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NOTTINGHAM CITY COUNCIL
OVERVIEW AND SCRUTINY COMMITTEE

Date: Wednesday, 4 November 2015

Time: 2.00 pm

Place: LB 31-32 - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Corporate Director for Resilience

Governance Officer: Rav Kalsi **Direct Dial:** 0115 8763759

AGENDA **Pages**

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE GOVERNANCE OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

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NOTTINGHAM CITY COUNCIL

OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of the meeting held at LB 31-32 - Loxley House, Station Street, Nottingham, NG2 3NG on 7 October 2015 from 14.00 - 16.00

Membership

Present	Absent
Councillor Brian Parbutt (Chair)	Councillor Ginny Klein
Councillor Glyn Jenkins	Beverley Frost
Councillor Azad Choudhry	Councillor Corall Jenkins
Councillor Georgina Culley	
Councillor Gul Nawaz Khan (Vice Chair)	
Councillor Neghat Nawaz Khan	
Councillor Anne Peach	
Councillor Pat Ferguson	
Councillor Leslie Ayoola	
Councillor Josh Cook	
Councillor Mohammed Ibrahim	
Councillor Patience Ifediora	

Colleagues, partners and others in attendance:

Ian Curryer	-	Chief Executive, Nottingham City Council
Glen O'Connell	-	Corporate Director for Resilience
Rav Kalsi	-	Senior Governance Officer
Debra La Mola	-	Head of Democratic Services
Sarah Wilson	-	Chief Elections Officer

12 APOLOGIES FOR ABSENCE

Councillor Corall Jenkins – Personal Reasons
Councillor Ginny Klein – Personal Reasons
Councillor Anne Peach (for Lateness) – Other Council Business
Beverley Frost – non Council business

13 DECLARATIONS OF INTERESTS

None.

14 MINUTES

The Committee agreed the minutes of the meeting held on 9 September 2015 and they were signed by the Chair.

15 MANAGEMENT AND ORGANISATION OF THE LOCAL AND PARLIAMENTARY ELECTIONS HELD IN MAY 2015

Ian Curryer, Chief Executive, led a presentation to the Committee with support from Debra La Mola, Head of Democratic Services, Glen O'Connell, Corporate Director for Resilience, and Sarah Wilson, Electoral Services Manager. The presentation covered the management and organisation of the Local and Parliamentary elections held in May 2015 and highlighted the following points:

(a) The 2015 elections were particularly complex due to the coincidence of the Parliamentary and Local elections, something which had last occurred in 1997. A large number of nominations were received with 19 Parliamentary Candidates and over 200 Local Candidates representing more parties than had ever been dealt with before. The introduction of Individual Electoral Registration (IER) resulted in the core Elections Team spending significant time on registration queries and having less time for preparing for the election. Significant changes in voting patterns including an increase in postal voting by around 8% and more stringent requirements regarding the checking of postal votes also impacted on the demands on the service.

(b) Locally, the failure of the service's externally provided IT system to cope with the requirements of IER resulted in the purchase of a new system in the run up to election day. Whilst this was the right decision to take, it did put extra pressure on the service as staff had to learn how to use a new system while also preparing for a major election.

(c) The turnout for the election was 56.7% citywide, an increase from 36.5% in 2011. This increase does not reflect the huge turnover of electors on the electoral register with existing electors coming off the register and new electors being added.

(d) The size of the temporary workforce required to support the election also posed a challenge. 322 individuals were appointed to 628 posts. All of the appointees had volunteered to support the election. Elections staff are paid but City Council colleagues could not be required to put themselves forward for roles, though if the opportunity to review contracts came up in future, this could be considered. There was a relatively high drop out rate amongst those who had volunteered, which caused difficulties with training and ensuring there were sufficient staff to cover all the key roles. There was a high proportion of new staff recruited who can now be approached for future elections. Around 50% of the staff at the local count on the Friday were new. While this addressed the problem of the experienced staff being very fatigued having worked the previous day it did mean that some were slower than more experienced staff might have been.

(e) All staff who worked on the election, either at Polling Stations or at the counts had attended training and polling station staff were required to pass an online test. On the day, where there were inexperienced staff in polling stations, they were prioritised by the inspectors to ensure they were confident in what they were doing and that all was being correctly.

(f) Other issues included:

- During postal vote opening, there were several challenges to processes from observers. Once the process was explained the observers were satisfied but this took time away from those who were working on postal vote opening;

- Poor quality nomination papers also caused issues with some having to be returned to candidates three or four times before they were correct. For future elections it would be helpful to have more colleagues working as Deputy Returning Officers and supporting the nominations process;

- The length and size of the 'grass skirt' sheets used to count ballot papers with multiple votes together with changes in voting patterns which resulted in fewer block votes posed a challenge for counters on the night, as did the requirement to count votes not cast. For future similar elections, having two Count Supervisors per ward may be advisable;

- The target time to complete verification and commence counting for the Parliamentary election was not met. Part of the delay came after the check in process, which worked very effectively, when ballot boxes were then checked again when they reached the count areas. This delayed the boxes being opened and verification commencing.

(g) Positives from the election included:
- The large number of new voters registered in time for the election;
- Effective management of the increased turnout, including management of queues where they occurred;
- The significant number of new staff used, increasing the pool of experienced and trained staff for future elections;
- The successful and accurate processing of the large number of postal votes, while under significant scrutiny;
- Very positive feedback on the training for polling and count staff;
- A successful election with no complaints of fraud.

During questions from Councillors the following points were discussed:

(h) All staff who participated in the election were trained, depending upon which role they performed and were required to answer at least 80% of online questions correctly. A view is also taken to match experienced individuals with those new to the role however, due to the number of people who drop-out the Council is often left with inexperienced individuals filling the void;

(i) There were four wards in particular that which declared outcomes significantly later than others, such as Berridge, Radford and Park, Sherwood and Wollaton West. This is largely due to the number of ballot papers issued which were issued in those wards and the number of candidates standing for election in each ward. Consequently, counting the votes took substantially longer;

(j) Some candidates had to queue for up to 30 minutes when entering the Tennis Centre for the Local Election Count on Friday 8 May. In the future, it would be useful to make use of the number of entry points and have two queues for entry;

(k) Where citizens provide alternative forms of contact, such as an email address or a telephone number, it is placed onto the electronic system and stored, but this is currently optional and not mandatory. Currently, Elections staff is carrying out their canvass over the phone where possible but there are some practices that require a formal letter to meet statutory duties;

(l) There is no set time limit for presiding officers to escort their ballot box over to the verification and count at the Tennis Centre and most stations are situated within 30 minutes of this location. Where there are queues, polling station staff are told to call to inform Inspectors of queues, as was the case at the Cathedral in Nottingham the election in May. In this case, all of those queueing were able to vote.

RESOLVED to

(1) Thank the Ian Curryer for his informative presentation and responses to questions posed during the discussion;

(2) Request that Nottingham City Council produce an instruction manual on the nomination process and how to successfully complete the nomination paperwork;

(3) Circulate the local electorate and turnout figures for the elections held in May 2015 to Committee members;

(4) Encourage periodic dialogue with local political parties on best practice in order to improve the standard of submissions in the future.

16 PROGRAMME FOR SCRUTINY

Rav Kalsi, Senior Governance Officer introduced the report of the Head of Democratic Services setting out the programme of activity for this Committee and the Overview and Scrutiny Review Panels for 2015/16.

RESOLVED to agree the work programme for the Overview and Scrutiny Committee and Review Panels for 2015/16, as summarised in the report.

OVERVIEW AND SCRUTINY COMMITTEE
4 NOVEMBER 2015
NOTTINGHAM CITY SAFEGUARDING CHILDREN'S BOARD (NCSCB) – ANNUAL REPORT 2014/15 AND NOTTINGHAM CITY ADULT SAFEGUARDING PARTNERSHIP BOARD (NCASPB) – ANNUAL REPORT 2014/15
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the NCSCB and NCASPB Annual Reports for 2014/15 and identify and issues arising from the Annual Reports that could be built into the work programme for future scrutiny activity.

2. Action required

2.1 To explore the issues identified in both Annual Reports and the progress made by the Boards following the recommendations arising from the review carried out by Ofsted in May 2014.

2.2 In the future, the Committee might consider referring the scrutiny of NCSCB's Annual Report to the Children and Young People Scrutiny Committee.

3. Background information

3.1 In the January 2014, Overview and Scrutiny reviewed NCSCB's Annual Report for 2013/14 and heard that six areas had been identified by Ofsted as requiring improvement. The Committee heard that improvement and recommendations were either complete or in progress.

3.2 It is a statutory requirement that the Nottingham City Safeguarding Children Board produce an Annual Report setting out its performance against key objectives and priorities for action in the Board Business Plan. On 1 April 2015, as a result of the Care Act 2014, it became a statutory responsibility to produce an Annual Report for the Safeguarding Adult Board though this requirement would apply to the year 2015/16. It has always been our practice in Nottingham City to produce an annual report for the Adult Safeguarding Board even though this has not been a statutory requirement.

3.3 The main purpose of the annual reports is to assess the impact of the work we have undertaken in 2014/15 on service quality and effectiveness and on outcomes for children, young people and adults in Nottingham City. Specifically the annual reports evaluate the performance against the priorities that have been set in Business Plans

2014/15 and other statutory functions that the Local Safeguarding Children Boards must undertake.

3.4 In the past, the annual reports for the two safeguarding boards have been combined into one report. This year this decision has been reverted to presenting separate annual reports for the NCSCB and the NCASPB. The reasons are twofold. Firstly, there have been changes to the statutory frameworks within which both Boards work that underline the need for bespoke annual reports. Secondly, feedback from readers of last years' annual report suggested that the combined report was too complex and lengthy and risked diverting attention from key issues in the children and adult safeguarding arenas.

3.5 For these reasons two separate annual reports have been produced and presented to the Health and Well-Being Board, Children's Partnership Board and now to the Overview and Scrutiny Committee.

4. List of attached information

Health and Wellbeing Board Report, 30 September 2015

Nottingham City Safeguarding Children's Board Annual Report 2014/15

Nottingham City Safeguarding Adults Partnership Board Annual Report 2014/15

5. Background papers, other than published works or those disclosing exempt or confidential information

None.

6. Published documents referred to in compiling this report

Overview and Scrutiny Committee minutes 7 January 2015.

7. Wards affected

City-wide.

8. Contact information

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Senior Governance Officer
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HEALTH AND WELLBEING BOARD - 30 September 2015

Title of paper:	NCSCB AND NCASPB ANNUAL REPORTS 2014/15	
Director(s)/ Corporate Director(s):	Alison Michalska (Corporate Director, Children and Adults)	**Wards affected:** All
Report author(s) and contact details:	Paul Burnett (Independent Chair – Nottingham City Safeguarding Board and Adult Safeguarding Partnership Board)	
Other colleagues who have provided input:	Safeguarding Boards Business Office	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☑
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☑
Deliver effective, value for money services to our citizens	☐
Relevant Health and Wellbeing Strategy Priority:	
Healthy Nottingham: Preventing alcohol misuse	☐
Integrated care: Supporting older people	☐
Early Intervention: Improving Mental Health	☐
Changing culture and systems: Priority Families	☐

Summary of issues (including benefits to citizens/service users and contribution to improving health & wellbeing and reducing inequalities):

The Safeguarding Boards key purposes are to secure effective safeguarding arrangements for the citizens of Nottingham and to secure effective co-ordination between all agencies responsible for safeguarding.

Recommendation(s):

1	To consider the annual report and identify any comments, proposed additions or amendments that the Board would wish to identify.
2	Subject to any comments, proposed additions or amendments to agree the Annual Report.
3	To identify any issues arising from the Annual that will be built into the Strategic Commissioning Plan formulated by the Health and Well-Being Board.

	How will these recommendations champion mental health and wellbeing in line with the Health and Wellbeing Board aspiration to give equal value to mental health and physical health ('parity of esteem'): Both safeguarding boards have included mental health and well-being as key priorities in their Business Plans since mental health can be a critical risk factor in safeguarding not just for individual children or adults but in the wider family and community context. The Boards are driving to secure stronger safeguarding practice in relation to mental health to reduce risk and to improve safeguarding outcomes.

1. REASONS FOR RECOMMENDATIONS

1.1 It has been agreed that the Health and Well-Being Board will be a partnership board that receives the Safeguarding Boards' Annual Report as part of the annual consultative process. In addition, it has been agreed that the Health and Well-Being Board will consider how the key objectives in the Safeguarding Boards' Annual Business Plans will be built into their own Strategic Commissioning Plans.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 It is a statutory requirement that the Nottingham City Safeguarding Children Board produce an Annual Report setting out its performance against key objectives and priorities for action in the Board Business Plan. On 1st April 2015, as a result of the Care Act 2014, it became a statutory responsibility to produce an Annual Report for the Safeguarding Adult Board though this requirement would apply to the year 2015/16. It has always been our practice in Nottingham City to produce an annual report for the Adult Safeguarding Board even though this has not been a statutory requirement.

2.2 The main purpose of the annual reports is to assess the impact of the work we have undertaken in 2014/15 on service quality and effectiveness and on outcomes for children, young people and adults in Nottingham City. Specifically the annual reports evaluate our performance against the priorities that we set in our Business Plans 2014/15 and other statutory functions that the LSCB must undertake.

2.3 Last year we combined the annual reports of the safeguarding boards into one report. This year we have reverted to presenting separate annual reports for the NCSCB and the NCASPB. The reasons are twofold. First there have been changes to the statutory frameworks within which both Boards work that underline the need for bespoke annual reports. Second, feedback from readers of last years' annual report suggested that the combined report was too complex and lengthy and risked diverting attention from key issues in the children and adult safeguarding arenas. For this reason two separate annual reports are being produced for presentation to the Health and Well-Being Board, the Scrutiny Committee, and the Children's Partnership Board. In addition there is an expectation that the Annual Reports will be presented to key strategic forums within those organisations that are members of the safeguarding boards.

2.4 The Annual Report covers a range of issues including:

- An outline of the local area safeguarding context setting out some core statistical and socio-economic profile information;

- The governance and accountability frameworks within which the Boards operate including the relationship between the two safeguarding boards and the Health and Well-Being Board and steps that have been taken to clarify inter-relationships between the safeguarding boards and the wider partnership geography in the city, such as the Children's Partnership Board and the Community Safety Partnership; this part of the annual report also sets out attendance at the board, an account of our annual expenditure and an analysis of the effectiveness of the Boards;
- Performance against the Business Plans for 2014/15 that analyses what we did and its impact on outcomes in relation to service effectiveness and outcomes for service users; this includes outlines of key work undertaken in safeguarding priority areas such as: sexual abuse; domestic violence (including the launch of DART); Missing Children; Child Sexual Exploitation Mental Capacity Act and Deprivation of Liberty Safeguards, Allegations Management; safeguarding policies and procedures; safeguarding training and development activity; safeguarding in childcare and early years settings; safeguarding in schools and education settings;
- Specific reports from the Serious Case Review and Child Death Overview sub-groups of the Children's Safeguarding Board;
- An outline of individual partner agency safeguarding performance during 2014/15;
- A digest of the future challenges facing the Boards including our Business Plan for 2015/16.
- Analysis of the Board's quality assurance and performance management work in 2014/15 is set out in relevant sections of the report

2.5 Each report recognises much positive progress in relation to priorities set in the Business Plans 2014/15. In addition the reports identify areas for development and improvement. Headlines include:

In relation to children and young people:

Strengths

- Continued commitment and engagement from the majority of partners on the Board and its constituent committees – including sharing of the chairing of sub-groups across agencies;
- Effective interfaces between NCSCB and the Children's Partnership Board and with the wider partnership geography through the Safeguarding Assurance Forum;
- Formulation and revision of practice guidance to ensure effective safeguarding and reflect national and local learning from reviews including serious case reviews;
- Significant focus on areas of improvement identified in the Ofsted inspection 2014 with some measure of success in many areas:
- Further embedding of 'Signs of Safety'
- Remodelled structures and organisational arrangements including review 'Front Door' arrangements and co-location of early help, targeted support/youth offending service and children's social care in one Directorate better to promote co-ordination of delivery and processes;
- CSE strategy and action plans have been health checked against the learning from national reviews in Rotherham, Oxfordshire and through Ofsted and

action taken to address any areas of improvement that need to be applied in Nottingham City;

- A range of CSE training and awareness including the Pint Sized Theatre production LUVU2 in schools;
- The Concerns Network has supported the development of cross-agency co-ordination and collaboration in relation to CSE;
- Work with schools in relation to domestic violence including the Great programmes and the implementation of the early alert system;
- Work of the Domestic Abuse Response Team which received positive evaluation from Ofsted;
- Major review and revision of cross-authority multi-agency safeguarding procedures to ensure that they are Working Together 2013/2015 with positive reviews of impact from subsequent audit processes;
- Creation of a Communication and Engagement Sub-Group, launch of new NCSCB bulletin and identification of engagement initiatives across the partnership that can provide the basis for wider engagement of children and young people;
- Extensive programme of training and development from which 'end of course' evaluation evidence high levels of satisfaction;
- Publication of two serious case reviews and the implementation of recommendations for these and four learning reviews – the impact of which will be tested through the Quality Assurance Framework in 2015/16;
- Effective CDOP arrangements that have led to improvements in services and impact on 'avoidable' deaths.

Key areas for development and improvement

- Improved attendance and engagement from NHS England and from schools
- Recruitment of new lay members
- Consistency of attendance at subgroups most importantly the Quality Assurance Subgroup which has failed to secure quoracy on a number of occasions during 2014/15;
- Secure full compliance with the new budget contribution formula which requires either a reduction in overall budget or an increase in the level of contribution from the City Council;
- Further test the impact and effectiveness of the assessment framework, threshold protocol (Family Support Pathway) and Learning and Improvement Framework that was introduced post-Working Together 2013;
- Improved engagement of partners in the provision of quality assurance and performance management information for the Board to ensure that it is effectively able to test its impact;
- Extension of the Board's engagement with children and young people to ensure that their views and opinions shape the work of the NCSCB;
- Improvements in the provision of data for CSE and a greater emphasis on prosecutions of CSE perpetrators
- The appointment of a CSE Co-ordinator

- Greater interaction between the NCSCB and the Priority Families Programme;
- Finalise the safeguarding competency framework against which the longer term impact of training and development activities are evaluated;
- Act on the areas of improvement identified in SCRs and other learning reviews including: the impact of emotional health and well-being/emotional abuse on safeguarding risk; escalation; children places on special guardianship orders; quality of assessments; responses to families out of hours. Further factors are also touched on in the main report;

These and other priorities for action are set out in the Business Plan 2015/16 which features as an appendix to the Annual Report

In relation to adults:

Strengths

- Continued commitment and engagement from the majority of partners on the Board and its constituent committees including those that now have a statutory duty to attend safeguarding adult boards – the City Council, Nottinghamshire Police and the CCG;
- Sharing of subgroup chairing responsibilities across the adult safeguarding partnership
- Effective interfaces between the NCASPB and other strategic partnership forums driven through the Safeguarding Assurance Forum and through regular reporting between NCASPB and the Health and Well-Being Board;
- Planned for and secured compliance with the new statutory requirements for Safeguarding Adults Boards created through the Care Act 2014 supported by the Care Act Task and Finish Group;
- In support of the expectations of the Care Act the NCASPB has supported: revision of cross-authority multi-agency procedures; development of Safeguarding Adult Reviews (SARs) procedures; formulated a training strategy; identified Designated Adult Safeguarding Managements in relevant partner agencies; secured assurance that contracts with providers have robust safeguarding clauses including the duty to share information; partners have secured Care Act compliance;
- Updated the Safeguarding Audit Framework to reflect Care Act expectations – next SAF will be completed during 2015/16;
- The Domestic Abuse Stalking Harassment and Honour Based Violence(DASH) and Risk Identification Checklist (RIC) has been revised;
- Learning from national Safeguarding Adult Reviews was used to support improvement in Nottingham City included learning from the SAR on Orchid View in East Sussex
- A communication and engagement subgroup has begun to support the NCASPB objective of hearing the voice of the service user in both planning, delivering and evaluating safeguarding arrangements. This included the formulation of a new communication and engagement strategy;

- An adult safeguarding Learning and Improvement framework was developed and agreed;
- All Board training materials and quality assurance arrangements were updated including revisions to secure compliance with Care Act expectations;
- The SAF evidenced that all agencies have safe recruitment processes in place
- Evaluations of training provision were positive

Key areas for development and improvement

- Continued implementation of the expectations of the Care Act in respect of the Safeguarding Adults Board;
- Effective scrutiny, challenge, quality assurance and performance management of the safeguarding implications of the Care Act on constituent organisations both individually and collectively;
- Integrate quality assurance and performance management arrangements into core subgroup activity rather than operating a separate Quality Assurance Subgroup;
- Establish a data and reporting group for Domestic Violence data to support Board strategic decision making in a more meaningful including the identification of key themes and trends;
- Further extend the engagement of service users in the work of the Board;

These and other priorities for action are set out in the Business Plan 2015/16 which features as an appendix to the Annual Report

Across the boards:

Strengths

- Steps taken to improve cross-reporting between children and adult services where each identifies safeguarding concerns in relation to service users in the other;
- A transitions document has been formulated with the County Council supported by a good practice guidance document – this is now being reviewed in the light of the Care Act
- Targets met through the Priority Families programme have supported the reduction in safeguarding risk for some families in the City

Key areas for development and improvement

- Ensure that the new Board arrangements with two Independent Chairs secure improved focus on children and adult safeguarding whilst continuing to ensure cohesion and co-ordination across the safeguarding agenda as a whole;
- Improve the interface between the two safeguarding boards and the Priority Families Programme to maximise improved performance that might have mutual benefit;

2.6 **Safeguarding performance** as evidenced through the quality assurance framework employed by the two Boards presents a mixed picture. Set out below are some of the headlines in relation to both children and adult safeguarding:

Safeguarding of Children and Young People – Performance across the Child's Journey

- Reduction in number of contacts – targets met;
- Assessments undertaken within 45 days (85%) which is above target and average for statistical neighbours;
- Reduction in the number of CAFs has caused a concern though we witnessed an increase in the last quarter of the year;
- 80% of CAFs record positive outcomes but there has been an increase in the number of cases escalating to social care which will be something that requires careful monitoring during 2015/16;
- The number of children subject to a Child Protection Plan has risen;
- 99% of child protection cases have been reviewed within timescale;
- The number of children in care has reduced slightly – and performance on key indicators is better than statistical neighbours
- The % of care leavers in suitable accommodation has reduced from 89.6% to 84.9%. The number of care leavers in suitable education, employment and training presents a challenge but does match statistical neighbours and is a 7% improvement on the previous year.

During the year two Serious Case Reviews were published, two were commissioned and one learning review was commissioned. There is strong evidence to show that learning from these reviews has been implemented and impact will be tested through the quality assurance framework

Safeguarding Adults

- the number of safeguarding investigations has remained similar to that recorded in 2013/15 – though the distribution of investigations across the four quarters of the year is more even;
- Over 75% of citizens against which alleged abuse took place were over 61 and there was an increase in the proportion over 81:
- The most common form of abuse cited in investigations is neglect or omission (44% of investigations) but financial abuse is a growing area of concern. Physical and psychological abuse also account for a significant proportion of investigations
- 37% of investigations related to abuse in the citizens own home and 39% are in residential or nursing home provision. Proportionately this is similar to last year. The proportion of 'unknowns' is a concern and we will need to seek more robust recording to ensure our knowledge of location is clear.
- 49.3% of investigations were substantiated – this is similar to the rate recorded in 2013/14 but higher than in previous years. 5% were partially substantiated.
- The significant increase in DoLS (deprivation of liberty safeguards) referrals is continued placing considerable pressure on resources and on responding to referrals within expected timescales.

It is important to note that the programme of audits to test the quality of service relating to the data above did not proceed as planned due to service pressures created by the Care Act. This work has been remitted to the Business Plan 2015/16

and will be an important improvement to the quality assurance and performance management role of the NCASPB next year.

2.7 Both Annual Reports set out the priorities for action in the current year (2015/16) and these have been incorporated into the business plans for 2015/16. Clearly the areas for improvement for the Board itself that are reported on within the annual reports are key priorities in the current year. In addition the NCSCB will take a role in monitoring and evaluating the performance of the local authority and its partners in response to the Ofsted inspection of 2014 and, indeed, inspection undertaken by other inspectorates such as CQC and HMIC. There is an expectation that an integrated inspection regime will be introduced in the near future in the children's services arena.

2.8 The Business Plan for 2015/16 has already been considered by the Health and Well Being Board. It sets out priorities for action for the current year and sets out both the quality assurance and performance management indicators that will be applied to assess impact against each of the priorities and the actions that will be undertaken to support the achievement of these impacts and outcomes.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 There are no other options presented.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

4.1 Both the NCSCB and NCASPB are funded through a budget to which all statutory partners contribute through a formula agreed by the Board. These contributions have been agreed and there are no financial implications specifically for the Health and Well-Being Board.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

5.1 The NCSCB and NCASPB operate their own risk registers that are monitored by both the Quality Assurance Sub-Group and the Operational Management Group.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions) ☑

No ☐

Yes – Equality Impact Assessment attached ☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

7.1 The NCSCB Annual Report is attached as Appendix 1. The NCASPB Annual Report is attached as Appendix 2.

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

8.1 The Business Plans for the NCSCB and NCASPB for 2015/16 are statutorily required and are published. Both are available on the Safeguarding Board websites.

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NOTTINGHAM CITY
Safeguarding
Children BOARD

ANNUAL REPORT 2014-15

FOREWORD FROM THE INDEPENDENT CHAIR

I am pleased to present the Annual Report for the Nottingham City Safeguarding Children Board (NCSCB) 2014/15.

Publication of an annual report is a statutory requirement of LSCBs as set out in Working Together to Safeguard Children 2015. Last year we published a combined annual report for the Children and Adult safeguarding boards. Changes to the statutory frameworks for the two Boards together with feedback from stakeholders has resulted in our reverting to the publication of two annual reports, one for the NCSCB and the other for the Nottingham City Adult Safeguarding Partnership Board (NCASPB). Some parts of the annual reports are shared since a key part of our Business Plan was to secure effectiveness across the children and adult arenas, reflecting our aim to 'think family' in the delivery of our work.

The key purpose of the report is to assess the impact of the work we have undertaken in 2014/15 on service quality and effectiveness and safeguarding outcomes for children and young people in Nottingham City. Specifically it evaluates our performance against the priorities that we set in our Business Plans 2014/15 and other statutory functions that the LSCB must undertake.

The last twelve months have witnessed some significant changes in the way we operate as a Board. At national level the implementation and embedding of the revised statutory framework established through Working Together 2015 has been a key focus. In addition the major focus and reporting on child sexual exploitation has been a key influence and driver for our work. Historic abuse has similarly been a key area of focus. In addition we have closely monitored outcomes of Ofsted reviews of LSCBs in other parts of the country to ensure that we learn from those judgements and build that learning into our own improvement strategies.

