarding practice

The NSCB will also seek to improve safeguarding practice and focus on the following areas of work:

- The appropriate application of thresholds through the Pathway to Provision, and reducing repeat referrals
- The quality of strategy discussions and involvement of agencies
- The effectiveness of child protection conferences
- Information sharing; the implications of General Data Protection Regulations (GDPR) and the work of Connected Nottinghamshire including implementation of the CPIS project and realisation of associated benefits
- Effective resolution of professional disagreements

Transition to new safeguarding arrangements

Between September and December 2018 the detail of the new safeguarding arrangements will be developed and NSCB members will be closely involved and consulted in the work being led by the safeguarding partners. Arrangements will be put in place to ensure that relevant data and information is handed over from the NSCB to the safeguarding arrangements and child death review arrangements.

The new safeguarding arrangements will be published in December 2018 and implementation will commence on 1st January 2019 and continue for a three month period during which the NSCB will continue to exist as a statutory body. From 1st April 2019 the NSCB will cease to operate, with the exception of the completion of any outstanding serious case reviews which it

MOVING FORWARD

will retain responsibility for. Any new case reviews will be commissioned under the new arrangements.

Regular updates will be available on the progress of this work through the NSCB ‘What’s New in Safeguarding Events’ and the NSCB website.

APPENDIX A

Appendix A

NSCB Membership List (at 1/08/18)

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 and Family Services, Nottinghamshire County Council.
Laurence Jones	Interim Service Director, Commissioning and Resources, Children and Family Services, Nottinghamshire County Council.
Steve Edwards	Service Director, Youth Families & Social Work, Children and Family Services, Nottinghamshire County Council.
Marion Clay	Service Director, Education, Learning & Skills, Education Standards and Inclusion, Children and Family Services, Nottinghamshire County Council.
Rachel Miller	Interim Group Manager, Early Help, Children and Family Services, Nottinghamshire County Council.
Joe Foley	Group Manager, Safeguarding Assurance and Improvement, Children's and Family Services, Nottinghamshire County Council.

APPENDIX A

Paul Johnson	Service Director, Adult Social Care, Strategic Commissioning, Access and Safeguarding, Health and Public Protection, Nottinghamshire County Council.
Kate Allen	Children's Commissioning and Consultant in Public Health, Children's Integrated Commissioning Hub and Public Health, Nottinghamshire County Council.
Health - commissioners	
Nicola Ryan	Interim Chief Nurse, Executive Lead, Quality and Patients Safety, NHS Bassetlaw CCG.
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, Greater Nottingham Clinical Commissioning Groups.
Health - providers	
Rick Dickinson	Acting Deputy Director of Nursing, Midwifery & Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust.
Bella Dorman	Head of 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, 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.

APPENDIX A

Andy Gowan	Detective Superintendent, Head of Public Protection, Nottinghamshire Police.
Clare Mayne	Head of Practice, 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).
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 Diamond Emmanuel 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, HR, Workforce and Organisational Development, Nottinghamshire County Council.

APPENDIX A

Bob Ross	NSCB Development Manager, Safeguarding Assurance and Improvement, Children and Family Services, Nottinghamshire County Council.
Steve Baumber	Service Manager Partnerships and Planning, Safeguarding Assurance and Improvement, Children and Families, Nottinghamshire County Council.
NSCB Business support	
Michelle Elliott	NSCB Administrator, Business Support, Nottinghamshire County Council.
Carol Fowler	Child Death Administrator, Business Support, Nottinghamshire County Council.
Sarah Bale	NSCB Training Administrator, HR, Workforce and Organisational Development, Nottinghamshire County Council.

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