At a local level, a key focus has been the recommendations arising from the review of the LSCB carried out by Ofsted in early 2014. I am pleased that the majority of these recommendations have now been successfully addressed. Alongside this we have scrutinised progress on the outcomes and recommendations of inspections carried out in partner agencies by, for example, Ofsted, CQC and HMIP. We have continued our vigilance in assessing the impact of the financial constraints within which partner agencies have operated and the structural and organisational changes that have taken place in response to both national reforms and local strategies to secure efficiencies. The Board has been closely monitoring

and evaluating these initiatives specifically to test their impact on the numbers entering child protection and care arrangements.

I am pleased that this report presents a considerable range of success and achievement for the Board. The assessment of our performance also indicates areas for further development and improvement, which have been incorporated into our Business Plan for 2015/16.

Many of you will know that this will be my last Annual Report since I am stepping down from the Independent Chair role in the early autumn of 2015. I would like to take this opportunity to thank all Board members and those who have participated in Subgroups for their continued commitment, not just in 2014/15 but across the three years in which it has been my privilege to chair the NCSCB. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the children and young people of Nottingham safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the two Safeguarding Boards but by staff working in the agencies that form our partnership. The further improvements we seek to achieve in 2015/16 will require continued commitment from all.

I commend this report to all our partner agencies.

Paul Burnett, Independent Chair, Nottingham City Safeguarding Children Board and Nottingham City Safeguarding Adults Partnership Board.

CONTENTS

CHAPTER 1

LOCAL SAFEGUARDING CONTEXT

The Nottingham City Safeguarding Children Board (NCSCB) serves the City of Nottingham.

The population of Nottingham at the time covered by this report was around 314,268 (mid-year population estimate 2014).

The number of children and young people aged 0-18 years is approximately 64,978 which represent around 20% of the total City population.

Demographic, social and economic context

The population is growing and has risen by almost 5000 since the census of 2011. International migration (recently from Eastern Europe) and an increase in student numbers are the main reasons for the population growth since 2001, together with an excess of births over deaths.

28% of the population are aged 18 to 29 – full-time university students comprise about 1 in 8 of the population.

The number of births has risen in recent years although the latest figures show a small decline.

The 2011 Census showed 35% of the population as being from black minority ethnic (BME) groups; an increase from 19% in 2001.

Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.

White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age-groups.

The City gains young adults due to migration, both international and within Britain, whilst losing all other age groups - this includes losing families with children as they move to the surrounding districts.

There is a high turnover of population.

From a social and economic perspective Nottingham is ranked 20th most deprived district in England in the 2010 Indices of Multiple Deprivation (IMD), a relative improvement on 7th in the 2004 IMD.

39.3% of children are affected by income deprivation.

Crime is the Index of Deprivation domain on which Nottingham does worst, followed by Education, Skills & Training and Health & Disability.

Nottingham ranks 346th out of the 354 districts in England in the 2009 Child Wellbeing Index - effectively the 9th worst district for Child Well-being in the Country.

A higher proportion of people aged 16-64 in Nottingham claim some form of benefit than regionally and nationally.

The unemployment rate is lower than the recent peak in March 2012, but remains higher than the regional and national average.

Specific safeguarding context

Children and Young People

Approximately 35% of the local authority's children are living in poverty.

The proportion of children entitled to free school meals:

- in primary schools is 32.3% (the national average is 18%)
- in secondary schools is 29.8% (the national average is 15%)

45.9% of children and young people are from minority ethnic groups

Child protection in this area

At 31 March 2015:

- 4927 completed children's assessments identified the need for children's service. This was an increase from 4652 at 31 March 2014.
- 1211 section 47 assessments were completed compared to 1011 at 31 March 2014.
- 875 Initial Child Protection Conferences were held during the year. This was an increase from 535 in the preceding year.
- 548 children and young people were the subject of a child protection plan. This was an increase of 14.4% from 479 at 31 March 2014.
- 18 children placed in new private fostering arrangements. This is a reduction from 21 at 31 March 2014.

Children looked after in

- ON 31st March 2015 575 children were being looked after by the local authority (a rate of 90 per 10,000 children). This is a decrease from 584 (93 per 10,000 children) at 31 March 2014. Of this number:
    - 339 (or 59%) live outside the local authority area
    - 78 live in residential children's homes, of whom 44 (56.4%) live out of the authority area (this includes those in internal residential homes)
    - 2 lived in residential special schools both of which were out of the authority area
    - 416 live with foster families, of whom 66.3% (276) live out of the authority area
    - 7 live with parents
    - 10 children are unaccompanied asylum-seeking children.

In the 12 months from 1st April 2014 – 31st March 2015 there have been:

- 70 adoptions (42 in 2013/14)
- 44 children became subject of special guardianship orders (43 in 2013/14)
- 292 children ceased to be looked after, of these 6.8% (20) returned to be looked after within the year.

On 31st March 2015:

- 87.4% care leavers were in suitable accommodation (83.4% in 2013/14)

CHAPTER 2

GOVERNANCE AND ACCOUNTABILITY

The NCSCB and NCASPB have been aligned since March 2012 and since that time have had the same Independent Chair, Paul Burnett. The purpose of this was to ensure effective coordination of the safeguarding agenda, develop consistency in approach and develop efficient ways of working across the boards and all agencies working within them. A specific ambition was to secure a collective approach where safeguarding, whether for children or adults, is seen as everyone's business.

The two Boards have always remained distinct entities with their own constitutions, governance and memberships. This reflects the differing statutory status of the Boards. A decision was taken in January 2015 to more clearly distinguish between the two Boards and steps will be taken to recruit independent chairs for each Board during 2015/16.

The **Nottingham City Safeguarding Children Board** is a statutory body established in compliance with The Children Act 2004 (Section 13) and The Local Safeguarding Children Boards Regulations 2006. The work of the Board is governed by Working Together 2015 which was issued in March of that year.

The statutory objectives and functions of LSCBs are set out in Section 14 of the Children Act 2004 and are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

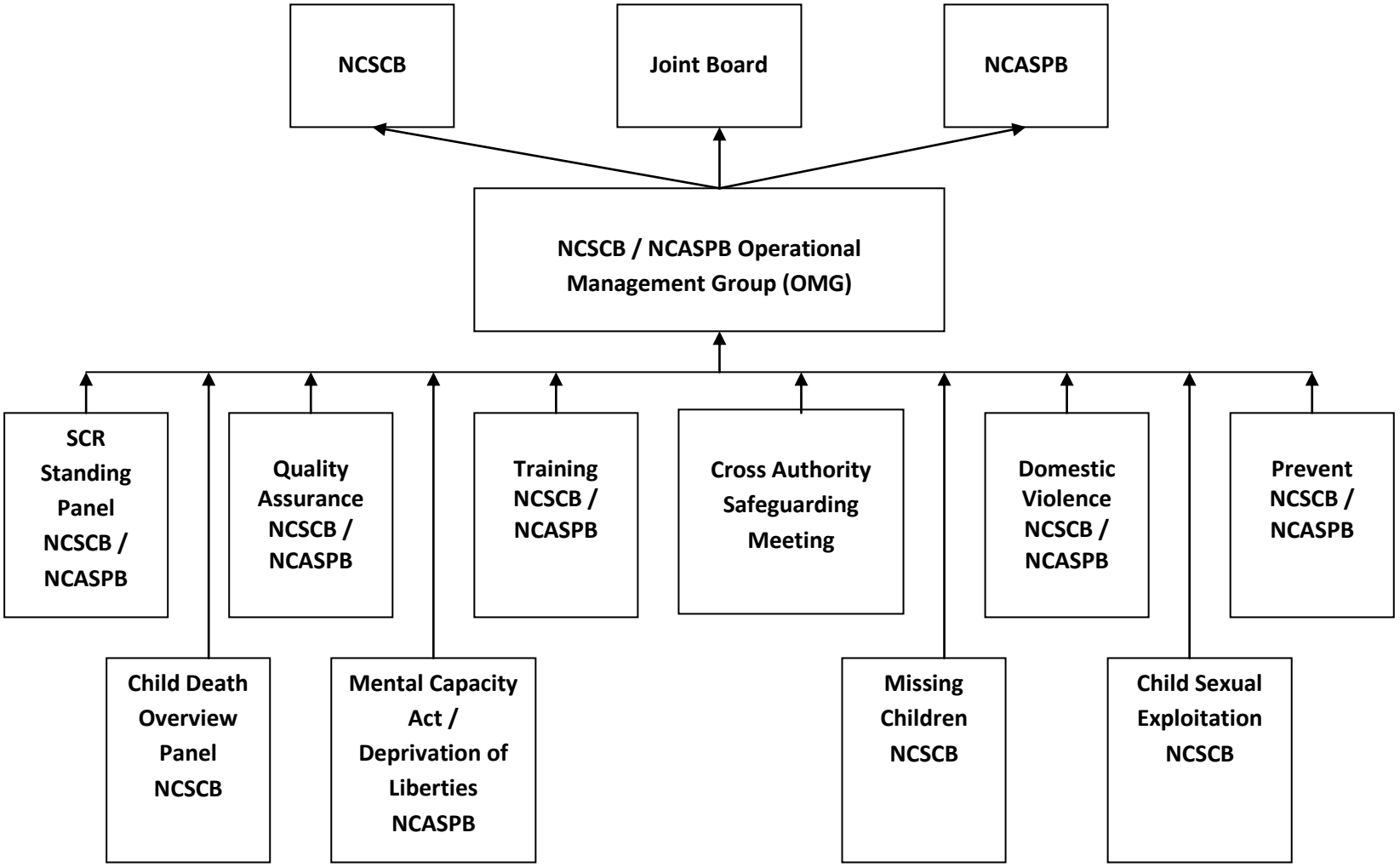
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

The Board in Nottingham meets four times a year, each Board meeting comprising a Children's Board meeting, an Adult Board meeting and a joint meeting of the two Boards.

An Operational Management Group (OMG) was established in 2012 following the decision to align the two safeguarding boards. OMG covers business relating to children and adult safeguarding. The OMG is also chaired by the Independent Chair and all the chairs of the NCSCB /NCASPB Sub Groups are members, both to represent their agency and to report on the work of the subgroup. Any agencies which provide services to children or vulnerable adults with significant involvement in safeguarding who are not represented through the chairing of sub groups are invited to become member of the OMG.

All of the sub groups work towards the priorities of the Business Plan and some of them work to both boards, as described in the diagram below.

BOARD GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS 2014/15



The NCSCB, OMG and each of the Sub Groups have their own Terms of Reference, work plans and reporting expectations. Each group is chaired by an agency representative, has multi-agency membership and is supported by the NCSCB / NCASPB Business Office where possible.

The OMG receives reports from all the sub groups on a regular basis and makes a full report to the NCSCB Strategic Board on progress, exceptions and risk.

All constitutions, governance arrangements, memberships and terms of reference have been kept under review to secure compliance with Working Together 2015.

Work will be undertaken during 2015/16 to review the OMG arrangements in light of the decision to more clearly distinguish between the work of the two safeguarding Boards.

Independent Chair

It is a requirement of Working Together 2015 that the NCSCB appoint an independent chair.

Independent Chair arrangements enable more objective scrutiny and challenge of agencies that are members of the Boards and better enable each individual agency to be held to account for its safeguarding performance and its contribution to co-ordinated safeguarding arrangements.

The Independent Chair during 2014/15 was Paul Burnett. He is a former Director of Children's Services in two local authorities and an experienced independent chair. During 2014/15 he chaired three other LSCBs and Adult Safeguarding Boards as well as those in Nottingham City.

As a result of Working Together 2013 line management arrangements for the Independent Chair transferred to the Chief Executive of Nottingham City Council. To reflect this change the Independent Chair now has quarterly performance management meetings with the Chief Executive and the Corporate Director for Children and Adults. The independent chair has agreed performance targets that are monitored through this meeting. It also provides an opportunity to address strategic issues including the inter-relationships between the safeguarding boards and other partnerships.

Membership

The NCSCB membership for 2014-15 is set out below including the attendance levels of constituent members/agencies. Two lay members were appointed to the NCSCB during the year.

NCSCB Strategic Board Membership / Attendance

Name	Organisation	Role	Attendance
Paul Burnett		Independent Chair	100%
Alison Michalska	Nottingham City Council	Corporate Director Children & Families	100%
Cllr David Mellen	Nottingham City Council	Lead Member	75%
Helen Blackman	Nottingham City Council	Director of Children's Safeguarding, Children & Families	100%
Supt Helen Chamberlain (Vice Chair)	Nottinghamshire Police	Head of Public Protection	100%
Sally Seeley/ Teressa Cope	NHS Nottingham City Clinical Commissioning Group	Assistant Director of Quality Governance	100%
Julie Gardner	Nottinghamshire Healthcare NHS Trust	Associate Director of Safeguarding and Social Care	100%
Sarah Kirkwood/ Tracy Tyrell	Nottingham City Care Partnership CIC	Director of Governance and Nursing	75%
Dr Stephen Fowlie	Nottingham University Hospitals Trust	Medical Director	75%
Nigel Hill	Nottinghamshire Probation Trust	Director	75%
Alastair Mclachlan	GP Safeguarding Lead	Clinical Commissioning Group	25%
Tracey Ydlibi	Schools - Special	Headteacher - Nethergate School	0%
Carol Fearria	Schools - Secondary	Headteacher – Nottingham Emmanuel School	100%
Sue Hoyland	Schools	Headteacher – Forest Fields Primary School	0%
Liz Tinsley	NSPCC	Service Manager	100%
Karen Moss / Marcia Lennon	CAFCASS	Regional Manager	50%
Claire Knowles	Legal & Democratic Service Directorate	Nominated Solicitor	75%
Dorne Collinson/ Hayley Frame/ Clive Chambers	Adult and & Children's Safeguarding	Head of Safeguarding & Quality Assurance	100%
Dr Caroline Brown / Dr Damian Wood	NHS Nottingham City	Consultant Paediatrician, Designated Doctor for Safeguarding	100%
Yvonne Cherrington /Nicola McGrath	Children & Families	Safeguarding Partnerships Service Manager	100%
Christine Parker	NCSCB Lay Member	NCSCB	0%
Barbra Coulson	NCSCB Lay Member	NCSCB	75%
Alfonzo Tramontano	NHS – England	ASSISTANT DIRECTOR OF NURSING	0%

The NCSCB membership complies with the expectations of Working Together 2015 in terms of both the representation and the levels of seniority expected.

The significant commitment of partners at times of significant change and re-organisation provides strong evidence of cross-agency commitment to safeguarding. Where attendance has been identified as an issue work will be undertaken to address this during the course of 2015/16. This will include

- Developing a wider engagement strategy with schools through the development of a network of Designated Safeguarding Leads
- Recruitment of new lay members

The Lead Member

The NCSCB Lead Member continues to be Councillor David Mellen, the portfolio holder for Children's Services, who has been a regular attendee and contributor at the NCSCB Strategic Board, providing consistent political support and challenge to the board. He chairs the Children's Partnership Board and provides support to the inter-relationship and cross-scrutiny and challenge between the two Boards. This has been particularly helpful in managing the development of the Assessment Framework, Threshold Protocol (which is incorporated into the Family Support Strategy) and the Learning and Improvement Framework – to which both Boards have made a contribution.

Budget

To function effectively the NCSCB (and the NCASPB) needs to be supported by member organisations with adequate and reliable resources. Contributions from the three key agencies (Nottingham City Council, Nottinghamshire Police and NHS Nottingham City CCG on behalf of all health trusts) were agreed for 2014/15.

The NCSCB Business Office resources are spilt between both boards with each having a dedicated Board Officer, a shared Service Manager, Training Coordinator and administration. The budgets for both boards have also been amalgamated.

The total budget to support NCSCB / NCASPB activity in 2014/15 was £336,159. Partner agency contribution was made up as follows:

Nottingham City Council – Children's Services	£116,426
Health	£181,833
Nottingham City Homes	£ 4,260
Police	£ 32,698
Probation	£ 2,392
Cafcass	£550
Total	**£336,159**

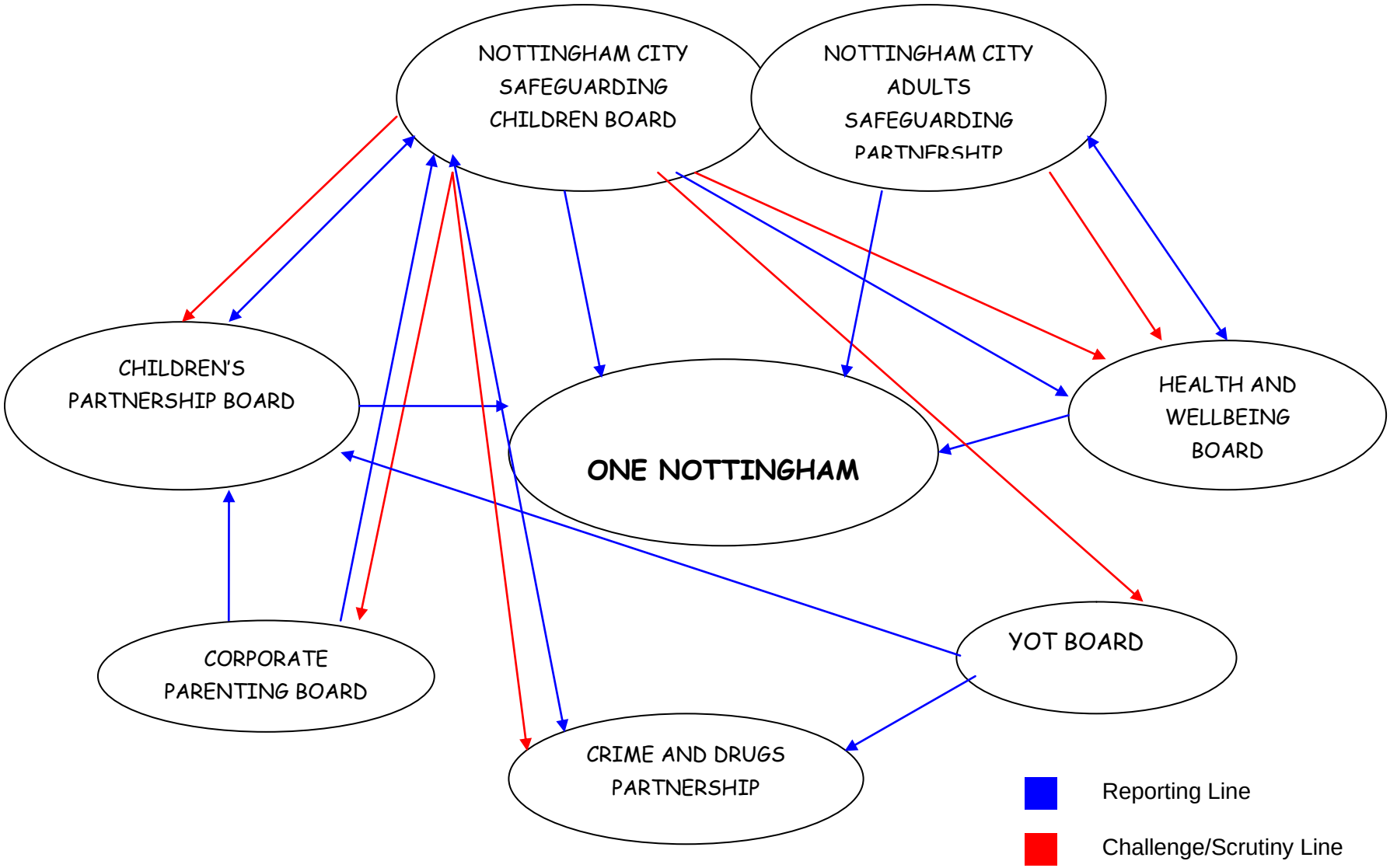
Expenditure for both NCSCB and NCASPB 2014 – 15 was:

Staffing Costs	£218,043
Training	£ 3,387
SCIMT	£ 74,650
Other non-pay costs	£ 54,036
Sub total	**£350,116**
Income from training	-£ 22,321
Total	**£327,795**

Additional costs included the development of Policy, Procedures and Practice Guidance, Serious Case Reviews and Publicity / Communications are agreed as required.

Relationships with other Partnership bodies

To maximise our effectiveness, specifically in relation to their scrutiny and challenge roles, the NCSCB has developed robust protocols and arrangements to secure effective inter-relationships with other key partnership bodies including One Nottingham, the Health and Wellbeing Board, the Children's Partnership Board and a range of other key partnership groups. A diagram illustrating the inter-relationships between these bodies is set out on the next page.


NOTTINGHAM CITY SAFEGUARDING CHILDREN BOARD
NOTTINGHAM CITY ADULTS SAFEGUARDING PARTNERSHIP
CHILDREN'S PARTNERSHIP BOARD
ONE NOTTINGHAM
HEALTH AND WELLBEING BOARD
CORPORATE PARENTING BOARD
YOT BOARD
CRIME AND DRUGS PARTNERSHIP
Reporting Line
Challenge/Scrutiny Line

I

Safeguarding Assurance Group

Strategic co-ordination across the partnership geography of Nottingham City is driven through the Safeguarding Assurance Group. This group comprises the Chairs of all the key partnerships together with the Corporate Director for Children and Adults and key officers. The Group was established to enable discussion of key safeguarding matters in the City and to determine how these would be addressed through the various partnership bodies. An important priority was to secure clarity in the roles and responsibilities of each partnership body in improving safeguarding in the city, to secure coherence and co-ordination in this activity and to avoid duplication.

The Health and Wellbeing Board.

The Health and Wellbeing Board was established in shadow form in 2011 and became a formal committee of the City Council in April 2013. It leads and advises on work to improve the health and wellbeing of the population of Nottingham City and specifically to reduce health inequalities. The Board is responsible for agreeing the Joint Strategic Needs Assessment (JSNA), agreeing a statutory Health and Wellbeing Strategy and promoting the integration of health and social care services for the benefit of patients and service users.

In Nottingham City we have agreed the need for a robust inter-relationship between the Health and Wellbeing Board and the two safeguarding boards based on reciprocal scrutiny and challenge. The safeguarding boards seek assurance that the Health and Wellbeing Strategy appropriately reflects and supports the achievement of safeguarding priorities for the city as set out in the annual safeguarding board business plans. Equally the safeguarding boards need to recognise the outcomes of the Joint Strategic Needs Assessment and the priorities set in the annual Health and Wellbeing Strategy when formulating their annual business plan.

To ensure effective co-ordination and coherence in the work of the three Boards, it has been agreed that:

1. Between September and November each year the two Safeguarding Boards will present their annual reports for the previous financial year to the Health and Wellbeing Board. This would be supplemented by a position statement on the Boards' performance for the current financial year. This provides them the opportunity to scrutinise and challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Health and Well-Being Strategy.

2. Between October and February the Health and Wellbeing Board will present to the safeguarding boards the review of the Health and Wellbeing Strategy, the refreshed JSNA and their proposed priorities and objectives. This will enable the safeguarding boards to scrutinise and challenge the performance

of the Health and Well-Being Board and to ensure that the Board Business Plans appropriately reflect their priorities.

3. In April/May the Boards will share their refreshed Plans for the coming financial year to ensure co-ordination and coherence.

The Children's Partnership Board

The Nottingham Children's Partnership Board (CPB) formulate, implement and review the Nottingham Children and Young People's Plan and the services provided to all children and young people in the city. The partnership has remained the key mechanism to support all partners to work together to deliver a joined up vision for children, young people and families, through the Children and Young People's Plan (CYPP), which has been sustained despite the change in legislation removing the statutory functions of this board. The plan sets out the collaborative work programme and priorities across all partners responsible for providing services to children, young people and families. All partners are accountable for the delivery of its priorities, objectives and specified targets. The Children's Partnership directs the required integrated working, joint planning, commissioning and resource allocation to achieve this. This focus on collective, co-ordinated working is key driver for the need for a robust and rigorous relationship between the NCSCB and the CPB.

As in the case of the Health and Wellbeing Board there are arrangements in place to secure an effective relationship between the NCSCB and the CPB. The Independent Chair of the safeguarding board attends the CPB twice a year to report to the CPB on the work of the NCSCB and the work of the partner agencies in safeguarding children. The Chair also presents the NCSCB Annual Report to the Children's Trust. The Independent Chair receives all minutes, agendas and papers for all meetings of the Trust and can make representation on matters arising.

These arrangements are reciprocated by the fact that the Chair of the CPB, Councillor Mellen, sits as an observer in his capacity as lead member for children and young people on the NCSCB. Additionally the Corporate Director for Children and Adults also sits on both bodies. This enables reporting from the CPB to the NCSCB in relation to the formulation and review of the Children and Young People's Plan and its impact. Stronger safeguarding remains a key strategic priority in this Plan.

A key area on which the two Boards have collaborated this year has been the review of thresholds triggered by Working Together 2013 which required the NCSCB to issue a threshold protocol. In Nottingham City this is incorporated within the Family Support Pathway – this is referred to in more detail later in this annual report.

<u>Looking Forward</u>

In setting our Business Plan for 2015/16 we have continued to draw together our work to improve the effectiveness and impact of the Board under the heading

‘Safeguarding is Everyone’s Business’. This is set out as Priority 2 in our 2015/16 Business Plan and includes actions to improve the effectiveness of the Board, strengthen its influence with other partnerships and ensure its ability to secure and evidence impact.

The detail of these objectives and the actions to support their achievement are set out in the Business Plan at appendix 1 together with the means by which performance against these goals will be tested.

CHAPTER 3:

BUSINESS PLAN PERFORMANCE 2013/14

The Business Plan for 2014/15 was the second integrated plan for the NCSCB and NCASPB. Given that we have now adopted separate annual reporting arrangements this section of the NCSCB Annual Report focuses only on those parts of the Business Plan that related to children and young people's safeguarding and to cross-cutting elements of the Business Plan.

We identified the following priorities for our work over the period 2014/15:

Priority 1: To be assured that 'Safeguarding is Everyone's Responsibility'
Priority 2a: To be assured that children and young people are safe across the child's journey including the transition to adult services.
Priority 2c: To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept.
Priority 3: To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults.

BUSINESS PLAN PRIORITY 1

To be assured that 'Safeguarding is Everyone's Responsibility'

What we planned

1.1 Ensure Board and partner agency compliance with Working Together 2013 (WT13) and the Care Bill

1.2 Ensure full agency compliance in Section 11 and SAF Audit processes.

1.3 Ensure that the Board, OMG and Subgroups:
a. have appropriate and regular attendance rates,
b. have capacity to deliver Business Plan expectations,

1.4 The Board drives partnerships and partner agencies to own, prioritise, resource, improve and positively impact on safeguarding.

1.5 The Board receives management information to evidence, scrutinise and challenge performance so that it knows the safeguarding strengths and weaknesses of agencies, both individually and collectively, and the safeguarding outcomes for service users.

1.6 The Board secures the effective implementation of new practice guidance issued in 2014.

1.7 Formulate and implement the Information Sharing Protocol.

1.8 Safeguarding roles and responsibilities and outcomes are explicit in the commissioning, contracting, monitoring and review of services.

1.9 The 'voice' of children, young people, adults and practitioners is heard and acted on across all priorities.

What we did

The key requirements of Working Together 2013 – the Single Assessment Framework, the Threshold Protocol and the Learning and Improvement Framework - were prepared for implementation by April 2014 as required. 2014/15 has, therefore been focused on the roll out of these three key strands of activity.

The NCSCB met four times during 2014/15. Attendance at Board meetings has been commented on in the preceding section. Membership continues to meet Working Together 2013/15 requirements. Indeed membership extends beyond the statutory requirement.

The Board is also supported by the range of expected designated safeguarding leads and legal advice that is expected.

The OMG and Subgroups have also operated effectively and sustained relevant membership and, in most cases, good levels of attendance. Difficulties have been experienced in sustaining quoracy at the Quality Assurance Subgroup.

The chairing of subgroups is well distributed across partner agencies as is set out in detail in the impact section below.

The NCSCB has continued to play a robust role in the partnership geography of Nottingham City. The Independent Chair has attended all meetings of the Safeguarding Assurance Forum that brings together the chairs of key partnership bodies in the City. In addition the business plans and annual reports of the NCSCB have been presented to the Children and Young People's Partnership Board, the Health and Well-Being Board and the Nottingham City scrutiny committee.

The Board has received a range of management information enable it to evidence, scrutinise and challenge performance including:

- Annual safeguarding reports from all constituent agencies most of which are headlined in Chapter 5 of this report

- The annual reports of the IRO service and the LADO – featured later in this report

As mentioned above, however, securing regular meeting of the Quality Assurance Sub-Group has presented a challenge primarily from the perspective of quoracy but also in terms of securing comprehensive submission of performance information. This is commented on further in the impact section below.

The NCSCB has continued to link to the Young People's Council to ensure that the views of children and young people in the City are heard and acted on. Young people were asked to identify their key safeguarding priorities and these were incorporated into the NCSCB Business Plan. The voice of children and young people is also commented on in every multi-agency audit led by the Board. The key issue identified by young people is e-safety.

In addition the Communications and Engagement Sub-Group was established during 2014/15 to drive forward improvements specifically in relation to the engagement of children and young people. The work undertaken by this group is outlined in the section below.

During the course of 201/15 we have reviewed and updated practice guidance in relation to the following areas of practice.

- Emotional abuse
- Sexual Abuse
- Self-harm
- Domestic abuse.

The revisions were made to reflect national and local learning, including learning from Serious Case Reviews and Learning Reviews. The domestic abuse practice guidance was streamlined in response to feedback from staff. All of the updates were developed with input from subject specialist from key local agencies.

Revised practice guidance was launched through seminars and other methods of communication. All local practice guidance is published on the NCSCB web pages, along with the local multi-agency Safeguarding Children Procedures.

What has been the impact?

The impact of the single assessment framework and the revised threshold protocol has been monitored through the quality assurance and performance framework and are covered in the analysis of performance in part 2 of this annual report.

As stated above attendance at NCSCB has, in the main, continued to be strong. Attendance levels for 2014/15 were set out Chapter 2: Governance and Accountability. One key concern has been the representation of NHS England. Since the organisational changes of 2013/14 that created the new NHS structures, NHS England has not been represented at the board despite expressions of concern to local area management. In addition one of our lay members has been unable to attend a meeting with the other having decided now to resign for health reasons. We will need to recruit new lay members in 2015/16.

At the annual development session held in January 2015 NCSCB members, alongside their counterparts on the NCASPB, reviewed the governance arrangements that have been in place for the past two years. Reflections on NCSCB arrangements were positive and there was recognition that the refocusing of Board and OMG agendas in the past year had enabled the Board better to focus on key strategic issues and decision-making with OMG focusing on the operational implementation of decisions and on managing Board agendas to sustain strategic focus. Outcomes from the Peer Review of adult safeguarding had, however, led to a review of the alignment of the NCSCB and NCASPB. Whilst it was felt important to sustain a focus on shared safeguarding priorities through the creation of a shared element of the new Business Plan for 2015/16 and for the two Boards to meet together on a regular basis during 2015/16, it was also agreed that greater distinction between the work of the two Boards be secured and this has subsequently resulted in the appointment of different chairs for the NCSCB and the NCASPB following the decision of the current chair to stand down.

OMG has similarly been well attended and received positive evaluation in the governance review at the Development Day.

At sub-group level we have sustained partnership engagement in the chairing of meetings. During 2014/15 chairing has been shared across the partnership as follows:

SCR Standing Panel	Mel Bowden, Nottinghamshire Police who took over from Helen Blackman during the course of 2014/15.
Child Death Overview Panel	Dr Caroline Brown, Designated Doctor, NHS
Quality Assurance Subgroup	Sarah Kirkwood CityCare Partnership /Sandra Morell, CCG

Training Subgroup	Janet Lewis,VCS
Missing Children Subgroup	Viv McCrossen, Nottingham City Council, replaced by Clive Chambers, Nottingham City Council in February 2015, after Ms McCrossen had left
Domestic Violence Subgroup	Tracey Nurse, Nottingham City Council
CSE Subgroup	Martin Hillier, Nottinghamshire Police

In the main attendance at subgroups has remained strong but in a minority of cases attendance has been less consistent. The most notable example is the Quality Assurance Subgroup which had to be cancelled on occasion due to both quoracy issues and a lack of data submitted. This has been a key concern for the Board particularly since this has prevented both OMG and the Board having up-to-date performance reporting against which to test business plan impact. Steps have now been taken to secure more regular meetings and compilation of performance reports. Critical to this will be re–establishing separate groups to focus on both children and adults at risk.

Dialogue through other partnerships has resulted in a range of actions and impacts that evidence the influence of the NCSCB in driving safeguarding improvement and effectiveness. Examples include:

- The Children and Young People's Partnership's work to enhance and develop early help provision;
- The Children and Young People's Partnership's leadership of the revision of thresholds in response to both Ofsted recommendations and Working Together 2013 expectations through their work on the Family Support Strategy and Pathways;
- The Health and Well-Being Boards considerations of means of strengthening the inclusion of safeguarding requirements within commissioning and contracting arrangements across the City;
- The work of the Nottingham Priority Families initiative.

1.10 The Board receives management information to evidence, scrutinise and challenge performance so that it knows the safeguarding strengths and weaknesses of agencies, both individually and collectively, and the safeguarding outcomes for service users.

The Board has received a range of performance data, primarily through the sub-group infrastructure. This includes information about return interviews, domestic abuse, missing children etc.

In addition to performance information the Board conducts biennial audits of compliance with the requirements of Section 11 of the Children Act 2004,

which sets out the arrangements agencies must have in place with regard to safeguarding and promoting the welfare of children and young people. The section audit considers 10 areas and uses specific criteria to enable agencies to make a judgement about compliance against each of these. The findings of the section 11 audit are set out below.

Category of standards	**% of agencies reporting full compliance with every standard within the category**
Leadership and Organisational Accountability	95% Health only section: 100%
Serious Case Reviews	90%
Safer Working Practices	95%
Training	87%
Supervision	86%
Policies and Procedures	96% Health only section: 100% Health and Police: 100% Health and children's social care: 100%
Whole Family/Think Family Approach	93%
Voice of Children	71%
Environment	100%
Local Standards	90%

1.11 The Board secures the effective implementation of new practice guidance issued in 2014.

As already indicated all new practice guidance was launched alongside seminars to promote learning and engagement.

1.12 Formulate and implement the Information Sharing Protocol.

We have an info sharing protocol but recognise the need to refresh and update it.

A Communication and Engagement Subgroup was established during 2014/15 primarily targeted at enhancing the' voice of the child' in the work of the NCSCB. Work undertaken during 2014/15 included:

- Formulation and agreement of a revised communication and engagement strategy for the NCSCB and NCASPB;

- An audit of existing engagement work across the partnership in relation to the three key engagement levels: strategic engagement; community of interest engagement and; engagement at service delivery level;
- Commissioning of activity to secure feedback from children and young people on their safeguarding priorities through existing mainstream engagement initiatives.

The drafting of our business plan for 2015/16 reflected the priorities that had been identified, primarily through work undertaken with the Nottingham City Youth Council.

What do we need to do in the future?

Work will be undertaken during the course of 2015/16 to update the Local Multi-Agency Child Protection Procedures. This will be undertaken address the changes resulting from the 2015 version of Working Together to Safeguard Children and incorporate learning from national and local processes such as Serious Case Reviews. We will also evaluate the impact of the revised practice guidance published during 2014/15 both through the multi-agency audit programme and seeking feedback from staff.

We will liaise with all agencies who undertook the Section 11 audit and seek confirmation that action is being taken to address issues of non-compliance where these were identified.

Priority 2 of the Business Plan for 2015/16 identifies key priorities that have arisen from our analysis of performance in 2014/15 that relate to our objective of making safeguarding everyone's business.

The key priorities identified for next year are:

- Testing the impact of implementing Working Together to Safeguard Children (2015) and the Family Support Pathway
- Improving performance & demonstrating impact – Section 11, staff survey, multi-agency audits, Serious Case Reviews (SCRs)
- Further enhancing the Voice of the Child in the work of the NCSCB
- Improving engagement with schools

Full details of the work intended to be carried out are set out in the Business Plan that is set out at appendix 1.

BUSINESS PLAN PRIORITY 2a

To be assured that children and young people are safe across the child's journey including the transition to adult services

What we planned

2a.1 The Local Authority Assessment Protocol is effectively implemented and secures impact.

2a.2 Thresholds for safeguarding children are clear, understood and consistently applied across the Partnership.

2a.3 That children receive the help and support they need at the earliest possible stage.

2a.4 That all children requiring protection and/or care have had the benefit of help and intervention at the earliest stage possible

2a.5 That children subject to child protection plans and those in need have high quality multi-agency support that reduces risks.

2a.6 Children at high risk/vulnerable are being identified and risks managed to secure positive outcomes. The groups that we prioritised for 2014/15 were: CSE; Missing; Domestic Violence/Abuse; Self-Harm.

2a.7 Effective transitions from children to adult services where appropriate.

2a.8 Children/young people who are privately fostered are identified and supported.

2a.9 The workforce has capacity to deliver effective safeguarding.

What we did

There has been a considerable amount of activity coordinated through the action plan that was developed to address issues identified in the Ofsted inspection of safeguarding, looked after services, services to care leavers and the effectiveness of the Safeguarding Children Board that took place in March 2014. Given that the previous annual report focussed on the findings of that inspection this report will summarise the actions taken to deliver this improvement. These have included:

- A review of the quality assurance framework and audit process/structure.
- A new Social Care case recording system has been commissioned and considerable work is being undertaken to prepare for the implementation of this in April 2016. It is anticipated this will significantly improve the efficiency

of our services and support improvements in key practice areas, including the preparation of chronologies.

- There has been significant work to further embed the use of the Signs of Safety model across the directorate. This has included the re-design of a number of forms and templates to more adequately reflect the key principles of the model and encourage a greater focus on the voice of the child/young person.
- Work to promote the voice of the child at a strategic level has included:
    - The Participation Sub-Group has been reconvened as a regular standing group with representative membership from a cross children's social care, including extensive and specialist services. A work plan for 2015-16 covering priorities for participation has been developed
    - The Children in Care council has led work on the Have your Say survey, which seeks the views of looked after children about the support they receive. The outcomes from the survey have subsequently been reported back to the Corporate Parenting Panel
- The fostering and adoption service has been remodelled.
- A new system has been introduced to enable the Independent Reviewing Service to monitor and report on outcomes for looked after children and those subject to a protection plan.

In addition to this there has been a re-structuring exercise in the City Council which has located Children's Social Care, Early Help, Targeted Support and the Youth Offending Service within the same directorate. This will promote a more joined up approach to families and reduce barriers to transitions between services as part of step up or step down processes.

Some headline developments across the child's journey include:

Early Help/Specialist Support for vulnerable families and Children in Need

- **Youth Offending Team bid** Nottingham City is part of a national partnership led by the NSPCC developing and testing an operational framework for children and young people who sexually harm

- **Schools** have committed to maintaining a number of children centres sites to help sustain outreach across city

- **A review of the "front-door" arrangements for children's services in the City Council** will Integrate social workers and early help specialists at Front Door / establish a consultation line for key professionals

- **Multi-Systemic Therapy (Child Abuse and Neglect) MST-CAN** £90k grant secured to treat trauma in neglectful parents and strengthen families

- **Safer Families for Children Project-** Support for families in Need- including family mentor and Host family to provide overnight stays –reduce family stress and prevent escalation

Children in Need/Child Protection/Looked After Children

- 10 additional newly qualified social workers have been recruited to children's social care teams.
- An Independent Reviewing Officer has been seconded for 3 months to lead on exit planning for Children in Need/Focus on through-put of CIN cases
- Senior managers focus on front door/First Response Team to divert contacts away from duty/reduce numbers of open assessments in duty
- Recruit more agency staff to reduce numbers of unallocated cases
- Council committed additional pay for social work retention

What was the impact of work undertaken?

Key achievements during the course of 2014/15 included:

- 80% of CAFs are closed with the identified needs of the family being met
- 85% of Children's Assessments completed in Children's Social Care were completed within timescale
- 99% of Child Protection reviews were held within timescale
- Only 7.9% of children who became the subject of a protection plan had been subject to a plan in the preceding two years.
- 17 new schools have been supported to achieve the Drug Aware standard. This is a robust standard of excellence in drug education and policy. Work continues on reaccreditation for schools who have previously achieved the standard.
- A pilot project has been established to test if education sessions led by Peer Mentors (previously homeless young people) can impact on the attitudes and eventual number of young people presenting as homeless in Nottingham.
- Although the overall numbers of first time entrants into the Youth Justice System remain high over the last year we have had a 22.4% reduction from the previous year compared with a 10.0% reduction for Statistical Neighbours and 14.4% nationally.

Clearly the key test of the impact of the NCSCB in this area of priority has been the effect of work on the child's journey through services. It is important here to both outline performance across this journey and highlight both areas of success and areas for further development and improvement.

Contacts, referrals and assessment

Performance in this area remains positive and contacts have decreased and targets met. The number of contacts has reduced to 4084 from 6330 in the previous year. There has been a 35% reduction in contacts when compared to 2013/14.

The number of assessments authorised has risen from 4651 in 2013/14 to 4927 in 2014/15.

The % of assessments authorised within 45 days is 84.9% which is above target and the average for statistical neighbours.

Demand for social care services remains high and, in some aspects of performance in this critical service area, has increased where the plan was to look to reduce this, as indicated in the section re Child Protection below. A Peer Review will take place in the second quarter of 2015/16 which will examine social care thresholds in order to ensure these are consistently applied and understood. The findings of this review will be reported back to the Board and will be incorporated into the Business planning and audit cycle.

Early Help

The NCSCB supported targets to increase the number of CAFs initiated as a means of both meeting needs earlier but also of reducing the number of children whose case escalates to formal child protection or care provision.

After three consecutive years of increases in the number of CAFs however (511, 801 and 1180 in each of the previous three financial years) the number has reduced to 939. This means that whilst there has been an increase in CAFs being initiated in Quarter 4, the year on year increase (Year 2013/14 to Year 14/15) has not been achieved. Data cleansing activity is still taking place to check that this is indeed an accurate picture. This will also consider the impact of the Priority Families programme, which uses a specific assessment tool to inform the work undertaken with highly vulnerable children, young people and adults.

In addition the number of CAFs closing and escalating to Social Care has increased though the overall proportion has reduced in the fourth quarter. Cases where increased risk is identified should rightly be escalated to Social Care and those that can be safely managed within vulnerable children and family services with extensive support will reduce the need to escalate.

On a positive note there has been an increase in the latter half of the year in the number of CAFs closing with an outcome of "Needs met". This suggests that early help when provided is proving effective in meeting needs and preventing cases escalating.

Child Protection

Referrals to social care have risen slightly from 5007 in 2013/14 to 5136 in 2014/15. The target was to secure a reduction in referrals particularly in light of the focus on early help interventions.

Levels of referral and demand remain high against statistical neighbours.

The Duty Service has been through a period of remodelling and Qualified Social Workers (QSWs) have been placed within screening to make this more robust. There have been some issues around implementation which are being proactively managed and this has impacted on the Service. It is hoped that once these changes are embedded we will see a reduction in the number of referrals coming into Children's Social Care (CSC). Work is also taking place to look at remodelling the Front Door and this too should have an impact on number of referrals coming into the Social Care system

The number of re-referrals has remained relatively static with a very minor reduction in the final quarter of the year. Re-referral rates remain the same as the 2013/14 outturn figure. The re-referral rate target has been revised to reflect benchmarking data on this new national measure. Local performance is 3% above the SN average which is nearly on target. This measure can indicate work being closed prematurely but as a responsive service Nottingham accepts more referrals than like authorities (judged appropriately so by Ofsted). There is a greater potential for increased re-referrals as any further contacts with the service become re-referrals.

The number of children subject to a Child Protection (CP) Plan in Q4 increased from 84 per 10,000 to 86 per 10,000. The high demand remains evident across the system. Ongoing work with the Signs of Safety model should serve to build resilience in families and increase protective factors. This needs to be embedded across Vulnerable Children & Families (formerly FCT) and the partnership to address need earlier and prevent escalation, and in children's social care to either act decisively for children in need of enduring alternate care or to secure better outcomes.

99% of child protection cases have been reviewed within timescale which is an increase of 3% on performance in the previous year, matches target and exceeds the average for statistical neighbours. Performance has been maintained consistently above the target throughout the year.

In terms of the proportion of children that have a second child protection plan within a two year period the target of 8% has been met – the end of year figure is 7.9%.

Performance in this area has shown sustained improvement over the last two years and we are currently exceeding our target. This is indicative that de-planning decisions are becoming increasingly robust and appropriate.

With regard to the number of child protection plans lasting over two years performance is the same as last year and on target. This performance indicates that we are intervening earlier and taking robust effective safeguarding decisions. The improvement highlighted in the previous quarters report has been sustained and delivered an annual performance rate that is comfortably within the agreed target.

Children in Care

The number of children in care has reduced from 584 to 575.

Demand has remained high but performance is better than statistical neighbours and meets the target set of 90 per 10,000 population. The 70 adoptions achieved represent a significant increase on the 2013 /14 data. Performance is currently strong; however the ending of adoption reform grant in April 2015 will provide a resource challenge. Special Guardianship Orders (SGO)ended the year at a total of 44 which represents a strong performance. There is a new focus on support legacy issues related to SGO in terms of both safeguarding and financial responsibilities of the Council post SGO.

The number of children in care with personal education plans (PEP) has similarly improved and matches that of our statistical neighbour group. The Virtual School Head, the governing body, and the Virtual school PEP co-ordinator continue to hold regular meetings with the Children in Care management team to discuss the PEP completion rate and identify where PEPs are incomplete. Under the latest Department for Education conditions of offer, the Virtual School head will expect all schools to demonstrate how they will use the new Pupil Premium funding to close the gap for all Look After Children (LAC) pupils. One to one tuition for pupils in Year 6 and Year 11 will continue, with an increased focus on analysis of impact.

There are a number of areas where performance has not met targets set notably:

- The percentage of children in care with a pathway plan reviewed within the last six months, although performance has improved in this regard
- The number of children placed for adoption within 426 days of being taken into care
- The number of children matched for adoption purposes within 121 days

The percentage of care leavers in suitable accommodation at age 19 has fallen from 89.6% to 84.9%. There is a robust protocol in place with Nottingham City Homes to prevent eviction and homelessness. Performance has also declined across our statistical neighbourhood group.

With regard to the number of care leavers in suitable education, employment and training performance continues to present a challenge. However there is now an

increasing focus on vocational training from government which should help with the provision of opportunities for our young people. The figure for the year does match that of our statistical neighbours and is an improvement of 7% on the 2013/14 data.

Workload

There has been significant investment in increased capacity in Children's Social Care. This has included the creation of additional social work posts and increased capacity in the Independent Reviewing Service. Despite this, retaining experienced staff continues to be a real challenge. This challenge is being partially addressed through the deployment of agency workers but this is an expensive, short term solution.

What are the challenges?

- The key challenge we have encountered is in the area of demand and capacity in specialist services. Although the number of CAFs has continued to increase, the rate of this increase has slowed down. During the same period the number of contacts to Children's Social Care has reduced, however the proportion of these which become referrals and go on to require some form of further assessment or intervention has significantly increased. There are increased demands across Children's Social Care which is reflected for example in an increase in the number of children subject to a protection plan and looked after.
- As part of the response to this a Resourcing and Retention Strategy has been developed following a specialist pilot to examine and address the Recruitment and Retention issues with Social Workers. Following this review a range of interventions have taken place to better recruit and retain social work staff. This has included a focus on the recruitment and retention of Independent Reviewing Officers. Temporary agency social workers have been recruited to fill gaps given the significant increases in work across the whole service. This has been impacted by other factors, e.g. more experienced workers having left to take up posts elsewhere in the Council. We are also recruiting to increase capacity. 10 new social workers have been recruited to train in duty before replacing agency workers in long term teams in 6 months. This is a challenging time but investment in SOS and more coordinators to support reflective case mapping will help with confidence. That said capacity in Children's Social Care remains a real challenge for the partnership. The work planned to undertake a Peer Review of thresholds will therefore be critical in ensuring that those children who require specialist services are referred for this type of support and that the needs of children and young people who do not require social care input are met through other means.

Children at high risk/vulnerable are being identified and risks managed to secure positive outcomes: CSE; Missing; Domestic Violence/Abuse; Self-Harm.

Child Sexual Exploitation (CSE)

Child Sexual Exploitation has been a priority in the NCSCB Business Plan for some years and work has been led by the Child Sexual Exploitation Cross-Authority Group (CSECAG) working across the Nottingham City and Nottinghamshire County Council.

The chair of CSECAG has changed recently following the retirement of DI Martin Hillier. The new chair is DCI Melanie Bowden from the Police Public Protection.

There has been considerable progress made by CSECAG during 2014/15 in driving the main work streams from the national action plan and our local strategy and action plan. This has included reviewing all recommendations from high profile publications over that period of time. The reports are all reviewed by CSECAG at the quarterly meetings and new recommendations will be included into the current work plan.

In the last year the main publication affecting the work of CSECAG has been the Rotherham report. It is fair to say that this report significantly impacted on the national perspective and focus in terms of child sexual exploitation and the working processes required to prevent and detect offending against children. There has been extensive media coverage around the issues raised which has raised the profile of CSE dramatically over the last year both nationally as well as locally. There has been intense scrutiny of our work in Ofsted, HMIC, College of Policing and DCLG inspections that all agencies have contributed to over the last year. These inspections provided a generally positive analysis of the work that has been undertaken across the partnership. That said they have highlighted opportunities to further strengthen our approach which have been included within the work plan.

What has been done during 2014/15?

A training programme across the agencies

This work stream is now established and is included in both Safeguarding Boards' training. It consists of one full days training that is aimed at professionals who come into direct contact with children vulnerable to child sexual exploitation. These events are multi-agency, cross authority and are run by practitioners from all agencies. The feedback from this training is positive with one of the major plus points being that practitioners experienced in this are involved directly with the training input.

This training is free and held at various locations around the City & County. During the course of 2015/16 we plan to complement this with the provision of e-learning.

Nottinghamshire Police have now introduced mandatory e-learning for all front line staff. This comprises of the College of Policing "Missing Daughter" e-learning package which a number of Police Forces have also adopted as the most appropriate e-learning package.

Further training sessions are now being targeted at General Practitioners and Fostering Dimensions including staff working with 16/17 year olds living in semi-independent accommodation. CSE training is also being planned for Community Protection officers in the City which will include training to the Street Pastors.

We will also specifically address issues linked to CSE in the termly sessions with Designated Safeguarding Leads in Schools (CDSLS).

Engaging with young people and raising awareness of CSE

The 2014/2015 tour of the Pint Sized Theatre production of "LUVU2" was well received. The overall feedback from the schools, students and professionals has been extremely positive and we have re-commissioned this in 2015/16 and increased the number of available performances.

There was a performance of LUVU2 at the recent CSE Seminar at Trent University in front of Councillors and the Sheriff of Nottingham. BBC East Midlands were present and recording highlights of the show. Ian Court and one of the actors were also interviewed by Jeremy Ball and it featured on the local news.

Children and Young People who have experienced Sexual Exploitation are referred for support to the NSPCC Protect and Respect Service. This service is fully funded by the NSPCC and works across Nottingham to provide specialist support and input.

Developing a pathway and research for information and intelligence from all organisations around CSE issues.

The Concerns Network (CN) has increased its membership from a number of both statutory and non-statutory organisations. The latest addition to the group is sexual health. The SEIU referral officer from Nottinghamshire Police provides the pathway for any information or intelligence relating to CSE to be received by the Police.

The Concerns Network meetings take place bi-monthly and are currently centred towards the City area although they are cross-authority.

The Concerns Networks main aim is to raise awareness of CSE and assist in the prevention, disruption and prosecution stages. Currently hotels, the street pastors, pubs and shops will be offered training in relation to CSE and the use of the CN form.

CSE awareness input to hotel and accommodation provider staff

The multi-agency meetings for the above have already started utilising the National Working Group (NWG) package of “See More Hear More”. The meetings are being chaired by the City Neighbourhood Policing Team and Community Protection. Members of CSECAG are linked into that group and will feedback into CSECAG meetings on the progress.

CSE awareness input and safeguarding training for taxi drivers

Consultation has taken place between taxi licensing, Community Protection and Nottinghamshire Police. The intention is to develop safeguarding training for all taxi drivers and new licence holders.

Develop engagement with communities for the to be involved in the awareness and prevention of CSE

The Community Cohesion team at Central Police Station who are part of Community Protection have brought together a multi-agency group including the Nottingham Women’s Muslim Network and CSECAG. The idea is to develop an action plan to progress this are of work as a matter of urgency.

One of the first actions of the group is to complete a survey of NGOs to establish their awareness of CSE and to look how to improve community awareness of CSE. We have sought to involve the widest possible range of voluntary sector organisations in our response to CSE and specifically held a meeting for this sector to this end.

What has been the impact?

Mapping the levels of CSE and related data across the City

The scoping and monitoring forms introduced last year are now being completed by all the Independent Reviewing Officers at the start of all CSE strategy meetings. This document should follow the child throughout the whole journey of the referral and should be updated regularly. The information from the document is being recorded in the CARoSE (Children at Risk of Sexual Exploitation) database by the referral officer from the SEIU.

The data is shred on a monthly basis to all agencies for their information. The idea behind CAROSE is that it is child centred and should include all information known around that child to inform action to prevent or address CSE.

The database now includes four risk levels to align with the definition of Child Sexual Exploitation and inform the necessary trigger plan for each level of risk. This data is

being recorded into both County and City. It has also been agreed that the database will be shared with Health.

In terms of the post of a CSE Coordinator the City will make an appointment in 2015/16. This post is funded directly by the NCSCB.

Work is underway to further develop the local problem profile in relation to CSE. All the information is being captured under the title of Operation STRIVER. It is recognised that there needs to be improved provision of data to inform and produce a CSE profile for the City and County. This should include data from all areas and agencies, currently the majority of data/referral information is provided by the Police and local authority. We anticipate the appointment of a CSE Coordinator will strengthen work in this area.

Children Missing

Work on children missing is overseen by the Missing Children Subgroup. The sub-group is very well attended and has membership from a range of agencies.

The Nottingham City Strategy for Missing Children has three core aims:

- Prevention
- Protection
- Provision

The key strategic priorities are to:

- Map data and needs in relation to levels of missing children
- Put systems in place to effectively respond to children who go missing or absent.
- Offer children who go missing or are absent a return interview in a timely manner (in line with the Joint Missing protocol).
- Increase understanding & awareness of missing children issues among children, their parents and carers as well as with professionals.
- To ensure that the voice of the young person is heard and responded to.
- To ensure a multi-agency response to meeting the needs of children and young people who are missing or absent.

There is a clear interface between this subgroup and the work of both the Cross Authority Child Sexual Exploitation Group and a cross authority group that meets monthly to look at the needs of individual children who have been reported missing on multiple occasions.

The subgroup meets quarterly.

What we did

The key objectives of the work plan for 2014/15 were:

- Reducing the number of children who go missing
- Reducing the risk of harm to those who go missing
- Providing missing children & families with support and guidance

In order to deliver the above an action plan was developed setting out a range of measures, which included:

- Ensure there is a clear local protocol in place which reflects national guidance in terms of identifying, responding and safeguarding children who are Missing/Absent.
- Establish robust information sharing processes between agencies.
- Have an understanding/knowledge of children who go missing/ absent repeatedly in order to reduce further episodes and safeguard them.
- Ensure Nottingham City children placed out of the city are supported appropriately and placement provider compliant with the protocol.
- Return Interviews to be completed on all children who go missing / absent. Ensure Independence of interviewer.
- Ensure compliance with missing protocol regarding repeated episodes of missing/ absent.
- Ensure there is a performance/data framework fit for purpose in terms of evidencing compliance with joint strategy and action plan.
- Raise awareness amongst C+F regarding support available.

The work of the subgroup addresses the following quadrants of the Quality Assurance Framework

- Quantitative – through the analysis of a range of data
- Engagement with front line practitioners –through the range of agencies represented and the connectivity with the CSESAG and Missing “hotspot” meetings

The sub-group also has the potential to bring service user perspectives through the work undertaken in relation to return interviews but does not currently maximise the benefit of these.

What is the impact?

The subgroup receives a range of data.

Work has been undertaken against all of the group's objectives, although some remain work in progress. Key achievements to date have included:

- The local cross-authority protocol has been updated in line with national guidance.
- Information sharing between the Police, City Council and other agencies enables a focus on both strategic/performance issues and the needs of individual children and young people.
- There is a clear process in place for return interviews and compliance with this is monitored through the sub-group. Return interviews are used to signpost those children and young people who need this to further support. Return interviews are used to assist early identification of those who are at risk of increased vulnerability and signposting them for earlier help.
- Awareness raising for staff is delivered through a range of training opportunities.
- There is a clear process in place to identify children and young people who are vulnerable as a consequence of, or as highlighted by, them going missing on multiple occasions.
- Children who are missing education are monitored until they are located. This work is linked to work to support those children who are without a school place.

What is planned for the future?

The Action Plan for 2015/16 is likely to include aims to:

- Finalise the agreed format for presenting management information regarding children who go missing, including the data regarding children missing education.
- Ensure that the commissioning arrangements for external placements enable the sub-group to evaluate the response to children looked after by Nottingham City Council but placed outside of the City who go missing.
- Ensure that the potential insights into children's experiences through return interviews are maximised and reported on systematically.
- Working with the Communication and Engagement sub-group review the information for children who go missing and their families.

Children and Domestic Abuse

Chairing arrangements for this sub-group have changed during the course of this year. The sub-group is very well attended and has membership from a range of agencies.

The Nottingham multi-agency response to domestic violence and abuse seeks to support survivors and their children and hold perpetrators to account. The objectives are as follows:

- To reduce the impact and prevent further incidents of domestic violence with a focus on early intervention
- To ensure provision of services for children and young people.

The NCSCB Domestic Violence sub-group promotes these objectives by co-ordinating, performance managing and reviewing data and local activity.

The subgroup meets quarterly.

What we did

The key objectives of the work plan for 2014/15 were:

- To reduce the impact and prevent further incidents of domestic violence with a focus on early intervention.
- To ensure that there is adequate provision of services for children and young people to safeguard them and promote their emotional mental health needs.
- To ensure an early alert to schools and early years settings of all incidents of DV where children and young peoples are present.
- To ensure that all services that are working with children and young people are appropriately trained to recognise the signs of domestic abuse and are able to support them effectively.
- To ensure that there is a link between adults and children's services where domestic violence occurs.

In order to deliver the above an action plan was developed setting out a range of measures, which included:

- All schools to access the GREAT and EQUATE programme (healthy relationship programmes delivered by Equation)
- Develop an effective screening/data tool to alert schools, colleges and early years settings

- Ensure that there is a mandatory expectation that staff working with children and young people are trained to recognise the signs and symptoms of DV and to know what to do about it

- Ensure that working with perpetrators is addressed

The work of the subgroup addresses the following quadrants of the Quality Assurance Framework:

- Quantitative – through the analysis of a range of data but primarily that linked to the DART.

- Engagement with front line practitioners – through the range of agencies represented and the connectivity with the DART

What was the impact

The subgroup receives a range of data. A key source of performance and activity data is the Domestic Abuse Referral Team.

Key achievements to date have included:

- The number of schools who have accessed the Great and Equate programmes has increased. Work is underway to finalise a list of all schools that have accessed these programmes in order to support a targeted approach to further extending delivery.

- Funding has been agreed to implement a pilot of an Early Alert system for schools that will be undertaken during the course of 2015/16. The results of this pilot will be fed back both to the sub-group and OMG.

- Capacity in the Domestic Abuse Referral Team has been increased.

- Training regarding domestic abuse is promoted through a number of avenues and forms a core component of the training Quality Assurance Framework adopted by the NCSCB and Nottinghamshire Safeguarding Children's Board (NSCB). This work will be further strengthened by work which is nearing completion to identify core competencies for staff who work with children and young people.

- A pilot project has been established to support staff working with both survivors and perpetrators of domestic abuse in the St Anns area.

The key challenge that has been identified by the work of the group is the volume of domestic abuse and therefore the demand on services. This has a number of consequences. One of the more significant of these is a significant backlog of standard risk assessments in the DART. Although capacity has been recently increased the level of demand will make both addressing this backlog and ensuring

that there is no further issue challenging. This issue is exacerbated by the temporary nature of elements of some of the funding for the DART. Work will be undertaken in 2015/16 to review the role and remit of the DART.

The quality of the work undertaken by Equation through the programmes that they deliver in schools has been evidenced both through external evaluation and the fact that interest in rolling out similar programmes has been received from other areas.

The work of the DART was positively viewed in the Ofsted inspection. Although this inspection took place in March 2014 this would not have been reported in the previous Annual report of the sub-group as the report was not published.

The work plan of the subgroup has been instrumental in supporting the development of two key developments which will improve the service offered to those impacted by domestic abuse, such as the development of the pilot for next day notification and the work with survivors and perpetrators in St Anns. The work of the group and sub-group members also supported the proposal to increase capacity in the DART.

What do we need to do in the future in relation to Domestic Abuse

The plans for 2015/16 include actions to:

- Ensure that work planned to review the initial response systems in Nottingham City Council considers the impact of the volume of reported domestic abuse and, in partnership, with other key agencies, identifies measures to manage this.

- Linked to the previous point, continue to address the capacity issue in the DART and monitor/report on any impact of the fact that elements of funding are not permanent.

- Ensure the learning from the Perpetrator/Survivor project and next day notification pilots are fully evaluated and fedback, through the sub-group, to the Board.

What do we need to do in the future in relation to the whole of Priority 2a?

The new Business Plan sets out our priorities for action in relation to assuring ourselves that children and young people in Nottingham City are safe across the child's journey.

Priority 1 in the new Business Plan is entitled: To be assured that children and young people are safe across the child's journey'. The key priorities for action are listed as:

- Thresholds – Family Support Pathway
- Escalation
- Private Fostering

- Child Sexual Exploitation (CSE)
- Self-harm and wellbeing
- Missing
- Neglect
- Signs of Safety (SOS)
- Child Death Overview Panel (CDOP)

The detailed actions to be undertaken are set out in Appendix 1 to this report

BUSINESS PLAN PRIORITY 2c

To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept

What we planned

2c.1 Adult services consistently to consider the safeguarding of children in households where they are working with an adult and make referrals for support and intervention where necessary.

2c.2 Children's services consistently to consider the safeguarding of adults in households where they are working with children and make referrals for support and intervention where necessary.

2c.3 Services that work with "whole" families are effectively coordinated (e.g. Priority Families) and secure added value in ensuring and co-ordinating effective safeguarding

In order to provide a regular monitoring sample of cases to test out the above the generic multi agency audit tool developed in early 2015 includes a specific section for adult services to complete. It focuses not only on adult services recognising the need for children's safeguarding referrals, but also on their engagement in cases, for example attendance at multi agency meetings, information sharing across adult and children's services and involvement in strategy discussion where appropriate. This will allow us to build over time an ongoing picture of the safeguarding of children by adult services.

Audits completed so far have been positive in these aspects and no immediate risk factors have been identified.

2c.2 is an area where we have not been able to commit further attention and resources during 2014/15 and this activity has been remitted to the 2015/16 Business plan.

In April 2015 Nottingham City Priority Families reported that the programme had achieved its national targets six months ahead of schedule. This programme is now in phase two of a five year development plan and have put down great foundations to build on in the future. The NCSCB QA subgroup is due to receive a full report from the Priority Families programme in January 2016.

In addition during 2014/15 the Nottinghamshire Healthcare Foundation Trust has been working on their Think Family strategy due to be implemented in May 2015.

What do we need to do in the future?

It is clear that this is an area for further work in 2015/16, and that it will need to be considered alongside the Nottingham City Partnership Board (NCASPB).

The NCSCB needs to ensure that a report requested from Vulnerable Children and Families Services is received and that it includes detail on evaluation of the impact of the Priority Families service against the four quadrants of the Quality Assurance Framework. This report should provide a comparative analysis of the impact of the service in working with adults at risk.

BUSINESS PLAN PRIORITY 3

To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults.

What we planned

3.1 Ensure learning from national, regional and local SCRs and other review/audit processes is incorporated into the practice of partner agencies and the partnership as a whole.

See Chapter 4 for what we did, its impact and what we need to do in the future.

3.2 Ensure the effectiveness of CDOP and lessons from child deaths are understood and consistently acted upon.

See Chapter 4 for what we did, its impact and what we need to do in the future.

3.3 Review safeguarding procedures and practice guidance to ensure they are 'fit for purpose' and reflect current learning and best practice.

What we did

A major review and restructure of the Cross Authority (in partnership with NSCB) Multi-agency Safeguarding Children Procedures was undertaken during this year, in order to become Working Together 2013 compliant, improve accessibility, accuracy and appropriateness of content. As a result, new web based procedures were launched in May 2014, with a number of launch events and an awareness raising programme.

What was its impact?

A review of the new procedures was undertaken after 6 months, resulting in positive feedback from partners that they were much more 'fit for purpose', and identifying minor improvements and additions required. Reviewed procedures were relaunched in November 2014.

What do we need to do in the future?

The following actions are planned for 2015/16:

- Collect and report on Google analytics data indicating levels of access of the procedures, which sections most accessed and from where.
- Collate and report on feedback received through the annual staff survey and other questionnaires.
- Continue to keep content under review.

3.4 Implement the communication and engagement strategy to secure awareness of safeguarding issues and the responsibilities of the Boards' partner agencies and the wider community in safeguarding.

What we did

In December 2014 we held the first communication and engagement sub group chaired by Paul Burnett. This group brought together key communication leads and participation leads from across the partnership.

The sub-group has established a meeting schedule, agreed terms of reference and ratified a communication protocol. In addition it has prepared the first NCSCB Independents Chair's newsletter, for circulation in June 2015, and completed mapping exercises for both communication pathways and participation opportunities.

NCSCB have participated in the Youth Council and the Primary Parliament to facilitate direct dialogue with children and young people.

What was its impact?

Links have been strengthened directly with organisations leads for communication and participation which has resulted in improved dissemination and cascading of key messages.

Work with the Youth Council and the Primary Parliament resulted in meaningful contributions from young people into the NCSCB 2015/16 business plan, particularly in relation to e-safety.

What do we need to do in the future?

The following actions are planned for 2015/16:

- Consolidate membership and achieve consistent membership.
- Publish 1st NCSCB newsletter, and establish a schedule of regular publication
- Use the data available from the engagement of the newsletter to inform future activity
- Identify a new Chair
- Build momentum to sustain ongoing activity of the sub-groups, and implementation of the communication protocol.

3.5 Monitor and evaluate the effectiveness of training and development in terms of the impact on the quality of safeguarding practice and outcomes for service users.

There were two aspects of the work of the NCSCB Training Sub Group which addressed this objective during 2014/15. Firstly the training programme delivered by the NCSCB:

What we did

An extensive programme of multi-agency safeguarding children training programme was delivered with a total attendance of 852 people attending 39 courses and 9 half day seminars. Whilst the largest attender at these courses continues to be the voluntary sector, there has been a marked increase in attendance from City Council, NUHT, the Police, primary schools and other City Council Departments, and with a minimum of 20% of those coming from Adult Services.

What was its impact?

End of course evaluations for children's safeguarding training demonstrate a high level of satisfaction with courses (average of 91% saying they were

good or very good across all criteria) and provide evidence of significant increase in confidence of participants. Whereas 57% of participants rated their level of confidence as good / very good before the courses, this increased to 98% after the courses.

In addition, some post course evaluation was undertaken and this further demonstrated increased confidence in those who attended, with an average of 95% of respondents reporting this and many providing specific examples to support their response.

The second aspect of the work of the Training Subgroup was the quality assurance of single agency training:

What we did

The Safeguarding Training Quality Assurance Scheme was established in 2012, in partnership with NSCB, and all single agency training being delivered by NCSCB partner organisations was quality assured and validated during the initial roll out of the scheme. During 2014 /15, the scheme was reviewed and updated, with an annual review process introduced to ensure ongoing review and validation of partner agency training content. In addition, initial work was undertaken to introduce an annual reporting process which will furnish the NCSCB with information about single agency attendance and evaluation at their training.

What was its impact?

The NCSCB has been assured that all partner organisations are delivering training materials for their introductory level safeguarding children training that are up to date and fit for purpose.

What do we need to do in the future?

Key areas for improvement identified for 2015/16 are:

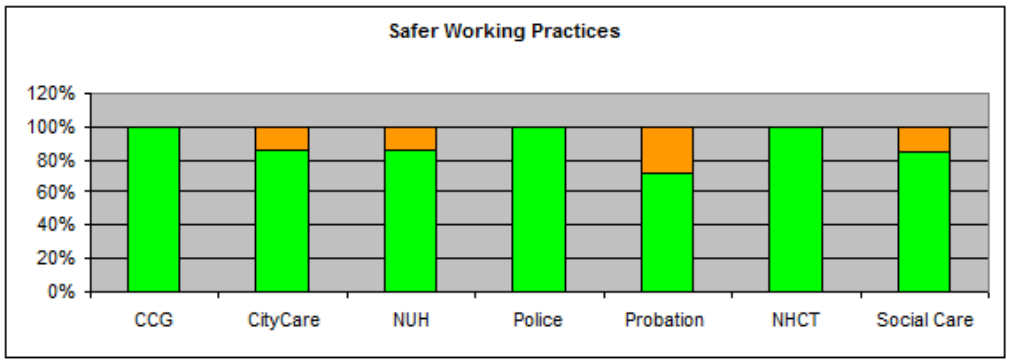
- A review of membership of the Training Sub group to ensure the right representation of partner agencies and improved attendance.
- Increased participation of Sub Group members in leading on particular work streams.
- Board partners to be challenged to ensure staff co-operate with requests for evidence of the impact of training and other work of the sub group.
- The establishment of an Adult Safeguarding training pool, to ensure sustainable delivery of a programme of training for the PVI sector.
- To effectively implement the Learning & Improvement Process.
- To finalise and agree Competence / Capability frameworks for both Adult and Children Safeguarding and collect information from partner agencies regarding competence levels of their staff teams.

3.6 Workforce is safely recruited.

3.7 Allegations made against people who work with children and adults are dealt with effectively

What we did

Safer recruitment and wider safer working practice is one of the issues specifically covered in the Section 11 audit.



Where agencies had rated themselves as amber the issues were as follows

- The CityCare Policy re liaison with the LADO required updating
- NUH were exploring the misappropriate mechanism for providing an annual report from their Named Senior Manager
- Work was under way in Social Care to specifically include requirements with regard to safeguarding in contract, although it was acknowledged that there were national standards and organisational policies already in place that required this.

The LADO and team dealt with 321 referrals during 2014 / 15.
The largest number of referrals were received from education (27%), with the second largest received from Children's Social Care (13%). Although 25% of referrals were received from the Police, these were largely historical. The rest came from a wide range of public and voluntary organisations.

The largest proportion of allegations were related to sexual abuse (48%), with physical abuse accounting for 36%, emotional 6%, neglect 5% and behaviour in private life accounting for another 5%.

222 of the referrals were identified as meeting the threshold for a strategy meeting, whereas 99 were handled through consultations which involve

providing the referrer with advice and guidance about how to handle the concern.

What was its impact?

Of the cases that were closed during the year, 17 were resolved within a month, a total of 61 were resolved within a year and a further 35 took over a year to resolve. Other referrals have been carried forward, being raised at different times within the year. It is important to note that some of the delays will occur due to police investigations, particularly those involving online abuse as the forensic analysis of computers, mobile phones etc can take considerable time. Delays are also caused within courts, with trial dates being set up to six months from initial plea and case management hearings. However, overall the statistics demonstrate that the majority of cases are dealt with in a timely manner where possible.

In terms of the outcomes of allegations, 47% were categorised as substantiated, 32% as unsubstantiated, 3% were malicious and 18% as unfounded. Six cases resulted in criminal convictions (with others currently awaiting the outcome of current court proceedings), and eight members of staff resigned during the investigation of the allegation.

A total of 20 cases were recommended to be referred to the Disclosure and Barring Service by the employing organisation.

What do we need to do in the future?

The following actions are planned for 2015/16:

1. Implementation of evaluation sheet (to be sent out once a case is concluded). Feedback on this will be reported in 2015/2016.
2. Ensure that the current data is stored effectively to ensure management information is accurate and easily accessible for the future. This will be linked to the development of a new social care recording system.
3. Aim to meet timescales as set out to ensure that all investigations are dealt with as quickly as possible.
4. Report on consultations more effectively.
6. Existing historical abuse processes to be refined.
7. Introduce ‘False’ category for education.
8. Highlight LADO role to those agencies that did not make a referral to LADO.
9. Offer workshops for foster carers to raise awareness about allegations and how to keep themselves safe.

10. Share information with regional group and analyse information to have comparative statistical data. Work with regional group regarding ‘thresholds’.
12. Liaise with Nottingham City regarding creating a bespoke LADO web page.

CHAPTER 4

SERIOUS CASE REVIEWS AND CHILD DEATH OVERVIEW REPORT

Serious Case Review Standing Panel (Children)

Nottingham City Serious Case Review Standing Panel (SCR SP) experienced a number of changes in chairing arrangements during 2014/15 and is now chaired by DCI Melanie Bowden from Nottinghamshire Police. The sub-group has membership from all key agencies.

Attendance at Panel Meetings is regular and consistent. Colleagues are proactive in identifying representation when they cannot attend and any partner agencies not being represented is rare.

The SCRSP meet monthly throughout the whole year and 12 meetings have taken place in 2014/15 in line with expectations.

The overall aim of the SCRSP is to ensure that lessons learned from Serious Case Reviews (SCR) and other types of review are shared with agencies and individuals to positively influence practice, improve the way in which they work, both individually and collectively, and to safeguard and promote the welfare of children.

The SCRSP seeks to continually develop Review Processes in line with local and national best practice, and consider themes or trends in serious incidents.

The SCR Process is a statutory requirement under Working Together 2015 and each local authority must have in place a framework for identifying cases that meet the statutory criteria for SCR. The SCRSP fulfils this requirement in Nottingham City.

In addition the SCRSP ensures Learning Reviews are conducted where there is identified multi-agency learning but the threshold for SCR is not met. This provides a process for robust challenge and effective identification/co-ordination of learning

The SCRSP is a critical contributor to the NCSCB Learning and Improvement Framework.

What has been undertaken in 2014/15?

During 2014/15 the SCR Panel received 4 new SCR referrals - a reduction of 2 from the previous year. As a result of the four referrals:

- 2 SCRs were commissioned

- 1 learning review was commissioned
- 1 case resulted in no further action. (on receipt of full medical reports and judgment in proceedings it was clear that this case did not meet the criteria for SCR)

In addition work was completed on cases initiated in the previous year as follows:

- Completion and sign off for the SCR strategic action plan for child G
- Monitoring and completion of action plans for four learning reviews
- Monitoring of SCR strategic and combined action plans for Child H
- Completion of one learning review and monitoring of resulting action plan.

Two SCRs have been published, one on Child G in February 2015 and that on Child H in March 2015.

The SCRSP has responded to the recent consultation on Working Together 2015 most notably the consideration for clearer definitions of *Serious Harm.*

All SCR and learning reviews have where appropriate included engagement with the family. Careful and sensitive preparation of family members has taken place in respect of the two SCR published earlier this year.

What has been the impact of the work undertaken?

As noted above there has been a reduction in the number of referrals this year, with 3 reviews being commissioned; 2 SCR and 1 Learning Review. All these are in process.

We have completed a comparison exercise with statistical neighbours and core cities, asking them about SCR activity since April 2013. The responses were varied with 5 being the highest number completed in one area; three safeguarding boards not undertaking any; and the others completing either 3 or 4. Nottingham City has commissioned 3 since April 2013 indicating we are not disproportionately high in comparison.

In relation to other types of Learning Reviews two safeguarding boards registered an increase in alternative types of reviews; the others stated that it was consistent with numbers prior to April 2013. Nottingham City have initiated 3 multi-agency learning reviews, 2 single agency reviews and 1 duel agency review, during this period. This is an increase for NCSCB.

ACHIEVEMENTS

The SCRSP have fulfilled their statutory responsibility on behalf of the NCSCB in relation to Serious Case Reviews.

The work of the SCRSP has been led by the reviews commissioned and the sub-group work plan. The work plan activity is all assessed as green with the exception of agency capacity to engage in SCR activity. Some partner agencies have experienced difficulty in returning requested information and reports in timescales, in part this has been due to the complexity of some of the cases but also agencies have identified capacity to meet the demand across adults and children reviews as having an impact.

Outputs and activity as a result of reviews commissioned include:

- Work undertaken to develop an Out of Hours Protocol between the Police, Children's Social Care and Health Colleagues.
- Multi-agency CAF training has resumed in Nottingham City under the remit of the NCSCB training programme.
- Multi-agency guidance produced and circulated in relation to conducting effective multi-agency meetings.
- Revision and update of the *Excellence in Safeguarding* guidance.
- A series of Learning briefings delivered to front line practitioners by Children's Social Care and more planned in conjunction with Vulnerable Children and Families practitioners.
- Awareness work with GPs in respect of guidance for prescribing anti-psychotic medication.
- Work to improve the effectiveness of *Red Card* concerns meetings within GP practices.
- Training for health visiting in respect of paternal mental health strengthened through mandatory training programme.
- Revised and improved Strategy Meeting template for use in Children's Social Care.
- New supporting guidance produced in respect of bruising to non-mobile babies agreed.
- Promoted the delivery of cross authority seminars on physical, emotional and sexual abuse.

- Changes to paperwork in acute services in respect of capturing caring responsibilities, and parenting responsibilities of patients in receipt of acute services.

- Following findings of one review *Think Family* training delivered as part of Level 1 and level 2 safeguarding training Nottinghamshire Healthcare Trust.

- Nottinghamshire Healthcare Trust has also developed information leaflets for clients in respect of historic abuse.

Themes emerging from reviews are identified as:

- Emotional Abuse - a continuing theme from the previous year, but cases reviewed have covered similar time frames. It is anticipated that the impact of new practice guidance, training and staff briefings will begin to be evidence in current cases. The Quality Assurance sub-group have undertaken an audit focussing on emotional abuse and they will be reporting the findings.

- Other themes emerging are
    - Failure to adhere to procedures
    - Non-attendance at medical appointments
    - The quality of assessments
    - Poor use of escalation processes
    - Children placed on Special Guardianship orders (SGO)

Children's Social Care is completing a full review of all children placed under a Special Guardianship Order; and the process for supporting them. The review is being conducted through a multi agency working group, chaired by a Head of Service, with a named Independent Reviewing Officer. The group meet monthly and have an action plan covering all aspects of SGO; the findings of which will be made available to the NCSCB.

The SCRSP has experienced some challenges in relation to the dissemination of learning despite the production of key learning briefing notes, guidance and tools being developed and distributed and NCSCB Seminars being delivered. We have struggled to identify evidence of impact on practice and outcomes despite key messages being incorporated into training and requests being sent to partner agencies for impact evidence. Some agencies have begun to deliver direct workshops to staff; this is seen as a positive way forward.

The SCRSP will be considering this in 2015/16 particularly in respect of developing recommendations and activity following the conclusion of all types of reviews.

Commissioning Lead Reviewers and Authors has in recent months been problematic and caused some delay in the initiation of reviews. Experienced and recommended reviewers are extremely busy and are declining approaches to submit expressions of interest to conduct reviews.

Work commissioned by the SCR SP has also had to be carefully managed alongside criminal investigations and court proceedings.

It is always the intention of the SCRSP to influence practice in relation to learning from SCR, to strengthen the multi-agency understanding and response to findings from reviews. This includes understanding the child / family experiences and incorporating them where possible into reviews. Combined this will ultimately improve outcomes. Outcomes for this year will be:

- Greater understanding of the complexities of Emotional Abuse
- Improved assessments in cases involving Emotional Abuse.
- Strengthened multi-agency (Police, health, Social Care) responses to families during *out of hours* service.
- Greater adherence to procedures.
- Routine use of reference points / use of quality assurance tools by individual practitioners. (such as the case briefing notes and excellence in safeguarding guidance)
- Improved response by Health Visitors to poor maternal mental health
- Improved dialogue between GP's and Health Visitors in respect of safeguarding concerns.
- Greater awareness for GPs in relation to prescribing guidelines.
- Improved recognition of caring responsibility, including parental responsibilities in acute medical services.
- Increased awareness across adult and children's services of potential safeguarding concerns and responses required

What do we plan to do in the future?

Recommendations for work in 2015/16 are:

- Continued development of effective participation in the Learning and Improvement Framework by developing new methods to disseminate learning; to ensure we can evidence impact.

- Exploration and identification of issues in relation to multi-agency engagement in escalation processes.
- Identification and greater understanding in relation to the impact of non-attendance at medical appointments and the impact of this on safeguarding.

Following positive feedback from the SCRSP members it is intended to conduct a development session on 1st May 2015. The key components of the agenda for this session have been agreed as:

- Exploring and learning more about models for conducting SCR
- Embedding learning and measuring impact
- Sharing models for multi-agency learning
- Escalation- exploring and identifying the issues

REPORT FROM THE CHILD DEATH OVERVIEW PANEL (CDOP)

The Chair of the Child Death Overview Panel (CDOP) is Caroline Brown, Designated Doctor for Safeguarding for the City. The sub-group comprises all key partner agencies across Health, Local authority, Police and Public Health.

The key aim of CDOP is to review child deaths so learning can be identified and actions undertaken to prevent future death or ill health to children and young people and contribute to the Learning and Improvement Framework. CDOP meets 12 times a year, plus two joint meetings with Nottinghamshire County CDOP.

CDOP is a statutory requirement under Working Together 2015. Its key objectives are to:

- Ensure compliance with Working Together 2015 in relation to Child Deaths.
- Ensure that lessons from national, regional and local CDOP are incorporated into the practice of partner agencies and the partnership as a whole.
- Provide learning to NCSCB to support the priority: To be assured that children and young people are safe across the child's journey

<u>What we did</u>

CDOP has met their full commitment of meetings and reviewed all cases promptly as soon as all required information has been made available. Reviews have effectively incorporated findings from SCR, SILP and other learning reviews (multi and single agency). Improved links have been made with the training sub group to ensure Partner agencies training leads have access to any key learning to directly incorporate into training for practitioners.

Work at CDOP has covered all four quadrants of the Performance Framework in the following ways:

- Quantitative: collection and comparison of data, includes statistical return to DfE annually.

- Qualitative: Case information gathered to support each review is detailed and descriptive in relation to information shared by partner agencies and in reviews there is much discussion about case management and findings.

- Engagement with frontline practitioners: They feedback directly in the rapid response procedures through initial and final case discussions, completion of information collection for expected deaths, increasing involvement with agreement and development of recommendations and desirable outcome

- Engagement with service users: parents and families are asked directly for feedback about care and support processes received by bereavement nurses, coroners officers, and the Rapid Response Team feed this into the case review

What was the impact of work undertaken?

STATISTICAL / COMPARATIVE INFORMATION

Data from 2014/15 shows:

- Number of deaths 42, of which 11 were unexpected deaths
- Number of cases reviewed and ratified 45 including 14 modifiable deaths, this is an increase of 13 reviews on the previous year.

National data for 2014/15 was released in July 2015 which shows a continuation of national trends; in that the decrease in child death reviews per year is consistent with a decrease in the number of registered deaths.

Nottingham is bucking this trend with an increase in deaths for the year and in the number of reviews completed. However it is significant that of the 45 cases reviewed, 24 were Neonatal deaths and 9 were of children with life limiting conditions, equating to 73% of deaths reviewed. This indicates that the figures should be treated with caution. This is further evidenced by 18 of the 24 Neonatal deaths (75%) being non modifiable.

Where Nottingham does excel is in the swift review of cases, with 32 cases (71%) reviewed in under 6 months against the national average of 32%; with only 3 cases (6%) taking longer than a year, against the national average of 30%. Regional data also supports this.

This means that any learning is quickly identified and learning disseminated.

OTHER ACHIEVEMENTS

CDOP processes have run in line with Working Together 2015. Learning is identified and reviewed on a 6 monthly basis.

Two key pieces of work have been ensuring evaluation of service provision by Midwifery and Public Health in relation to antenatal care for smoking and maternal obesity; and furthering local understanding of possible ways to reduce consanguinity and the effect of this on mortality and morbidity.

Review of the learning from 2013/14 has established impact in the following areas:

- Guidance for detection of Herpes Simplex Virus antenatal being developed in NUH and training for postnatal detection delivered.
- Better understanding and improved resources in relation to suicides across City/County
- Better understanding of access to health promotion antenatally
- Better use of interpreting services within NUH

CDOP has been involved with a number of changes in practice across partner agencies. Where key health guidelines have been implemented we rarely see similar cases coming through.

We have made a difference to the bereavement support and planning for expected child death through supporting commissioning change.

CDOP reviews provide the opportunity to make a difference to the lives for the communities as we share learning with Public Health, research programmes and service providers. Ultimately this supports a reduction in deaths where there are modifiable factors and aims to reduce ill health and enable earlier identification of need for intervention.

CDOP Data feeds into the national picture in relation to child deaths, including patterns and trends. Locally the numbers are too small to draw any significant conclusions.

CDOP continues to fulfil its statutory function for NCSCB, with good representation from partnership agencies, positive links with the Nottinghamshire CDOP, and improved practice in relation to learning and disseminating lessons

<u>What do we need to do in the future?</u>

The main barrier to the work of CDOP is time and capacity. The majority of the Panel have no formal time identified in their day to day role to attend and undertake work both in reviewing cases and follow up of key learning to ensure significant distribution and change in practice. Due to capacity our plan to review data from 2008 onwards has not happened. This is on the new work-plan for 2015/16.

Recommendations for action in 2015/16 are as follows:

- That dedicated business office time is allocated to a full review of data of the Nottingham City CDOP to ensure no loss of learning due to small case numbers.
- A working group is established to review “safe” sleeping deaths and agree local response alongside Nottingham County CDOP.
- Public Health to review local data alongside national findings and give consideration to including in the Joint Strategic Needs Assessment.

CHAPTER 5

INDIVIDUAL AGENCY PERFORMANCE

Whilst the Annual Report focuses on multi-agency priorities set out in the Business Plan safeguarding effectiveness in individual agencies is, nonetheless, an important facet of performance. Indeed effective partnership working to secure effective safeguarding relies heavily on the quality of safeguarding practice and performance in individual agencies that form the Board partnerships.

The information provided in these reports is set out in Appendix 3 to this report.

CHAPTER 6

FUTURE CHALLENGES: OUR BUSINESS PLAN FOR 2014/15

The Business plan for 2015/16 has been agreed by the Board and is attached to this report as an appendix (Appendix 1). We have maintained the approach of having the plan in two parts, one of which is shared with the Nottingham City Safeguarding Adult Partnership Board. As will be seen there are four overarching priorities set out in the Business plan, each of which has a number of associated actions. The overarching priorities are:

- To be assured that children and young people are safe across the child's journey
- To be assured that safeguarding is everyone's responsibility
- To be assured that safeguarding services are effectively coordinated across children and adult services ('Think Family')
- To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults

There are a number of issues which are critical to the successful implementation of this business plan. Changes to the Board structures and operating processes will be introduced through the new chairing arrangements and will need to be implemented effectively. It is likely that a revised constitution for the Board will be required that reflects the new way of working. In drafting this and managing the transition, careful consideration will be given to ensure that the current commitment from agencies and individuals is maintained and built upon.

This is directly related to an issue that has a wider and more direct relevance, which is the issue of capacity. We are fortunate in Nottingham City to have across the partnership a workforce that is, in the main, hard-working and dedicated to safeguarding and promoting the welfare of children and young people. We know that many of these services are experiencing significant and increasing demand and this appears unlikely in the short-term to be reduced. Ensuring that there is sufficient capacity in critical services for vulnerable children and families will be challenging given the current financial situation in the public sector which sees all agencies needing to deliver efficiency savings.

The Board will monitor this issue, along with the specific issues set out in the Business plan. Although this will be a challenge my experience during the period I have been the Independent Chair of the NCSCB gives me great confidence that this

is an issue which is understood by Senior Managers and Politicians, who are fully committed to ensuring that families receive the right help at the right time.

Paul Burnett

Independent Chair, Nottingham City Safeguarding Children Board and Nottingham City Adult Safeguarding Partnership Board

APPENDICES

Appendix 1: **NCSCB Business Plan 2015/16**

Appendix 2: **NCSCB and NCASPB Joint Business Plan 2015/16**

Appendix 3: **Individual Agency reports**

Appendix 1

NOTTINGHAM CITY SAFEGUARDING CHILDREN BOARD

BUSINESS PLAN 2015/16

Nottingham City Children's Safeguarding Board Business Plan 2015/16

Priority 1: **To be assured that children and young people are safe across the child's journey**

- Thresholds – Family Support Pathway
- Escalation
- Private Fostering
- Child Sexual Exploitation (CSE)
- Self-harm and wellbeing
- Missing
- Neglect
- Signs of Safety (SOS)
- Child Death Overview Panel (CDOP)

Priority 2: **To be assured that safeguarding is everyone's responsibility**

- Impact of implementing Working Together to safeguard Children (2015) and the Family Support Pathway.
- Improving performance & demonstrating impact – Section 11, staff survey, multi-agency audits, Serious Case Reviews (SCRs)
- Voice of the Child
- Improved engagement with schools

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating
1.1	Thresholds across the spectrum of children's services are being applied in line with the Family Support Pathway by all agencies across the partnership.	Request a report from Vulnerable Children and Families Services evaluating the impact of the CAF process against the four quadrants of the Quality Assurance Framework. This report should provide a comparative analysis of CAFs undertaken by all partner agencies.	Children's QA subgroup	Quarterly CAF report received by Children's QA subgroup	**July 15** **Oct 15** **Jan 16**		
				Children's QA subgroup report to OMG	**Oct 15** **Dec 15** **Feb 16**		
		Monitor and evaluate the application of thresholds across the child's journey through the QA and PM framework	Children's QA subgroup	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15** **Feb 16**		

		Finalise a standard Board audit tool ensuring that this consistently captures information regarding the use of the Family Support Pathway in order to enable this to be fed back to the Board.	Children's QA subgroup	Use of standard tool in multi-agency audits	**June 15**		
1.2	Single agency whistle blowing arrangements and escalation procedures reflect the escalation process set out in the Family Support Pathway	Ensure that all Board partner agencies have whistle blowing and escalation processes that reflects the principles of the Family Support Pathway and that there is a mechanism for ensuring compliance	NCSCB Strategic Board Members	Assurance reports received by OMG from individual agencies	**Dec 15**		
		Evaluate impact through the multi-agency audit programme	Children's QA subgroup	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15** **Feb 16**		

1.3	The needs of children who are privately fostered are recognised and that they receive appropriate and timely support	Analyse numbers of private fostering arrangements and referral sources in order to develop a more informed hypothesis regarding professional and community understanding.	Children's QA subgroup	Report received by Children's QA subgroup	**Oct 15**		
				Children's QA subgroup report to OMG	**Dec 15**		
		Scrutinise local practice to ensure that national indicator targets are met in relation to assessments and visiting timescales.	Children's QA subgroup	Report received by Children's QA subgroup	**Oct 15**		
				Children's QA subgroup report to OMG	**Dec 15**		

		Support the work of the Lead Officer in undertaking a publicity campaign aimed at schools, GPs, early years and youth agencies with a view to increasing the number of private fostering notifications received.	Lead Officer/Comms and engagement group	Comms and engagement report to OMG	**March 16**		
1.4	The needs of children who are, or are at risk of becoming, sexually exploited are proactively recognised and that they receive appropriate and timely support	Through the delivery of the cross authority CSECAG subgroup work plan and securing the targets set out in relation to: ○ Prevention and response ○ Safeguarding and Protection ○ Bringing offenders to justice ○ Public confidence	CSECAG group	CSECAG group will provide regular updates to OMG on the delivery of their plan.	**July 15** **Dec 15**		
		NCSCB will provide an analysis of local performance in	Independent Chair	Annual Report	**July 2015**		

		addressing CSE					
		Delivery of Missing work plan	Missing subgroup	Missing subgroup will provide regular updates to OMG on the delivery of their plan.	**Oct 15** **Feb 16**		
1.5	Signs of safety is understood and used where appropriate across the partnership.	Develop a multi-agency implementation plan in order to ensure all partner agencies are engaged with this model	NCSCB	Report received by OMG from Mandy Goodenough	**July 15**		
		Delivery of SOS training programme with a view to this becoming multi-agency led.	Training subgroup	Training subgroup report to OMG	**Oct 15**		
		Audit work will consider the extent to which SOS is rolled out across the child's journey and that there is consistency of	Children's QA subgroup	Children's QA subgroup to OMG	**Feb 16**		

		application					
1.6	Lessons from child deaths are understood and consistently acted upon.	Delivery of CDOP subgroup's work plan.	CDOP	CDOP will provide regular updates to OMG on the delivery of their plan.	**July 15** **Dec 15**		
		Review the local prevalence and offer for children who self-harm by scrutinising the evaluation of the impact of the Nottingham City Pathway for Children and Young People with Behavioural, Emotional or Mental Health Needs 2014	CDOP Chair	CDOP will provide regular updates to OMG on the delivery of their plan.	**July 15** **Dec 15**		
1.7	Local procedures are fully compliant with national statutory guidance	Work with Tri-X to update the local Child Protection procedures to reflect the changes to Working Together to Safeguard Children 2015		Report to Board highlighting changes Memo to all	**July 2015**		

				staff setting out the changes	**July 2015**		

Priority 2: **To be assured that safeguarding is everyone's responsibility**

No.	**What do we want to achieve?**	**How are we going to do it?**	**Who will lead?**	**How will we know we have achieved our goal?**	**When are we going to achieve this?**	**Comment on Progress**	**RAG rating**
2.1	The learning and improvement framework is having a positive impact on local practice.	Develop plans of action to address the outcomes of learning and improvement undertaken in 2014-15.	Training subgroup	Training subgroup report to OMG	**July 15**		
		Relaunch Excellence in Safeguarding tool	Comms and Engagement group	Comms and Engagement group to OMG	**Oct 15**		
		Audit programme to be designed to evaluate impact of learning and improvement framework.	Training subgroup	Training subgroup report to OMG	**Oct 15**		

2.2	The challenge and scrutiny function of the board leads to improved outcomes for vulnerable children and families	Reinvigorate the QA subgroup and ensure it provides information that enhances the Board's capacity to scrutinise and challenge performance of both individual agencies and multi-agency safeguarding arrangements.	Children's QA subgroup	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15** **Feb 16**		
		Delivery of the core functions of the QA subgroup - section 11, staff survey and audit programme	Children's QA subgroup	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15** **Feb 16**		

		Develop Annual programme for the QA subgroup in order that all agencies are clear what is required to be submitted, when and what will happen if we do not comply with this.	Children's QA subgroup	Children's QA subgroup report to OMG	**April 15**		
2.3	Voice of the child is heard and acted upon	Engagement strategy agreed and implemented.	Comms and Engagement	Comms and Engagement group to OMG	**Oct 15**		
		Identify evidence that the views and opinions of children and young people have impacted on business plan priorities and actions.	Comms and Engagement	Comms and Engagement group to OMG	**March 16**		
		Audit work will consider the extent to which the voice of the child is heard and acted upon.	Children's QA subgroup	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15**		

					Feb 16		
2.4	Improved engagement with schools ensures that this critical sector is fully engaged in work to safeguard children and young people	Attendance at board, OMG and other appropriate board meetings.	Board Manager	Report to NCSCB	**Sept 15**		
		Engagement in the multi-agency audit process.	Education Safeguarding Coordinator	Children's QA subgroup report to OMG	**July 15** **Oct 15** **Dec 15** **Feb 16**		
		Review and update the compliance checklist and process.	Education Safeguarding Coordinator	Children's QA subgroup report to OMG	**June 15**		

		Undertake further work with schools to embed the principles of escalation.	Children's Board Officer	SCRSP subgroup report to OMG	**July 15**		

RAG Rating key	
Clear	Work is underway and, in the judgement of the lead individual/subgroup, is expected to be completed within the agreed timescale
Red	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by more than 3 months and/or • The impact of missing this deadline is likely to be significant
Amber	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by less than 3 months and • The impact of missing this deadline is unlikely to be significant
Green	Action completed
Blue	Impact of the action has been evaluated and found to have addressed the issue identified

Appendix 2

NOTTINGHAM CITY SAFEGUARDING CHILDREN BOARD AND ADULT SAFEGUARGING PARTNERSHIP BOARD

JOINT BUSINESS PLAN 2015/16

Nottingham City Children's and Adults Safeguarding Board

Priority 1: **To be assured that safeguarding services are effectively coordinated across children and adult services ('Think Family')**

DV, modern slavery and FGM

Priority Families

Transitions

Information sharing

Priority 2: **To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults**

To be assured that the workforce across all partner agencies has adequate basic knowledge and that this has been effective in improving practice, responding to areas of improvement identified.

Ensure learning is identified and disseminated from and between partner agencies, including how this will be embedded into practice.

Measuring the impact on practice and outcomes for children, young people and adults, basic and improved knowledge, demonstrated through a mechanism with clear outcomes identified.

Improvement of citizen awareness of their responsibility for the welfare of children and adults.

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating
1.1	Effective safeguarding arrangements in relation to domestic abuse are in place across the partnership.	Delivery of the domestic violence strategic group and action plan.	DVSG chair	DV strategic group reports to OMG	**Oct 15** **Feb 16**		
		Delivery of the domestic abuse and children subgroup's work plan.	DA Children's subgroup chair	DV children's subgroup reports to OMG	**Oct 15** **Feb 16**		
		Establish effective lines of connectivity with adult safeguarding board to reflect the requirements of the Care Act.	Care Act task and finish group	Care Act task and finish group reports to OMG	**July 15** **Dec 15**		
1.2	The Boards receive a report	Liaise with DVSG chair to add indicators to DV data	DVSG/Board	DV strategic group reports	**Oct 15**		

	on current intelligence in relation to modern slavery and identify further action that may be required in response.	regarding how many case of modern slavery there are and what action was taken.	manager	to OMG	**Feb 16**		
1.3	The Boards are assured that work in relation to FGM is addressing key expectations in relation to awareness raising, identification and response.	Delivery of the FGM board work plan.	Chair of the FGM board	FGM update to Board	**April 15** **Oct 15**	**Green**	

1.4	The Priority Families programme incorporates robust safeguarding arrangements and coordinates effectively with formal safeguarding processes where appropriate.	The board will receive a report from Vulnerable Children and Families Services evaluating the impact of the Priority Families service against the four quadrants of the Quality Assurance Framework. This report should provide a comparative analysis of the impact of the service in working with adults at risk.	Children's QA subgroup	Report received by Children's QA subgroup Children's QA subgroup report to OMG	**Jan 16** **Feb 16**		
			Care Act task and finish group	Report received by Care Act task and finish group Care Act task and finish group report to OMG	**Dec 15** **Feb 16**		

1.5	The Board is assured that agencies are successfully transitioning individuals from children's to adults services, applying best practice principles.	Health, social care and education provide evidence that SEND forms are being completed and are effective.	Children's QA subgroup	Report received by Children's QA subgroup Children's QA report to OMG	**Oct 15** **Dec 16**		
		The transitions document is updated in line with the Care Act.	Care Act task and finish group	Care Act task and finish group report to OMG	**July 15**		
		The transitions document in publicised.	Comms& Engagement task and finish	Comms and Engagement report to OMG	**Oct 15**		
		Boards receive reports from Children's social care setting out the efficacy of local arrangements to support care	OMG/Head of Safeguarding	Report to NCSCB	**Jan 15**		

		leavers. The Board will then formally communicate its views regarding these arrangements to the Corporate Parenting Panel.					
1.6	Information sharing protocols are fit for purpose	Information sharing protocol for children's amended in light of revised statutory guidance required in line with TriX updates.	Board Service Manager	Report on Trix updates to OMG	**July 15**		
		Information sharing protocol for adults benchmarked against requirements of the Care Act and amended if necessary.	Care Act task and finish group	Care Act report to OMG	**July 15**		

1.7	The Boards are assured that work in relation to children and vulnerable adults at risk of radicalisation is robust and effect in diverting and supporting the individuals and their families	The board will receive a report from local Prevent Leads evaluating the impact of local practice against the four quadrants of the Quality Assurance Framework. This report should provide analysis of the efficacy of local Chanel Panel arrangements	OMG/Head of Safeguarding	Report to NCSCB	**Oct 15**		

Priority 2: **To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults**

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating
1.8	The Board is assured that the learning and Improvement Framework enables staff and volunteers to identify safeguarding risks for both children and	Embed the function of the Learning and Improvement process.	Training subgroup	Training subgroup report to OMG	**Oct 15**		
		Test that the training and development programme reflects key Business plan priorities and the recommendations arising from SCRs, SILPs and other	Training subgroup	Training subgroup report to OMG	**Oct 15**		

	adults, and act accordingly	reviews.					
		Strengthen the training and development evaluation process to test impact on service quality and safeguarding outcomes for children, young people and adults at risk including a safeguarding competence framework.	Training subgroup	Training subgroup report to OMG	**July 15** **Oct 15** **Feb 16**		
		Ascertain numbers of referrals from children's services to adult services.	Children's QA subgroup	Children's QA subgroup report to OMG	**Oct 15**		
		Ascertain number of referrals from adult services to children's services.	Care Act task and finish group	Care Act task and finish group report to OMG	**Oct 15**		
RAG Rating key							

Clear	Work is underway and, in the judgement of the lead individual/subgroup, is expected to be completed within the agreed timescale
Red	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either The deadline will be missed by more than 3 months and/or The impact of missing this deadline is likely to be significant
Amber	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either The deadline will be missed by less than 3 months and The impact of missing this deadline is unlikely to be significant
Green	Action completed
Blue	Impact of the action has been evaluated and found to have addressed the issue identified

APPENDIX 3: INDIVIDUAL AGENCY REPORTS

DERBYSHIRE, LEICESTERSHIRE, NOTTINGHAMSHIRE AND RUTLAND COMMUNITY REHABILIATION SERVICE

On 1 June 2014, responsibility for the provision of probation services in Nottinghamshire was transferred from the Nottinghamshire Probation Trust to two, newly created organisations: the National Probation Service and the Derbyshire, Leicestershire, Nottingham and Rutland Community Rehabilitation Company Limited (DLNR CRC). The DLNR CRC is responsible for the supervision of offenders assessed as presenting a low or medium risk of harm. The National Probation Services provides services to Courts, including the preparation of reports, and the supervision of offenders assessed as high risk of harm.

The CRC is committed to working in partnership with other agencies. Arrangements are in place to reflect the importance of safeguarding and promoting the welfare of children. All members of staff are aware that safeguarding is everybody's responsibility. An Assistant Chief Officer has responsibility for safeguarding.

What the agency planned to do -

Develop harmonised policy and practice in relation to all safeguarding matters, across the three areas which came together to form the DLNR CRC: this work will be completed in the next few months.

A priority for the newly formed organisation was to ensure that all staff were trained in safeguarding matters.

The annual Learning and Development Plan included the delivery of Introductory Safeguarding Children and Adults training through a blended learning approach composed of e-learning and face to face training.

What we did.

The CRC took part in a Section 11 Children Act 2004, self-assessment audit and is making progress with the areas identified for development (i.e. ensuring that a whole family approach is incorporated into training programmes and evidenced in referrals, work in relation to attendance at safeguarding and multi-agency meetings, an audit of complaints by children and families and contracts in view of organisational changes).

Attendance at Child Protection Conferences by Offender Management staff was monitored. The multi-agency child protection report template was embedded in practice, with positive results.

We delivered Introductory Safeguarding Children and Adults training to new starters within their first 3 months in post. Local Safeguarding Children and Adult Boards' training was advertised to all relevant colleagues, and attendance was monitored and supported. Training materials were reviewed and updated in light of national and local guidance and legislation.

The revised guidance and legislative changes were communicated to all colleagues via email, Leadership Forums and local intranet. To support this further and help embed learning into practice a series of Leadership Forum presentations and workshops were delivered to managers and relevant colleagues. These included Child Sexual Exploitation, Safeguarding Adults, The Care Act, Risk of Harm and Safeguarding Children (including finding from serious case reviews and domestic homicide reviews).

We have a designated safeguarding page on our intranet, accessible across the CRC. This also has links to relevant partnership websites, guidance, procedures, policies best practice toolkits and other useful learning material. This resource supports the organisation's commitment to safeguarding and continuous professional development. Recently it has been updated to include guidance in relation to Child Sexual Exploitation and Female Genital Mutilation.

The DLNR CRC established a Quality Improvement Group which will monitor practice and develop an improvement plan which will respond to the findings of Serious Case Reviews and Stakeholder feedback as well as Focus Groups, the findings from Serious Further Offence investigations, Case Audits and inspections of DLNR CRC practice. The Quality Improvement Group meets regularly.

What has been the impact of that work?

DLNR CRC are committed to ensuring that learning from inspections, reviews and training is embedded within the organisation through continuous improvement at both organisational and individual levels . Professional development is monitored through the learning and development team's training database and in practitioners' supervision and appraisal. Organisational level development is tracked though the safeguarding deliverable of the Quality Improvement Group which is 100% complete.

DLNR CRC undertook an audit of risk registers in January 2015 to ensure a harmonised understanding across the three merging areas. Case records, as at May 2015, show that DLNR (Nottinghamshire cluster) are currently managing nearly 1000 cases with a current domestic violence risk indicator, 124 cases with a current child protection plan and 159 other cases who were identified as presenting a risk to children (average caseload 2900).

What we need to do in the future.

- DLNR CRC will continue to embed learning from serious case and other reviews.
- Implementation of the Care Act will continue to be monitored.
- DLNR CRC will play an active role in the local prioritisation of the CSE agenda.
- Safeguarding training will remain the cornerstone of individual practitioner's competency to work with cases with a safeguarding or associated concern.
- Frontline practice will be enhanced by a review of the three merging areas' safeguarding policies to produce one harmonised version of best practice.
- Internal audit of safeguarding cases through the DLNR CRC Quality Improvement Group.

NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP

This report outline safeguarding arrangement across the local health community and the mechanisms used to quality assure safeguarding standards within the services it contracts and commissions. The report is an overview of the work during 2014/15 to safeguard children and young people and highlights risk, challenges and a specific area for development during 2015/16.

What the agency planned to do

During 2014/15 the CCG planned to focus on the following risk and challenges:

- Information and Technology Systems –
- Discharge of Statutory Duties and Functions for Safeguarding
- Suicide and Self Harm of Young People in Nottingham City
- Embed the Think Family Approach across Service Delivery and Commissioning
- Domestic Violence
- Equality and Diversity
- Audit, Review and Inspection Priorities for 2014 / 2015 by maintaining and strengthening assurance processes.
- GP training and development through safeguarding leads meetings in accordance with the General Practitioner training Strategy and its effectiveness audited.

What we did

- CPIS - NHS Nottingham City CCG with Health Providers are currently working with the local authority to embed the Child Protection – Information Sharing project (CPIS) which for the first time will share child protection information at a national level. This continues to challenge how information is shared and stored about children and is recorded on NHS Nottingham City Risk Register although recognised as a longstanding, national issue. The development of a cross authority working group has developed an action and Nottingham City is progressed the project. It was highlighted in the CQC action plan
- The CCG continued to review the discharge of functions in the continuing development of NHS Nottingham City delivery of care. The key priority is to ensure compliance with “Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework” and “Working Together to Safeguard Children 2013” both published in March 2013.
- NHS Nottingham CCG reviewed through an audit requested by the internal Quality Improvement Committee the cases identified within the city. The findings, although limited by cases, suggests there is nothing identified that differs from the information known locally or nationally.
- It has been acknowledged in multi-agency reviews that further work is required and there is further work required to continue to focus how providers can identify further opportunities for this.
- Domestic Violence information is shared with GP practices and cases of concern for health need to be discussed with other health professionals via the Red Card meetings as a minimum. GP leads have received information on the DART process at meetings and advised to cascade in practices.
- Work will continue to embed issues of equality and diversity into the all agendas when developing any key messages from the safeguarding arena.
- The quality and information schedule of the NHS standard contract and service specifications contain standards for safeguarding which are monitored regularly via Quality and Contract Reviews meetings. This will include receipt of annual safeguarding reports and self-assessment audit tools, and scrutiny of declarations which, as previously mentioned, are required to be completed by all NHS organisations, quality and contract monitoring will continue to monitor performance against agreed performance indicators, and progress on action plans arising from incident reporting and case reviews. The development of the Safeguarding Health Overview Group (SHOG) has now begun to formalise a plan of work to identify areas for action in relation to health issues. This can be utilised to give consistent to the Quality Assurance Sub –group of the LSCB. The CCG are scrutinising the updates from the CQC report Safeguarding and Looked after Children from June 2014 by implementing the recommendations within an action plan devised and quarterly updates are reviewed, with a plan to look at evidence and impact as actions are reported to be completed.

- GP leads meetings continue quarterly in nominated clusters and there continues to be increased attendance and a variety of speakers have further enhanced the learning of the wider safeguarding agenda. The group has continued to develop the agenda with a Think Family focus and have forged strong links with the local authority within children and young people's department in attending the meetings and it is envisaged to further develop this with the adults. A training event to GP practices which included all Primary care staff was delivered with updates in both the children, young peoples and adult arena of safeguarding. Additionally there was training delivered on the Prevent agenda. The CCG are also encouraging the use of e-learning packages and these are regularly disseminated via the GP leads and practice managers.
- The CCG staff have also been trained to the level of safeguarding for children and adults as part of the mandatory input for training requirements.

What has been the impact of that work?

There has continued to be a high priority given to the recognition of keeping children safe in our community and through the continued development of the Safeguarding leads meeting and the PLT training events this has further enhanced the knowledge and skill of our Primary Care teams. It is recognised there is need to further develop other key professionals in primary care teams who have significant contacts with children and young people.

The CCG has led on the action plan formulated post the CQC inspection of Safeguarding and Looked after Children in June 2014. The actions are monitored through quarterly reports and the embedding and impact of the developments has noted the themes which have been highlighted within reviews and audits as improving the care delivery to the most vulnerable children and young people we are responsible for.

Within the CCG quality monitoring has embedded safeguarding questions in all reviews and visits and the designated professionals engaged in visits when the services commissioned has significant contacts with children and young people.

What agencies need to do in the future?

The CCG will continue to review all areas of safeguarding in the health community of Nottingham relating to children and young people. The review of the think family agenda will be considered further as the Safeguarding team at the CCG.

Other priorities will be developed as the co-commissioning arrangements for GP's is now developed within the CCG.

Embed the Prevent agenda with the arrangements for reporting to the CCG in Nottingham City.

Review the reporting for FGM with the development of the Dataset and reporting required by acute trusts, mental health trusts and GP's by October 2015.

NOTTINGHAM CITY COUNCIL, CHILDREN AND VULNERABLE FAMILYIES DIRECTORATE

Action taken over the past year

Much of the work of the directorate has already been incorporated into the main body of the report. This is a reflection of the nature of services which are delivered across the Directorate. There has been a considerable amount of activity coordinated through the action plan that was developed to address issues identified in the Ofsted inspection of safeguarding, looked after services, services to care leavers and the effectiveness of the safeguarding children board that took place in March 2014.

What will be the focus for 2015/16?

Our priorities and plans for the coming year are set out in detail in a document entitled Early Help, Safeguarding and Family Support Services: who we are and what we do. The priorities feed directly into the wider priorities of the Council and fall within the following themes

Priority 1 - "A Learning City"

We will play an active role in supporting families to address the issues which can become barriers to learning and aspiration in children, young people and their parents/carers. We will work with education colleagues to support vulnerable learners, including looked after children. This will contribute to the successful delivery of Nottingham City's Education Improvement Strategy. We will promote a learning culture within our services that ensures our practice is informed by a strong evidence-base, emerging best practice and learning from Serious Case Reviews (SCRs) and other serious incidents. We will act on the findings of inspections, peer reviews, audit activity and our regular performance monitoring. We will deliver a number of improvements in this priority, including

- Implementation of the recommendations in the Child Development Review to create an evidence-based menu of interventions for practitioners and families.
- Review and refresh the Family Support Strategy and Pathway to ensure it reflects the needs of our local community, learning from SCRs, inspection and describes new ways of working based on good practice.
- Create an integrated Learning and Improvement Framework for Safeguarding and Family Support Services.

Priority 2 - “Resilience in Children, Families and Communities”

We will provide early help, parenting and family support, targeted interventions and specialist services to build resilience, not dependence, in the children and families we serve. We will work with our communities to build their capacity to support one another. We will work to safeguard children and young people from harm, abuse and exploitation and we will support children who are in our care and their carers. We will use restorative approaches with young offenders to enable them to make a positive contribution to their communities. We will deliver a number of improvements in this priority, including

- Continue to roll-out Signs of Safety as a consistent and strength based approach across the partnership.
- Successfully turn around 1200 families through delivery of Phase 2 of the Priority Families programme
- Supporting the deliver the Small Steps, Big Changes programme in 4 areas of the City to improve early social and emotional development, communication and language and nutrition.
- Improve front door arrangements to ensure children and families get a timely and proportionate support
- Develop more collaborative locality-based approach between our family support and child protection services to better manage the needs of the children and work with their families
- Develop packages of support for those young people leaving custody (particularly those identified from vulnerable groups) within the East Midlands Resettlement Consortia.

Priority 3 - “Healthy Minds and Relationships”

We will work with our partners to ensure children and young people have the self-esteem, confidence and knowledge to keep themselves safe in their relationships, seeking help when needed. We will, at the earliest opportunity, directly support children, young people and their families that are struggling with significant mental health issues that may result in harm to themselves or others. We will deliver a number of improvements in this priority, including

- Develop the youth and play offer (both commissioned and provided by NCC) to provide effective open access and targeted provision which delivers early identification and support.

- Further strengthen our local multi-agency practice to identify and support children who may be vulnerable to or who are at risk of child sexual exploitation.

- Develop and deliver a pilot of advocacy services for children with mental health needs

These priorities will be based on six key principles

1. Ensure the right children get the right support at the right time

2. Create a responsive and flexible system

3. Help families to help themselves

4. Work in partnership with children and their families

5. Focus resources on what will make a positive difference

6. Ensure a balance between professional autonomy and accountability

NOTTINGHAMSHIRE POLICE

WHAT WE PLANNED TO DO

- Exercise the duties imposed by sections 10 and 11 of the Children Act, at both a strategic and tactical/operational level. The 5 year strategic policing plan 2013-15 references safeguarding within the section 'Protect, support and respond to victims, witnesses and vulnerable people'.

- Maintain strong governance through the ACC lead and Head of Public Protection.

- Work closely in partnership with other statutory and voluntary agencies. Be active members of the Nottingham City Safeguarding Adult and Children's Boards plus associated sub-groups.

- Bring offenders to justice and continually strive to improve the outcomes for victims and their families.

- Actively participate in multi-agency audits, serious case and learning reviews.

- Disseminate key learning through briefings and use of an internal police web-site. Ensure that learning is incorporated into policy and procedural rewrites/updates.

- Promote the escalation policy in line with local procedures.

- Ensure all Nottinghamshire Police employees undergo rigorous vetting processes at the appropriate level for their role.
- Work with partners in the development and delivery of joint training events. Ensure all front-line officers complete a mandatory e-learning on child safeguarding. Deliver bespoke training to Child Abuse Detectives following judicial feedback on the length of the visually recorded interviews and also to promote greater understanding, awareness and use of the witness intermediaries.
- Complete a CSE Problem Profile and develop local/Force/Regional CSE Tasking Mechanism through corresponding intelligence units. Develop an external and internal media/communications strategy to raise awareness. Work collaboratively with NCA/CEOP.
- Secure departmental growth in Sexual Exploitation Investigation Unit and develop on-line and CSE teams within SEIU
- Undertake customer satisfaction surveys and utilise third sector support agencies to seek feedback from service users.
- Ensure historic abuse is accurately recorded and investigated
- Ensure child abuse crimes are accurately recorded in line with National Crime Recording Standards
- Create a centre of expertise for the investigation of child deaths
- Improve the connectivity between child abuse and domestic abuse.

WHAT WE DID

- Conducted a self-assessment for the HMIC and a series of audits
- Reviewed the internal police processes within the MASH to reduce the amount of double keying and improve the timeliness of information transfer.
- Secured assistance with other teams outside of Public Protection to assist with crime recording compliance.
- Implemented daily domestic violence meetings in the County and assisted with the implementation of Operation Encompass (schools project).
- Rolled out awareness sessions to all control room operatives to reinforce the need to ‘flag’ incidents where children reside or frequent domestic abuse households.

- Created a specialise cadre of on-call Detective Inspectors available 24/7 from Public Protection to take primacy for dealing with child deaths and associated investigations.
- Implemented the victim's code throughout the force. Mandatory e-learning to be completed by all officers.
- A CSE problem profile has been commissioned that will encompass both the City and County. This should be completed by end of June/early July 2015.
- The Force commissioned a peer review which was undertaken by the College of Policing on 1st-3rd December 2014.
- Regional CSE Strategic Governance Group established chaired by Supt Chamberlain. Operation Striver developed designed to identify CSE derived intelligence.
- The external media can be found here http://www.nottinghamshire.police.uk/advice/cse
- The force has established and maintained productive relations with CEOP/NCA who have lead on a number of national operations.
- The staffing establishment for Public Protection has increased with the creation of an additional Detective Sergeant and 4 full time equivalent officers for SEIU alone. This has allowed the creation of an additional team for on-line CSE investigations.

WHAT HAS BEEN THE IMPACT OF THAT WORK

- HMIC identified areas of vulnerability for the organisation and this has enabled a targeted action plan to be developed.
- Robust and accurate recording in line with NCRS, ensuring victims of abuse are afforded all of the rights with victim code.
- Op Encompass - improved communication between police social care and health
- Professionalising investigations into child death, improving the investigation vs. sensitivity, quality of coroners communications and consistent commitment to the child death process - very positive feedback from professionals and bereaved families
- Development of a Strategic Management Group to oversee the work of the two historic child abuse enquiries (Operation Daybreak and Xeres) and for the development of best practice, nationally and locally.

- The impact of the CSE profile work is yet to be determined however it is anticipated that the problem will drive CSE business by ensuring that pro-active resources are directed toward the people and places most vulnerable to risk, threat and harm.

- The findings of the peer review are defining the Force action plan which is currently in development. The Force action plan will also lean upon the CoP action plan and the Jay report into CSE in Rotherham.

- Regional CSE Strategic Governance Group has ensured that, following the identification of CSE as a Force priority it has equally become a regional priority for the ROCU (Regional Organised Crime Unit). It has provided a forum for sharing best practice and lead to the establishing of Regional CSE Coordinator Dedicated CSE Analyst post (advertised) that will sit within the Regional Intelligence Unit, draw from National experience/best practice and disseminate and co-ordinate cross border law enforcement activity in relation to CSE.

- CSE intelligence submissions have increased month on month since January 2015 demonstrating a broader understanding among frontline officers of the risk indicators to CSE. A process is now in place between Public Protection and divisional intelligence units which ensure that this intelligence is actioned (where necessary) and is not missed by one thinking the other is addressing it. This represents a cohesive approach spanning from Neighbourhood Policing Teams locally to Specialist Units (SEIU) with Force responsibility.

- The Force was a pilot for Operation Notorise, a National CEOP co-ordinated investigation into the distribution of Indecent Images of Children. Similarly, the Force has lead on Operation Nautilite, assisted by CEOP nationally and internationally.

- The unit has greater capacity to deal with the increased demand symptomatic of the broader understanding of CSE post Rotherham which has led to an increase in public reporting, an increase in multi-agency referrals and increase in officers identifying children potentially at risk.

- Investigations receive increased internal scrutiny so as to ensure that all reasonable opportunities for disruption/prosecution are pursued. The department can now attribute the officers with the correct skill set to the most appropriate investigation type.

WHAT WE NEED TO DO IN THE FUTURE

- In the backdrop of financial restraint work more constructively with our partners to identify ways of enhancing the journey for victims of abuse and ensure the best possible outcomes.

- Reflect on the lessons learnt from previous reviews and inspections and avoid ways of duplicating effort
- Work smarter and think innovatively. Public Protection terms of reference will expand and the challenge is to ensure the quality of service does not reduce.
- Explore ways to modernise the workforce and create Omni competence.
- Review attendance at ICPC and related meetings
- Produce an Adult at Risk Safeguarding Procedure following the Care Act.
- Promote and establish a Concerns Network in the County
- Develop pro-active safeguarding opportunities through better use of intelligence
- Narrow the gap between missing children investigations and CSE investigations and ensure return interviews are used as intelligence gathering opportunities.
- Make better use of OCG mapping
- Develop opportunities for perpetrators lead investigation to avoid investigation being disproportionately directed toward children who have been identified at risk and interventions undertaken rendering them safe whilst perpetrator's, sometimes unidentified continue to potentially offend.
- Improve the number of joint and police led investigations and speed in which they move through the referral/MASH process.
- Improve the quality of strategy discussions
- Ensure Education is engaged and aware when a child is being exposed to domestic abuse.

NOTTINGHAM UNIVERSITY HOSPITALS TRUST

What the agency planned to do.

In 2014-2015 Nottingham University Hospitals NHS Trust devised a work plan to deliver its requirements under the safeguarding children's agenda and submitted a Safeguarding report to the Trust Board (January 15) detailing activity and outlining the priorities for 2015.

Training

Deliver safeguarding mandatory training to all relevant staff to meet the requirements of the Intercollegiate Document and the Think Family agenda

Ensure learning from all reviews are disseminated across NUH and embedded into practice.

Supervision

Increase uptake of safeguarding supervision to relevant practitioners

Statutory Requirements and Assurance

To ensure that NUH is compliant with its statutory duties under Section 11 of the Children Act and Working Together 2015

Multi-agency work

Ensure robust representation at local safeguarding boards and relevant subgroups.

What we did

Training

Training at NUH met trajectory at year end March 2015.

The mandatory Training programme and material was reviewed and updated to include the Think Family and Prevent agenda

Supervision

Policy updated in 2014. Planned sessions are delivered; the focus is on delivery to midwives and specialist nursing teams. The safeguarding team are also available to provide advice and support on an ad hoc basis. For medical staff involved in safeguarding monthly peer review sessions take place to promote discussion and learning.

Statutory Requirements and Assurance

Internally NUH has a regular Safeguarding Children's Committee and an Safeguarding Annual report is submitted to the Trust Board, with a half annual report submitted to the Quality Assurance Committee.

NUH has robust internal governance arrangements and provides assurance to the local safeguarding board in the form of the completion of the safeguarding Section 11 and Markers of Good practice assurance framework.

Multi-agency work

Multi-agency work continues as a priority. NUH is represented and are active members SCRSP, Quality Assurance, Audit and training committees.

Learning from reviews

NUH has a subgroup of the safeguarding adults and children's committee which terms of reference include to monitor NUH action plans from safeguarding reviews (adults and children) and domestic homicide reviews.

As a result of reviews during 2014-15 training has been reviewed to include a focus on 'think family' and ascertaining carers and those with caring responsibilities.

What has been the impact of this work?

Each year during November and December NUH completed the Safety of the Vulnerable Patients benchmark. Year on year this demonstrates improvement and this year has been no exception.

In order to gain a better understanding of staff knowledge across the trust, minimal changes were made to the benchmark since it was last scored in 2013

Safety of Vulnerable Patients - Children's Benchmark

12 of the 13 children's areas scored Gold or Green. Table 1 shows the indicators of best practice for children's. All of the indicators of best practice were achieved by at least 90% of children's areas

Table 1: Indicators of Best Practice – Safety of Vulnerable Patients (Children) 2014

1	Staff are aware of types of abuse and potential indicators of abuse.
2	Staff are aware of how to make a safeguarding children or adults referral.
3	Staff are aware of the NUH restraint policy and have an understanding of what constitutes proportional restraint.
4	The Ward/ Department has a Safeguarding folder, which is accessible to all staff OR staff are aware how to access information in the 'virtual folder' on the safeguarding vulnerable adults or children's intranet sites.
5	Staff are aware of who the safeguarding Champions/leads are for both: • The clinical area • The Trust
6	Staff know how to access the Mental Capacity Act/Deprivation of Liberty Safeguards policies and how to contact the Adult SG Team for advice.
7	Staff awareness and acknowledgment of importance of clarifying who has parental responsibility and how this can be determined if adult is unsure.
8	Staff understand the importance of robust, accurate, timely record-keeping when it comes to dealing with safeguarding concerns.

What we need to do in the future

Continue to promote the Think family approach to safeguarding and working to amalgamate the Children and Adult safeguarding teams.

Improve data collection systems for safeguarding and recording of referrals and continue work towards the CPIS information sharing system

Improve sharing and learning from SCRs and audit implementation of actions

Develop a system for recording of FGM in line with national requirements

Develop e-learning to support face-to-face training.

CITYCARE PARTNERSHIP

During the last year we have achieved the following:

Safeguarding Children

- The roll out of the 'Think Family' safeguarding group supervision model commenced in the summer of 2014 and has been positively received by staff undertaking the supervision model.
- An audit of the 1:1 supervision model via focus group and questionnaire to both supervisors and supervisees, implemented early in 2014, has been completed and a report of the findings is being compiled.
- The Safeguarding Children policy has been rewritten to provide staff with practice guidance on dealing with safeguarding concerns and to ensure that internal procedures are compliant with Working Together to Safeguard Children (2015) and Care Act requirements, specifically in relation to transition to adult services.
- CityCare completed Individual Management Reviews for several Serious Case Reviews (SCR) / Serious Incident Learning Process (SILP).
- Development and roll out of training programme in relation to Child Sexual Exploitation.
- Completion of Section 11 Self-Assessment Framework
- Organisational process and pathways developed to respond to 'Children Missing from Home' and 'Home Educated Children' agenda.
- Targeted awareness raising within CityCare Children's services of the updated Local Authority Family Support Pathway

Domestic Abuse

- Review of Domestic Abuse Referral Team Pathways and procedures

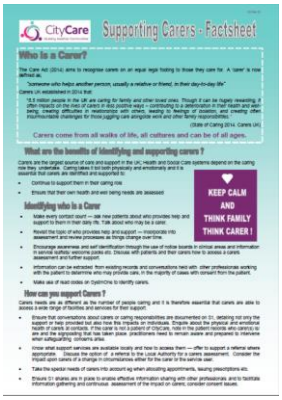
- Implementation of the Domestic Violence Disclosure process (DVDS – previously referred to as Claire's Law)
- Domestic Abuse Nurse Specialist gained accreditation as a trainer for Honour based Violence and Forced marriage.

PREVENT

- Following the completion of the PREVENT 'Train the Trainer' course, the accredited trainers have delivered PREVENT training to over 300 staff since July 2014. A rolling programme of PREVENT training is in place as part of the safeguarding 'Think Family' training matrix.
- The PREVENT lead has supported practitioners with managing a number of PREVENT concerns that have been raised by frontline staff, liaising with statutory organisations to ensure a co-ordinated multi-agency response is in place.

Strategic work

- Introduction of the Serious Incident Review Group (SIRG) which is a sub group to the Safeguarding Group, tasked with reviewing and implementing recommendations from serious safeguarding incidents (including SCR / SILP).
- Development of the CityCare safeguarding intranet pages – a one stop shop for policy and guidance documents (internal, local and national documents) relating to safeguarding.
- Development of a Carers strategy and 'Supporting Carers' factsheet for frontline staff
- Development of the 'Think Family' factsheet for frontline staff



Key Priorities for 2015/16

- Development of level 2 Safeguarding Adults and Safeguarding Children training for identified Adult Services staff
- Safeguarding Conference for CityCare staff

- Safeguarding Champions Network
- Completion of Safeguarding Adults Self-Assessment Framework
- Appointment of designated MCA Lead Practitioner role
- Development and Implementation of Safeguarding Adults service
- Audit of 'Think Family' group supervision model

NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

The Nottinghamshire Healthcare NHS Foundation Trust sees an effective safeguarding service as one that ensures that vulnerable people, whether our patients, their carers, or our staff and their relatives, are kept safe and have the best possible experience whilst in our care.

What NHCT planned to do?

Nottinghamshire Healthcare's Business Plan was developed to cover a three year period 2012 – 2015

What we did this year;

- Review the recommendations that have emerged from reviews, reports and other national enquiries
- Embed and consolidate our approach to domestic violence and abuse by ensuring that it is aligned to that of our partners in order to avoid duplication of effort and maximise our effectiveness.
- Ensure organisational learning from internal and external issues, Serious Case Reviews, Domestic Homicide Reviews, alternative reviews and audit is embedded and evaluated against impact and sustainability
- Develop new, imaginative and innovative ways of extending learning and development.
- Refresh our approach to Think Family 'in order to support the implementation of the Trust's first 'Think Family Strategy'.
- Improve our involvement with members, service users and carers to guide our development and measure our effectiveness
- Align our programme to the Strategic Objectives of the Trust and the identified priorities of the Local Safeguarding Adults and Children's Boards.
- Deliver a robust governance system and continue to develop our methods of reporting to reflect the quality of the service we deliver.
- provide a greater focus on the quality of safeguarding leadership and integration to ensure that all our staff are supported, confident and well-equipped to meet the demanding challenges of the safeguarding responsibilities they undertake on behalf of users of our services and their families

What has been the impact?

The plan between 2012 and 2015 has been reviewed and established that all the actions planned for completion by the end of 2015 have been achieved on time or have been embedded into our longer term and ongoing activities.

Highlights this year include

- Our active participation on LSBs / DV multi – agency executive Groups and sub structures
- Robustly responding and adapting National, regional , local changes and emerging themes - including , e safety , modern slavery , child sexual exploitation
- Delivering a Trust wide Think family approach, in everything we do
- The delivery of high quality accessible training , supervision and support
- Consolidation of our approach to Domestic Violence & Abuse including sexual violence
- Engagement in safeguarding research
- Development of the first Trust wide Quality and Performance framework
- Producing high quality individual and multi - agency investigation reports such as SCRs SARS and DHRs to ensure learning is timey , effective and respectful to the
  Service user, their family and our staff

What we need to do in the future

The year ahead sees the launch a new phase in our work , a refreshed 5 year plan with an emphasis on leadership , learning and improvement and a commitment to strengthen of our ability to evidence we are making a difference,

Priority 1: To demonstrate Nottinghamshire Healthcare has a strong integrated and sustainable culture of both safeguarding leadership and strategic and operational working across the Trust.

Priority 2: To demonstrate that we are assured that safeguarding is everyone's responsibility and we are able to evidence that we are making a difference.

Priority 3 To demonstrate that we are assured that learning and improvement is raising the awareness and the quality of safeguarding practice and ensure that training, procedures and guidance support improvements in safeguarding children and adults.

This approach is in line with the POSITVE values and vision of Nottinghamshire Healthcare Foundation Trust. Furthermore it encompasses a clear overarching message and framework for all staff which ensures safeguarding is

'**Everyone's business.**'

Nottingham City
Adult Safeguarding
Partnership Board

ANNUAL REPORT

2014-15

FOREWORD FROM THE INDEPENDENT CHAIR

I am pleased to present the Annual Report for the Nottingham City Adult Safeguarding Partnership Board (NCASPB) for 2014/15. Publication of annual report for Safeguarding Adult Boards became a statutory requirement following the implementation of the Care Act 2014 from 1st April 2015. In Nottingham City we have been publishing such reports for some years. Last year we published a combined annual report for the Children and Adult Safeguarding Boards.

Changes to the statutory frameworks for the two Boards together with feedback from stakeholders has resulted in our reverting to the publication of two annual reports, one for the Nottingham City Safeguarding Childrens Board and the other for the NCASPB. Some parts of the annual reports are shared since a key part of our Business Plan was to secure effectiveness across the children and adult arenas, reflecting our aim to 'think family' in the delivery of our work.

The key purpose of the report is to assess the impact of the work we have undertaken in 2014/15 on service quality and effectiveness and on safeguarding outcomes for children, young people and adults in Nottingham City. Specifically it evaluates our performance against the priorities that we set in our Business Plans 2014/15.

The last twelve months have witnessed some significant changes in the way we operate as a Board. At national level the implementation of the Care Act 2014 has moved the NCASPB on to a statutory footing and a key focus of our work in 2014/15 was to prepare the Board for the expectations of this new legislation that 'went live' in April 2015. In addition, the NCSAPB has closely monitored the impact of the Supreme Court judgement relating to Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) application and the resulting significant increases in DoLS referrals. The Board has continued the work it began in 2013/14 in monitoring local implementation of recommendations arising from the Winterbourne View and North Staffordshire Hospital review recommendations as they apply to safeguarding practice.

At a local level we have continued our vigilance in assessing the impact of the financial constraints within which partner agencies have operated and the

structural and organisational changes that have taken place in response to both national reforms and local strategies to secure efficiencies. In addition we have focused on adapting our operations to reflect changes flowing from the Care Act. This has included closer working with Prisons and their engagement in the work of the NCASPB. The Board has been closely monitoring and evaluating these initiatives.

I am pleased that this report presents a considerable range of success and achievement for the Board. The assessment of our performance also indicates areas for further development and improvement which have been incorporated into our Business Plan for 2015/16.

Many of you will know that this will be my last Annual Report since I am stepping down from the Independent Chair role in the early autumn of 2015. I would like to take this opportunity to thank all Board members and those who have participated in Subgroups for their continued commitment not just in 2014/15 but across the three years in which it has been my privilege to chair the NCASPB. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the people of Nottingham safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the two Safeguarding Boards but by staff working in the agencies that form our partnership. The further improvements we seek to achieve in 2014/15 will require continued commitment from all to ensure that adults in Nottingham are safe.

I commend this report to all our partner agencies.

Paul Burnett, Independent Chair, Nottingham City Safeguarding Children Board and Nottingham City Safeguarding Adults Partnership Board.

CONTENTS

CHAPTER 1 LOCAL SAFEGUARDING CONTEXT

1.1 Introduction

1.1.1 The Nottingham City Safeguarding Adults Partnership Board (NCASPB) serves the City of Nottingham.

1.1.2 The population of Nottingham at the time covered by this report was around 308,700.

1.1.3 The number of adults 18+ living in the City is approximately 246,306 which represents around 80% of the total City population.

1.2 Demographic, social and economic context

1.2.1 The population is growing and has risen by almost 5000 since the census of 2011. International migration (recently from Eastern Europe) and an increase in student numbers are the main reasons for the population growth since 2001, together with an excess of births over deaths.

1.2.2 The 2011 Census showed 35% of the population as being from black minority ethnic (BME) groups; an increase from 19% in 2001.

1.2.3 Despite its young age structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability. White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age-groups.

1.2.4 The City gains young adults due to migration, both international and within Britain, whilst losing all other age groups. There is a high turnover of population.

1.2.5 From a social and economic perspective Nottingham is ranked 20th most deprived district in England in the 2010 Indices of Multiple Deprivation (IMD), a relative improvement on 7th in the 2004 IMD.Crime is the Index of Deprivation domain on which Nottingham does worst, followed by Education, Skills & Training and Health & Disability.

1.2.6 A higher proportion of people aged 16-64 in Nottingham claim some form of benefit than regionally and nationally. The unemployment rate is lower than the recent peak in March 2012, but remains higher than the regional and national average.

CHAPTER 2GOVERNANCE AND ACCOUNTABILITY

2.1 Introduction

2.1.1 The Nottingham City Children's Safeguarding Board and NCASPB have been aligned since March 2012 and since that time have had the same Independent Chair, Paul Burnett.

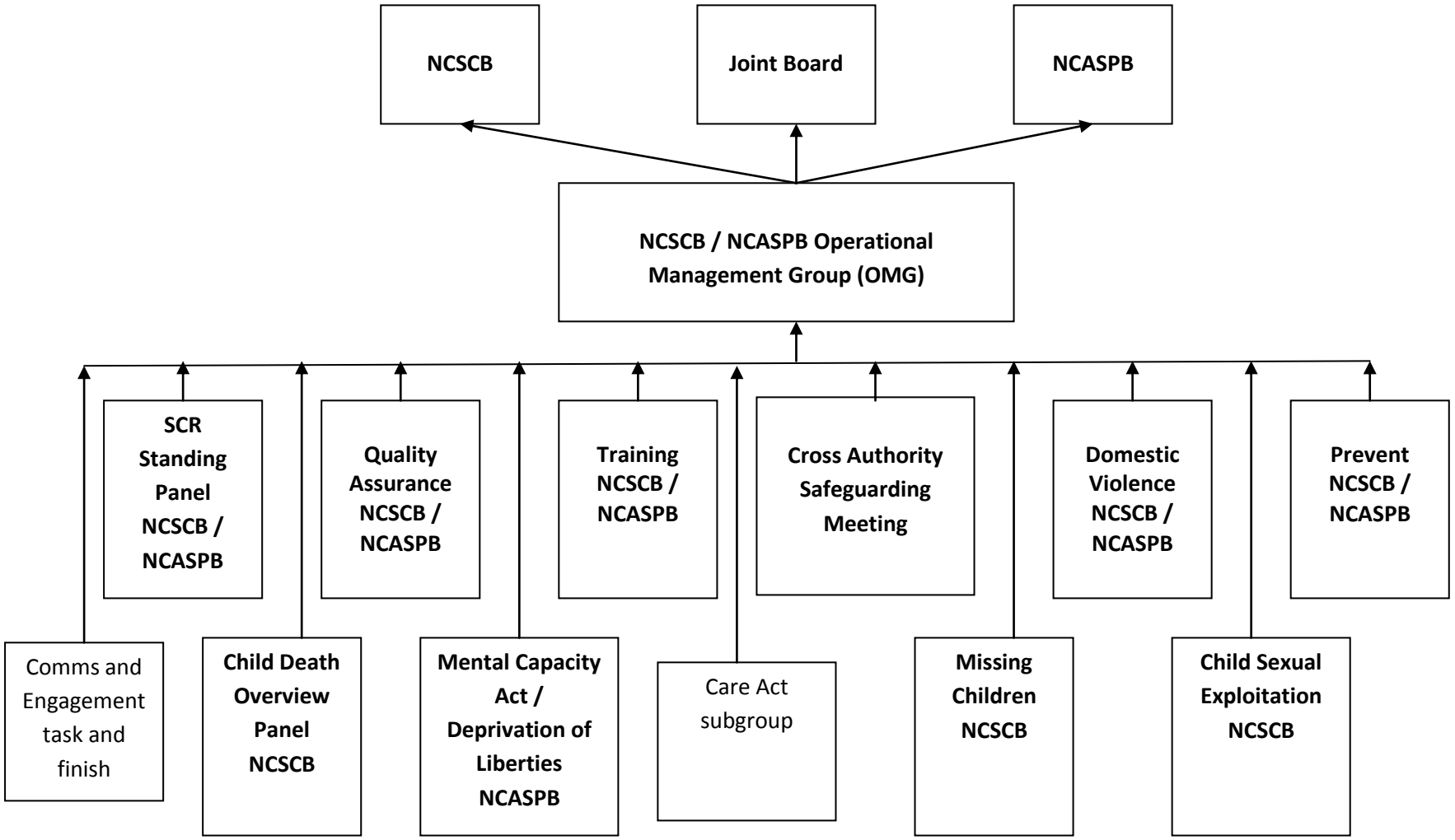
2.1.2 The two Boards have always remained distinct entities with their own constitutions, governance and memberships. This reflects the differing statutory status of the Boards. A decision has been taken in January 2015 to more clearly distinguish between the two Boards and steps will be taken to recruit independent chairs for each Board during 2015/16.

2.1.3 The NCASPB became a statutory body on 1st April 2015 as a result of the Care Act 2014. The role of the NCASPB has been to safeguard and promote the welfare of vulnerable adults and to ensure that local agencies co-operate and work well to achieve this. A key priority of the NCASPB during 2013/14 has been to review and revise its arrangements to secure compliance with the Care Act.The Board continues to undertake this work in 2015/16.

2.1.4 The Board has met four times during 2014/15. Each Board meeting has comprised a meeting of the NCASPB together with a joint meeting with the NCSCB to focus on those elements of our Business Plan that cross-cut. Changes to these arrangements may result from the appointment of new chairs during 2015/16.

2.1.5 An Operational Management Group (OMG) was established in 2012 following the decision to align the two safeguarding boards. OMG covers business relating to children and adult safeguarding. The OMG is also chaired by the Independent Chair and all the chairs of the NCSCB /NCASPB Sub Groups are members of the OMG, both to represent their agency and to report on the work of the subgroup. Any agencies which provide services to children or vulnerable adults with significant involvement in safeguarding who are not represented through the chairing of sub groups are invited to become member of the OMG. All of the sub groups work towards the priorities of the Business Plan and some of them work to both boards, as described in the diagram below.

BOARD GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS 2014/15



2.1.6 The NCASPB, OMG and each of the Sub Groups have their own Terms of Reference, work plans and reporting expectations. Each group is chaired by an agency representative, has multi-agency membership and is supported by the NCSCB / NCASPB Business Office where possible.

2.1.7 The OMG receives reports from all the sub groups on a regular basis and makes a full report to the NCASPB Strategic Board on progress, exceptions and risk.

2.2 Independent Chair

2.2.1 During 2014/15 the NCSCB and the NCASPB continued to be led by a single independent chair. The Independent Chair during 2014/15 was Paul Burnett. He is a former Director of Children's Services in two local authorities and an experienced independent chair.

2.2.2 Line management arrangements for the Independent Chair transferred to the Chief Executive of Nottingham City Council. The independent chair has agreed performance targets that are monitored through quarterly meetings. It also provides an opportunity to address strategic issues including the inter-relationships between the safeguarding boards and other partnerships.

2.3 Membership

2.3.1 The NCASPB membership for 2014 – 15 is set out below in Fig 1 including the attendance levels of constituent members/agencies.

Fig 1 - NCASPB Strategic Board Membership / Attendance

Name	Organisation	Role	Attendance
Paul Burnett		Independent Chair	100%
Alison Michalska	Nottingham City Council	Corporate Director Children & Families	100%
Cllr Liversidge/Cllr Alex Norris	Nottingham City Council	Nottingham City Council Portfolio Holder for Adult Services & Health	75%
Helen Jones	Nottingham City Council	Director of Adult Services	100%
Supt Helen Chamberlain (Vice Chair)	Nottinghamshire Police	Head of Public Protection	100%
Sally Seeley/ Teresa Cope (Vice Chair)	NHSNottingham City Clinical Commissioning Group	Assistant Director of Quality Governance	100%
Julie Gardner	Nottinghamshire Healthcare NHS Trust	Associate Director of Safeguarding and Social Care	100%
Sarah Kirkwood/ PhylisBrackenbury	NottinghamCityCare Partnership CIC	Director of Governance and Nursing	75%
Dr Stephen Fowlie	Nottingham University Hospitals Trust	Medical Director	75%
Nigel Hill	National Probation Service	Nottinghamshire Director	75%
Alastair Mclachlan	GP Safeguarding Lead	Clinical Commissioning Group	25%
Peter Moyes	Crime and Drugs Partnership	Director, Neighbourhood, Crime and Justice	25%
Claire Knowles	Legal & Democratic Service Directorate	Nominated Solicitor	75%
Hayley Frame/Clive Chambers/	Children's Safeguarding	Head of Safeguarding & Quality Assurance (Children)	100%
Julie Sanderson	Adult Safeguarding	Head of Safeguarding & Quality Assurance (Adults)	100%
Nicola McGrath	Children & Families	Safeguarding Partnerships Service Manager	100%

2.3.2 The NCASPB membership complies with the expectations of the Care Act 2014 in terms of both the representation expected and the levels of seniority that enable members to:

- speak for their organisation with authority;
- commit their organisation on policy and practice matters; and
- hold their own organisation to account and hold others to account.

2.3.3 The continued commitment of partners at times of significant change and re-organisation provides strong evidence of cross-agency commitment to safeguarding.

2.4 The Lead Member

2.4.1 The NCASPB Lead Member transferred from Councillor Liversidge to Councillor Norris, and both have been regular attendees and contributors at the NCASPB, providing consistent political support and challenge to the board. Councillor Norris chairs the Health and Well-Being Board and provides support to the inter-relationship and cross-scrutiny and challenge between the two Boards.

2.5 Budget

2.5.1 To function effectively the NCASPB needs to be supported by member organisations with adequate and reliable resources. Contributions from the three key agencies (Nottingham City Council, Nottinghamshire Police and NHS Nottingham City CCG on behalf of all health trusts) were agreed for 2014/15.

2.5.2 The Business Office resources are spilt between the NCASPB and NCSCB with each having a dedicated Board Officer, a shared Service Manager, Training Coordinator and administration. The budgets for both boards have also been amalgamated.

2.5.3 The budget statement for 2014-15 is in Fig 2:

Fig 2 – Budget statement for 2014-15

NOTTINGHAM CITY CHILDREN/ADULT SAFEGUARDING BOARD

FINANCIAL STATEMENT FOR THE YEAR 2014-15

SAFEGUARDING BOARD CONTRIBUTORS

	£
NOTTINGHAM HEALTH	181,833
POLICE	32,698
NATIONAL PROBATION SERVICE	2,392
NOTTINGHAM CITY - HOUSING	4,260
NOTTINGHAM CITY - CHILDRENS SERVICES	114,426
CAFCASS	550
TOTAL INCOME	**336,159**

	Budget 2014/15	Actual Expenditure 2014/15	Variance
Safeguarding Children Information Management Team	£	£	
EXPENDITURE			
STAFFING	92049	74,650	17,400
NON PAY COSTS:	260	260	0
TOTAL	**92,309**	**74,910**	**17,400**

	Budget 2014/15	Actual Expenditure 2014/15	Variance
CHILDREN/ADULTS SAFEGAURDING BOARD	£	£	
EXPENDITURE			
STAFFING	212,008	218,043	-6,035
NON PAY COSTS:	53,940	53,776	164
LESS INCOME RECEIVED RE TRAINING COURSE		-22,321	22,321
TOTAL	**265,948**	**249,499**	**16,449**

	Budget 2014/15	Actual Expenditure 2014/15	Variance
SAFEGUARDING BOARD - TRAINING	£	£	
EXPENDITURE			
STAFFING - under Safeguarding Board Staffing			
NON PAY COSTS:	10,210	3,387	6,823
TOTAL	**10,210**	**3,387**	**6,823**
BOARD TOTAL EXPENDITURE FOR 2014-15	**368,467**	**327,795**	**40,672**

2.6 Relationships with other Partnership bodies

2.6.1 To maximise their effectiveness, specifically in relation to their scrutiny and challenge roles, the NCASPB has developed robust protocols and arrangements to secure effective inter-relationships with other key partnership bodies including One Nottingham, the Health and Wellbeing Board and the Children's Safeguarding Board

2.7 Safeguarding Assurance Group

2.7.1 Strategic co-ordination across the partnership geography of Nottingham City is driven through the Safeguarding Assurance Group. This group comprises the Chairs of all the key partnerships together with the Corporate Director for Children and Adults and key officers. The Group was established to enable discussion of key safeguarding matters in the City and to determine how these would be addressed through the various partnership bodies. An important priority was to secure clarity in the roles and responsibilities of each partnership body in improving safeguarding in the city, to secure coherence and co-ordination in this activity and to avoid duplication.

2.8 The Health and Wellbeing Board.

2.8.1 The Health and Wellbeing Board leads and advises on work to improve the health and wellbeing of the population of Nottingham City and specifically to reduce health inequalities. The Board is responsible for agreeing the Joint Strategic Needs Assessment (JSNA) for Health and Social Care, agreeing a statutory Health and Wellbeing Strategy and promoting the integration of health and social care services for the benefit of patients and service users.

2.8.2 The opportunities presented by a formal working relationship between the Nottingham City Health and Wellbeing Board and the NCASPB can be summarised as follows:

- Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA
- Aligning the work of the NCASPB business plan with the HWB Strategy and related priority setting.
- Ensuring safeguarding is ''everyone's business'', reflected in the public health agenda and related determinant of health policies and strategies
- Evaluating the impact of the Health and Wellbeing Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health outcomes
- Identifying coordinated approach to performance management, transformational change and commissioning

- Cross Board scrutiny and challenge and ‘’holding to account’’: the Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the HWB Strategy

2.9 Children’s Safeguarding Board

2.9.1 As outlined above, the children’s and the adults safeguarding boards have the same independent chair to allow for joint working across the two boards. This has resulted in a joint action plan for cross cutting themes such as domestic abuse, priority families and transitions.

CHAPTER 3: BUSINESS PLAN PERFORMANCE 2014/15

3.1 Introduction

3.1.1 The Business Plan for 2014/15 was the second integrated plan for the NCSCB and NCASPB. The following priorities were identified for the period 2014/15:

Priority 1: To be assured that 'Safeguarding is Everyone's Responsibility' (shared with the NCSCB)
Priority 2b: To be assured that adults in need of safeguarding are safe.
Priority 2c: To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept.
Priority 3: To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults.

3.3 Business Plan Priority 1 - To be assured that 'Safeguarding is Everyone's Responsibility'

Ensure Boards' and partner agency compliance with the emerging expectations of the Care Bill – now the Care Act 2014

3.3.1 A key element of the Board's work during 2014/15 has been preparation for the implementation of the Care Act 2014. This key piece of legislation had major implications for the work of the NCASPB and as a result it was agreed to establish a Care Act Task and Finish Group to ensure focus on key issues and prepare the NCASPB for implementation of and compliance with the new legislation.The Care Act makes it a statutory requirement that Local Authorities set up a safeguarding board and Boards now have a statutory duty to hold safeguarding adult reviews and to hold partner agencies to account regarding information sharing.

3.3.2 The subgroup is a multi-agency group that meets monthly and is well attended. The functions of the Care Act task and finish group are:

- To agree and implement the project plan for ensuring the NCASPB is compliant

- To ensure delivery of work required to update and amend policy and procedures
- To make recommendations on further work required of the NCASPB

3.3.3 The group has had 4 meetings since inception. The phase 1 project plan has been completed within timescales and phase 2 is in development. The following tasks have been completed:

- Multi-agency procedures and guidance and the SAR procedures have been amended and created as cross authority documents
- A training strategy has been written, training has been updated in line with Care Act requirements and agencies have been asked to submit evidence that their training has been updated as part of the training QA scheme
- DASMs and safeguarding leads have been identified in relevant partner agencies and this is reflected in the Governance document
- Assurance has been given that contracts with providers have safeguarding clauses including a duty to share information
- If necessary advocates can be commissioned to support citizens during the SAR process
- Partner agencies have submitted a statement of assurance stating that they are compliant with Care Act requirements

3.3.4 No barriers to progress have been encountered. Partner agencies are committed to ensuring the Care Act is implemented within their own organisations as well as Board compliance. Cross authority working with Nottinghamshire County has been successful in the completion of cross authority Multi-agency Adult Safeguarding Procedures and Guidance and the cross authority Safeguarding Adults Review (SAR) Process.

<u>Ensure full agency compliance in Safeguarding Adult Assurance Framework (SAAF) Audit processes</u>

3.3.5 In 2013-14, the NCASPB agreed that the Safeguarding Adult Assurance Framework (SAAF) would take place on a biannual basis. Having been completed in 2013-14, agencies that reported to be working towards an objective produced and completed an action plan within 2014-15. Action plans were requested from the Police, Nottingham Healthcare Trust and Nottingham University Hospital Trust, and in May 2014, these agencies were able to report that they were delivering against all objectives in the SAAF.

3.3.6 The SAAF has been updated in line with Care Act requirements and will be completed within 2015-16 to be reported on in the next Annual report.

Ensure that the Board, OMG and Subgroups:

a. have appropriate and regular attendance rates

b. have capacity to deliver Business Plan expectations

3.3.7 The NCASPB met four times during 2014/15 and attendance at Board meetings has continued to be strong. Membership meets the new Care Act requirements and extends beyond the statutory requirement. Attendance levels at NCASPB are reported in Chapter 2.

3.3.8 The OMG and Subgroups have also operated effectively and sustained relevant membership and, in most cases, good levels of attendance. Difficulties have been experienced in sustaining quoracy at the Quality Assurance Subgroup.

3.3.9 The chairing of subgroups is well distributed across partner agencies as is set out in detail in the impact section below.

The Board drives partnerships and partner agencies to own, prioritise, resource, improve and positively impact on safeguarding

3.3.10 The NCASPB completes an organisational audit (the SAAF) on a biannual basis as mentioned in 1.3. The purpose of the audit is to ensure that there are effective safeguarding mechanisms across the partnership.

3.3.11 The NCASPB also initiates Serious Case Reviews (SCRs) where the criteria is met which focuses partner agencies on identifying where there are issues with safeguarding mechanisms and ensures these are addressed. Other learning processes are instigated where SCR criteria are not met but there is learning to be identified. Further details on SCRs are included in chapter 4.

The Board receives management information to evidence, scrutinise and challenge performance so that it knows the safeguarding strengths and weaknesses of agencies, both individually and collectively, and the safeguarding outcomes for service users

3.3.12 The Board has received a range of management information to enable it to evidence, scrutinise and challenge performance including:

- Annual safeguarding reports from all constituent agencies (in Chapter 5 of this report)
- Reports on the implementation of the Care Act

- Reports on MCA/DoLS including performance data on Dols
- Staff survey
- Organisational audit (SAAF)

3.3.13 Securing regular meetings of the Quality Assurance Sub-Group has presented a challenge primarily from the perspective of quoracy but also in terms of securing comprehensive submission of performance information. This is commented on further in the impact section below. Action is planned which will address this issue moving forward.

Secures the effective implementation of new practice guidance issued in 2014

3.3.14 Transitions good practice guidance has been issued within 2014-15 as a result of an action from a Nottinghamshire County SCR. The document is a joint document across Nottingham City and Nottinghamshire County, and has been disseminated to partner agencies. The document will be updated in line with the Care Act.

3.3.15 Work began on amending the Nottingham and Nottinghamshire multi-agency procedures to ensure they are compliant with the Care Act and the amended versions were issued on 1st April 2015.

3.3.16 The SCR procedures were amended as a cross authority document with Nottinghamshire County to ensure they are compliant with the Care Act.

Formulate and implement the Information Sharing Protocol

3.3.17 The NCASPB works to the Nottingham and Nottinghamshire Information Sharing Protocol which most statutory partner agencies of the Board are signed up to. The Police were identified as not forming part of the protocol but they signed up to the protocol in March 2015. Work will be undertaken in 2015-16 to ensure that the protocol is still fit-for-purpose and meets the requirements of the Care Act.

Safeguarding roles and responsibilities and outcomes are explicit in the commissioning, contracting, monitoring and review of services

3.3.18 In response to an action from a SCR and in preparing for the Care Act, assurance was sought from the Local Authorities commissioning department and from the Nottingham CCG that safeguarding is built into the commissioning and contracting processes where appropriate. Assurance was given in response and accepted by the relevant subgroups.

The ‘voice’ of adults and practitioners is heard and acted on across all priorities

3.3.19 It is standard practice within SCRs and other learning reviews that the views of the adult, if possible, and/or their family members are sought for inclusion in the review. It is also standard practice to ensure that practitioners' voices are sought in reviews, not only to ensure that reviews are thorough and take into account all opinions, but also to improve communication between frontline staff and strategic managers. During 2014-15, one SCR and one learning review took place and in both, views of the subject and/or their family and practitioners were sought as appropriate.

3.3.20 A staff survey takes place on an annual basis. This is the second year the staff survey in adults has been completed. The key headlines are as follows:

- There has been a significant drop in the number of responses from 552 in 2013 to 382 in 2014. Two agencies to increase their number of responses were the Police and Nottingham City Homes. There was a significant reduction in responses from all health agencies except NUH.
- The number of practitioners aware of the multi-agency procedures and guidance has dropped. This could be because the procedures have not been publicised recently; however, they have been refreshed as part of the work on the Care Act so we should see an increase next year.
- Although nearly 30% of practitioners have never referred to the multi-agency procedures and guidance, nearly all practitioners are aware of their agency's internal safeguarding procedures.
- The number of practitioners who have completed a DASH RIC assessment and feel confident in doing so has increased.
- The number of practitioners aware of DOLs has increased which could relate to the publicity around Cheshire West.

3.3.20 Some progress has been made in securing greater engagement of service users. The Communications and Engagement Sub-Group was created during 2014/15 to drive forward improvements specifically in relation to the engagement of adult service users and opportunities for Service User engagement has been mapped out across Nottingham City.

What has been the impact?

3.3.21 As stated above attendance at NCASPB has, in the main, continued to be strong. Attendance levels for 2014/15 were set out Chapter 2: Governance and Accountability. One key concern has been the representation of NHS England. Since the organisational changes of 2013/14 that created the new NHS structures, NHS England has not been represented at the board despite expressions of concern to local area management.

3.3.22 At the annual development session held in January 2015 NCASPB members, alongside their counterparts on the NCSCB, reviewed the governance arrangements that have been in place for the past two years. Reflections on NCASPB arrangements were positive and there was recognition that the refocusing of Board and OMG agendas in the past year had enabled the Board to better focus on key strategic issues and decision-making with OMG focusing on the operational implementation of decisions and on managing Board agendas to sustain strategic focus. However, outcomes from the Peer Review of adult safeguarding, led to a review of the alignment of the NCSCB and NCASPB (see appendix A). Whilst it was felt important to sustain a focus on shared safeguarding priorities through the creation of a shared element of the new Business Plan for 2015/16 and for the two Boards to meet together on a regular basis during 2015/16, it was also agreed that greater distinction between the work of the two Boards be secured. This has subsequently resulted in the appointment of different chairs for the NCSCB and the NCASPB following the decision of the current chair to stand down.

3.3.23 OMG has similarly been well attended and received positive evaluation in the governance review at the Development Day.

3.3.24 At sub-group level we have sustained partnership engagement in the chairing of meetings. During 2014/15 chairing has been shared across the partnership as follows:

○ SCR Subgroup	Bella Furse, NUH
○ Quality Assurance Subgroup	Sarah Kirkwood/Sandra Morell, CityCare Partnership
○ Training Subgroup	Janet Lewis, VCS
○ Domestic Violence Subgroup	Sue Barnett, CityCare Partnership
○ MCA/DoLs Group	Steve Oakley, Nottingham City Council
○ Care Act subgroup	Hayley Frame, Independent

3.3.25 Dialogue through other partnerships has resulted in a range of actions and impacts that evidence the influence of the NCASPB in driving safeguarding improvement and effectiveness. Examples include:

- The Health and Well-Being Board's considerations of strengthening the inclusion of safeguarding requirements within commissioning and contracting arrangements across the City;
- The work of the Nottingham Priority Families initiative
- A Communication and Engagement Subgroup was established during 2014/15 primarily targeted at enhancing the' voice of the service' in the work of the NCASPB.

3.4 Business Plan Priority 2b: To be assured that adults in need of safeguarding are safe

Vulnerable adults are receiving the support they need at the earliest possible stage and any safeguarding concerns are appropriately identified and referred

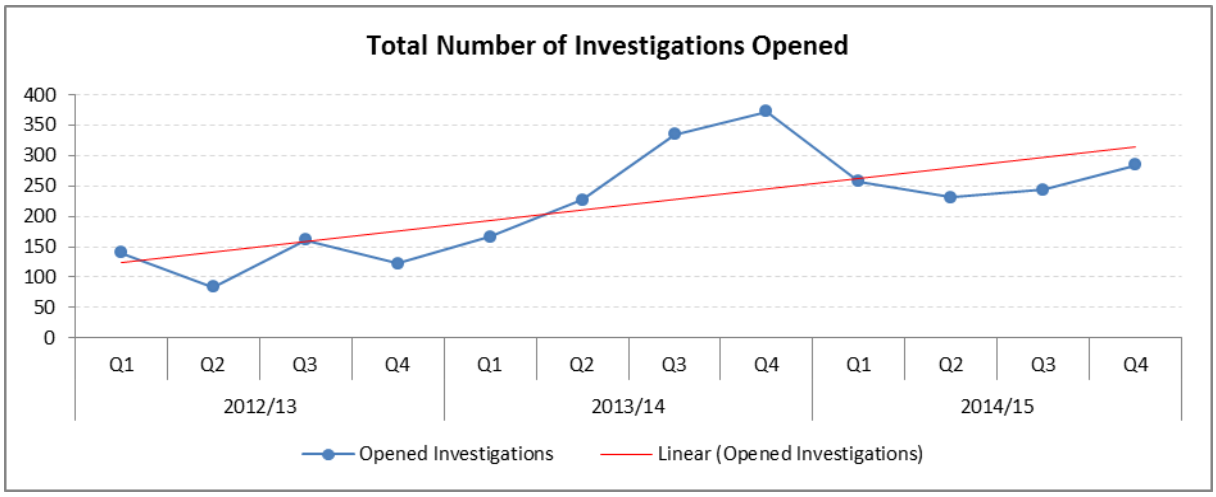
3.4.1 At the beginning of April 2014 the way in which safeguarding alerts and investigations were recorded changed. Instead of separate alert and investigation forms, a single safeguarding referral form was designed and built, allowing for a more streamlined approach to recording safeguarding. The new process means that the 2014/15 is not comparable to previous data.

3.4.2 The following data was received by the NCASPB to provide assurance that safeguarding alerts and investigations were being processed as appropriate.

Adult safeguarding data

3.4.3 There were 1,017 investigations opened in 2014/15, with a slight upward trend in quarter 3 and quarter 4 (see chart 1). This is a similar number to that opened in 2013/14; however the distribution of opened investigations is more even across the four quarters than in the previous year, when there was a large increase recorded in quarters three and four.

Chart 1: Total Number of Investigations Opened



3.4.4 Examining the demographics of citizens that alleged abuse took place against shows that the majority were of a White ethnicity (78.2%), a marked reduction in the percentage recorded in the three previous years (2011/12 – 86.6%, 2012/13 – 86.4%, 2013/14 – 83.2%). Citizens of a Black/Black British

ethnicity account for 7.5% of citizens, an increase of 1.3% from the previous year, with citizens of an unknown ethnicity also accounting for 7.5% of citizen's ethnic make-up. Comparing this to the ethnic make-up of the older local population (60+), as supplied by the 2011 census, shows that the high proportion of citizens with a white ethnicity is representative of the population as a whole. The increase in numbers from BME background could be indicative of an increase in awareness. This is an issue which will be further explored in 2015/16. Please see charts 2, 3 and 4 for further details.

Chart 2: Nottingham City Population by Ethnicity (60+)

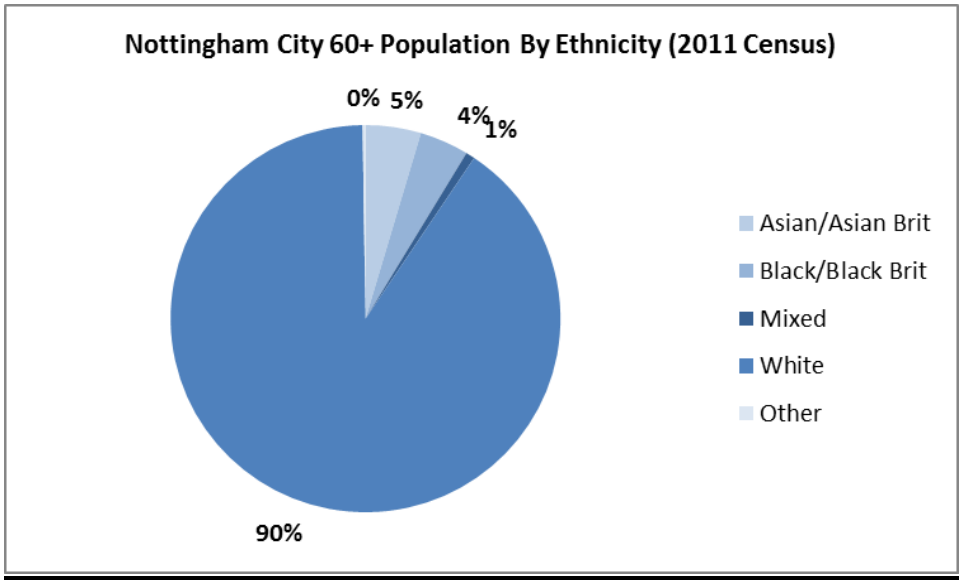


Chart 3: Ethnicity of Citizen for Opened Investigations in 2014/15 (Volume)

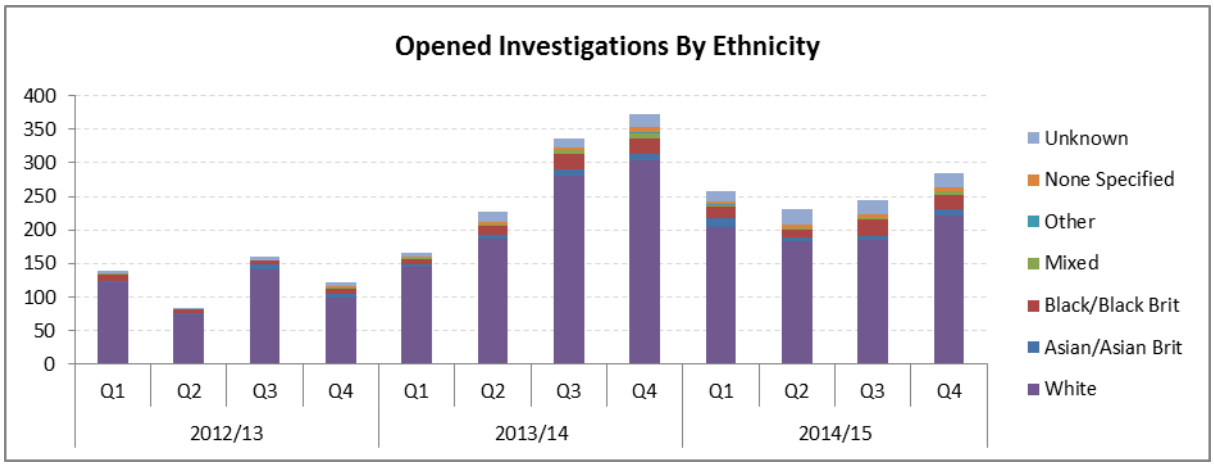
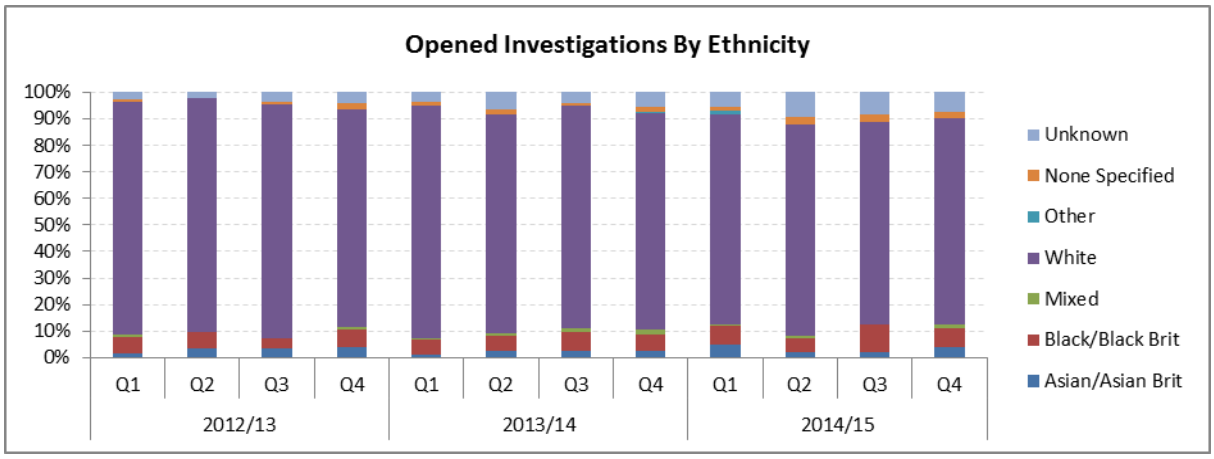


Chart 4: Ethnicity of Citizen for Opened Investigations in 2014/15 (Percentage)



3.4.5 In terms of age range the highest proportion of citizens were aged 81 years old or over (45.4%), with a slight increase in percentage recorded compared to 2013/14 and a similar level to that seen in 2012/13. 20.1% of citizens were aged between 71 and 80 and a further 10.0% were aged between 61 and 70 years old, meaning that 75.0% of citizens against whom alleged abuse took place were aged 61 and over. The increased percentage in alleged abuse against those aged 81 or over coupled with 75.0% of citizens being over the age of 61 shows that despite a similar percentage of citizens aged 61 or over having alleged abuse recorded against them, the citizens within this group are distinctly older than in 2013/14, with the average age of citizens (chart 5) indicating this, particularly in quarters 1 and 4 of 2014/15 when the average age of a citizen was 73 years old (the oldest average age since quarter 2 of 2012/13). Please see charts 6 and 7 for more information on citizen age breakdown.

Chart 5: Average Age of Citizen

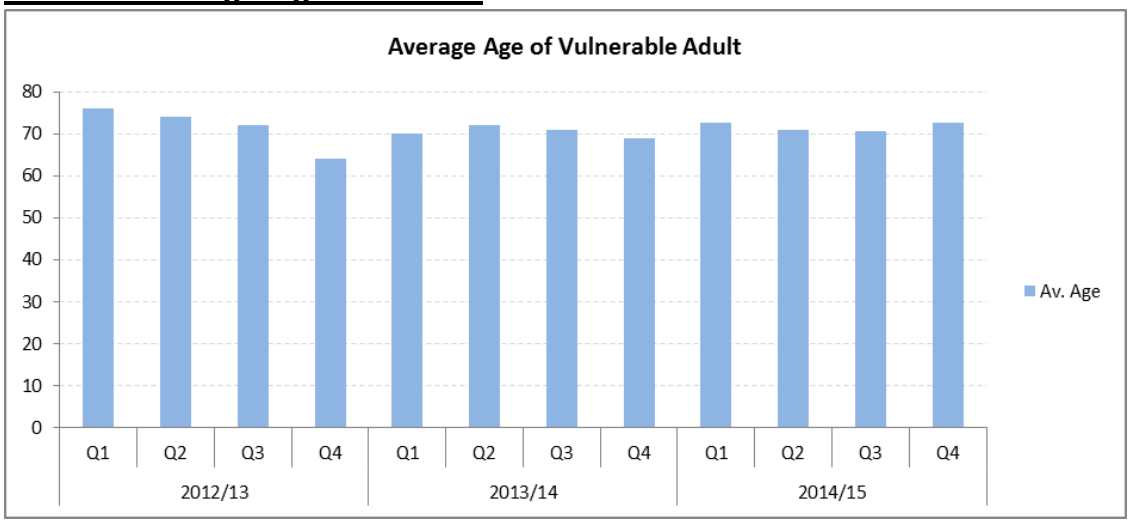


Chart 6: Age Band for Citizens with Opened Investigation (Volume)

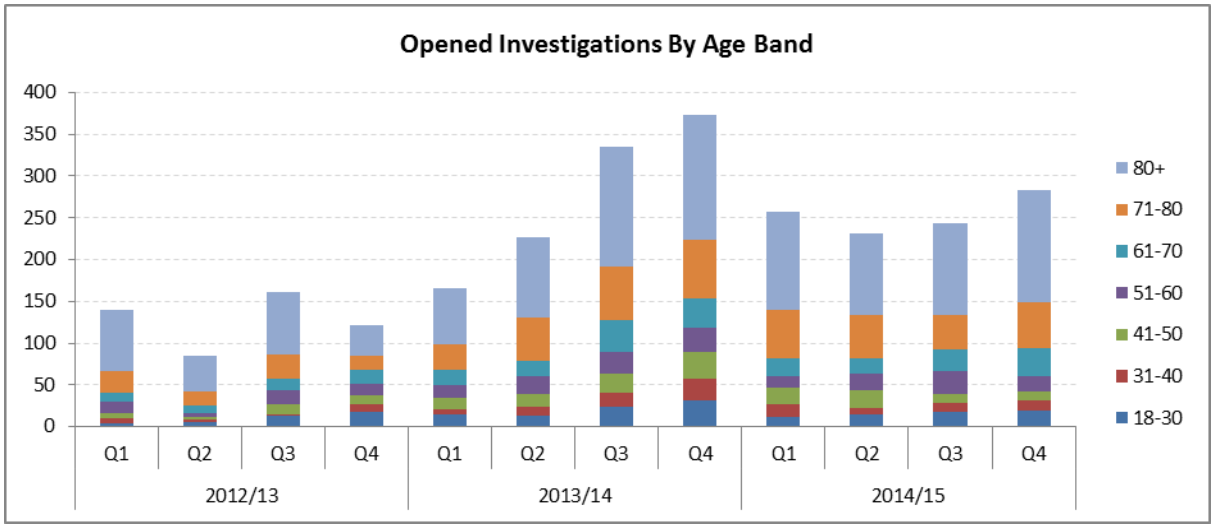
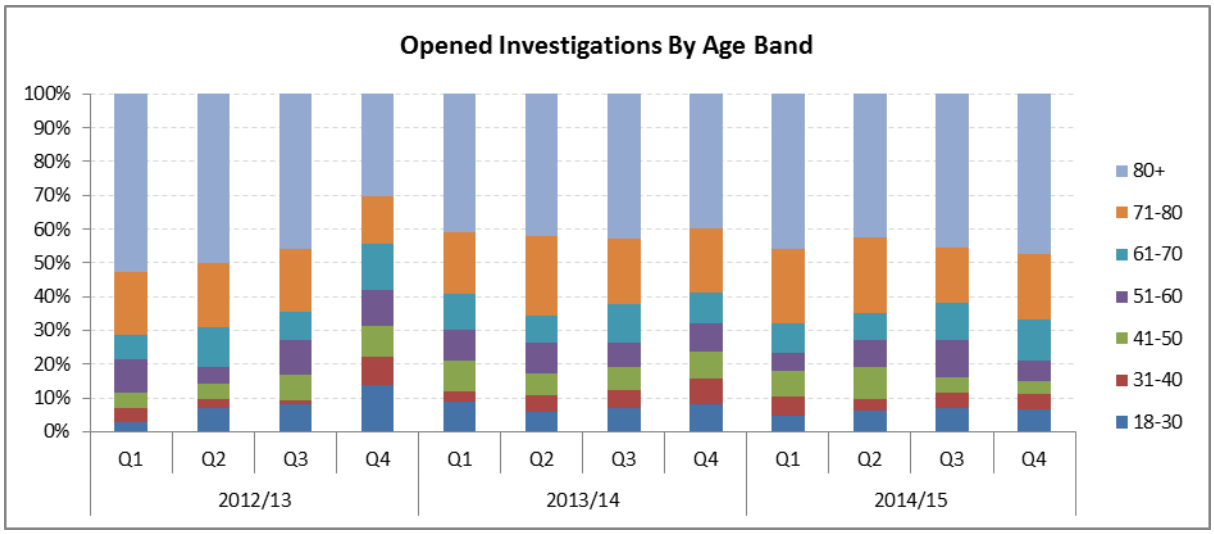
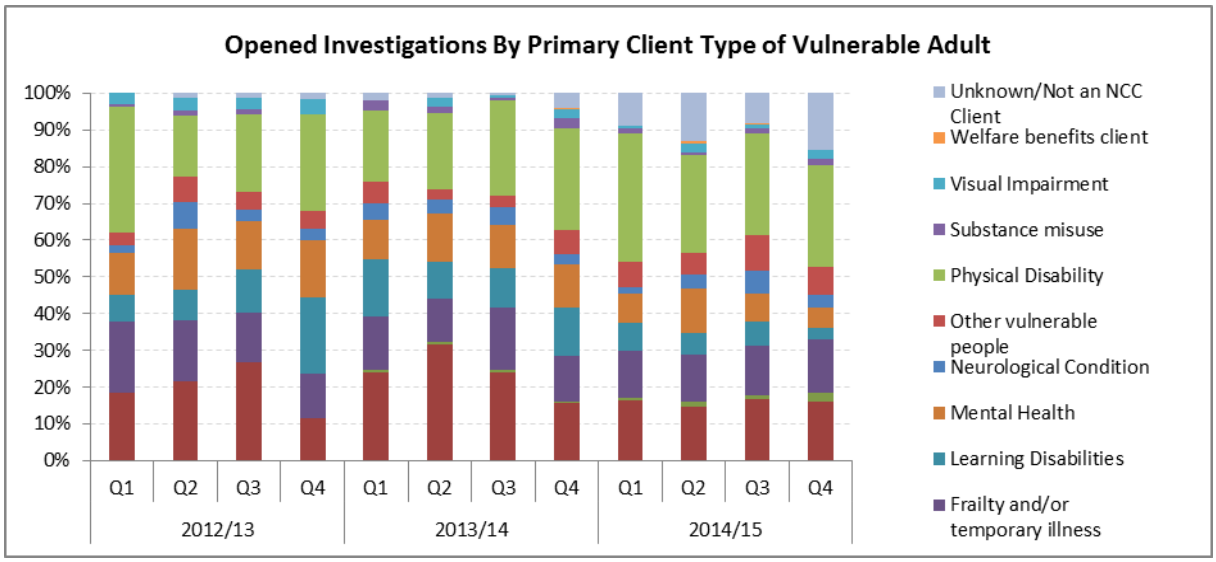


Chart 7: Age Band for Citizens with Opened Investigation (Percentage)



3.4.6 Looking at the Primary Client Category (PCC) of the citizen with an opened investigation shows that around 30.0% of citizens had a physical disability, 16.0% had dementia and 13.5% had frailty and/or a temporary illness. The PCC of citizens with an opened investigation is much more varied than in other demographic categories, partly because there are so many categories, but the percentages recorded reflect the overall profile of the population to which Nottingham City Council provides a service to. Please see chart 8 for a full breakdown of citizen PCCs.

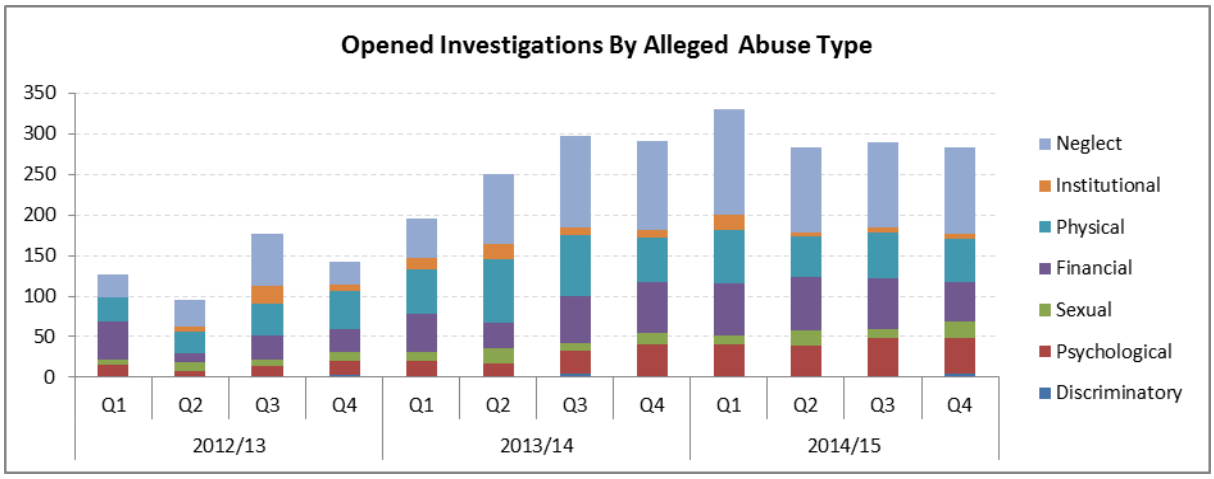
Chart 8: Primary Client Category of Citizens with an Opened Investigation (Percentage)



3.4.7 Before examining the type of alleged abuse in opened investigations, please note that more than one type of abuse can be alleged in an investigation and so percentages described in the below section may not add up to one hundred percent. Although neglect was the most common type of abuse recorded, alleged in 44.0% of investigations, financial abuse continued the trend seen in quarters 3 and 4 of 2013/14 by accounting for a growing number of investigations (23.9% of investigations alleged financial abuse in 2014/15). Alleged physical abuse (22.0%) and psychological abuse (16.3%) also accounted for a significant proportion of investigations.

3.4.8 Chart 9 also shows that despite a similar number of investigations opening in 2014/15 than in 2013/14, a larger amount of abuse was alleged this year than in the previous one. There are two key reasons for this, the first is an increase in the number of investigations that had two or more types of abuse alleged, and the second is due to a change in the process of recording safeguarding on the system. Significantly fewer investigations were not taken further this year compared to last allowing for all the details of alleged abuse to be recorded, something that was not the case in every instance if an investigation was not taken further at an early stage in 2013/14.

Chart 9: Alleged Abuse of Opened Investigations (Volume)



3.4.9 The location of alleged abuse was most likely to be in a care home, with 39.0% taking place in these settings (21.8% in residential care homes and 17.2% in care homes with nursing). Slightly less, 37.3% of investigations stated that the alleged abuse was in the citizen's own home. Proportionately this pattern is similar to that seen in the previous year, however far fewer investigations have an unknown/not completed yet location in 2014/15 than in the previous year with investigation revealing that the majority of the unknowns in the previous year relating to investigations which were not taken further (something that is far rarer in 2014/15 due to a process change). Please see charts 10 and 11 for further detail on location.

Chart 10: Opened Investigations by Location (Volume)

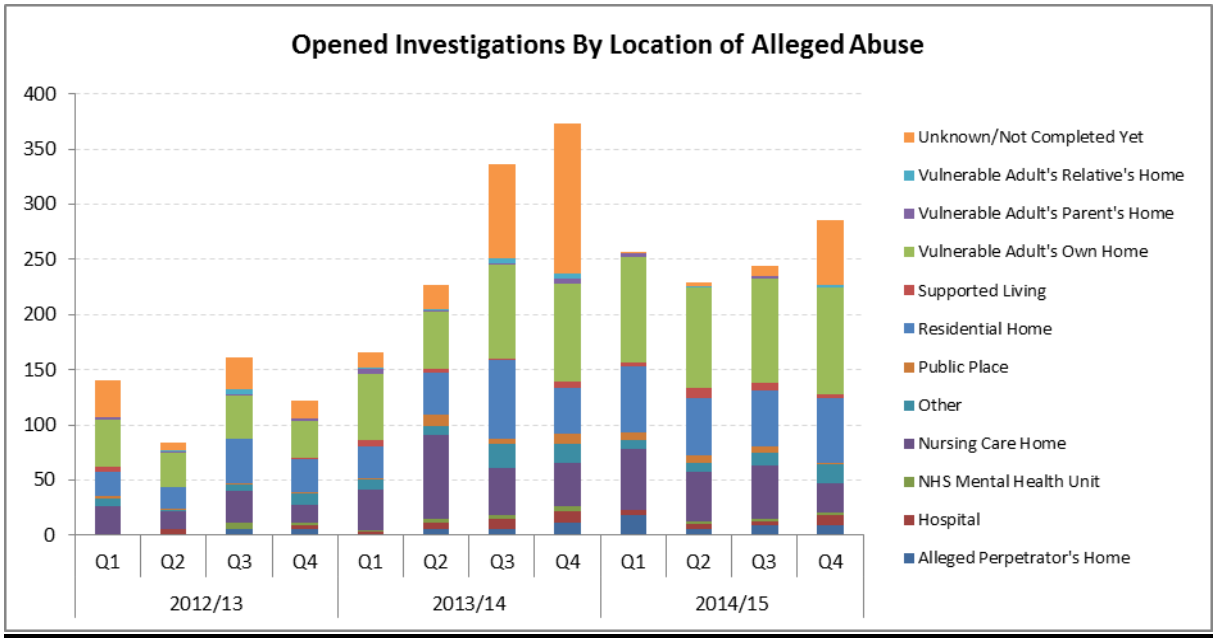
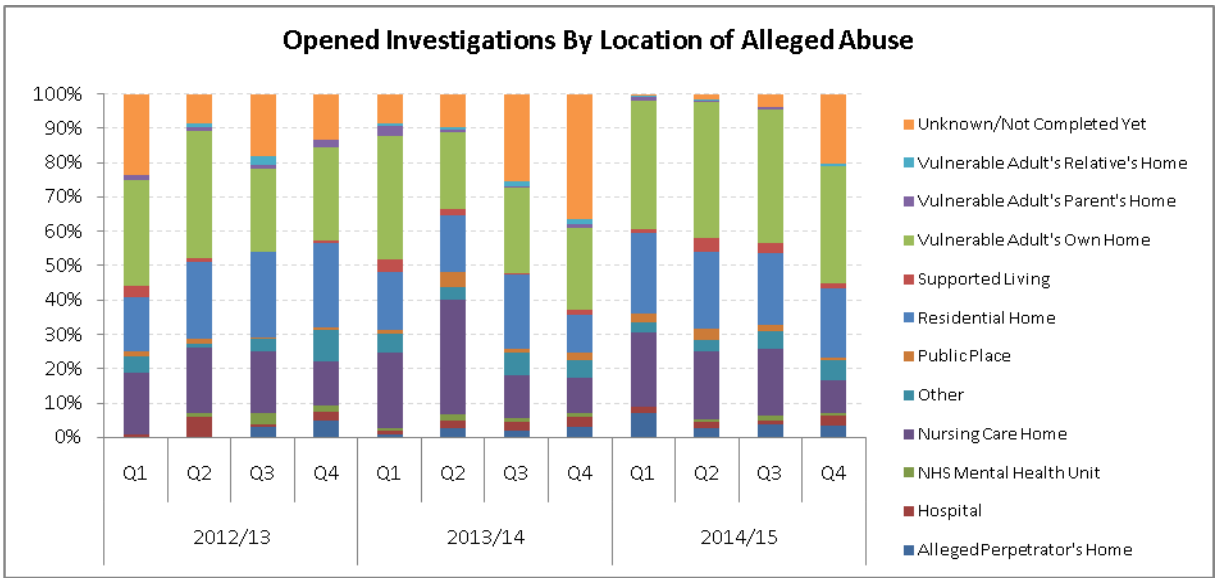


Chart 11: Opened Investigations by Location (Percentage)



3.4.10 In terms of outcome of the investigations opened in 2014/15 49.3% were substantiated, with 45.6% unsubstantiated. However there are still a number of investigations not concluded from quarter four of this year and this could change the above percentages. The first three quarters of 2014/15 recorded a substantiated rate of 50.8%, with this dropping to 44.4% in quarter 4 mainly due to a number of investigations not yet being completed. The percentage of investigations substantiated is at a similar level to that seen in 2013/14 (see chart 12), which was an increase on the two previous years. 5.0% of

investigations were partially substantiated, and as with fully substantiated investigations, the volume of those partially substantiated was much higher in the first two quarters of the year than in the second two (7.6% quarters 1 and 2 compared to 2.3% quarters three and four). See charts 13 and 14 for a full breakdown of conclusions for opened investigations.

Chart 12: Opened & Concluded Investigations by Conclusion (Volume)

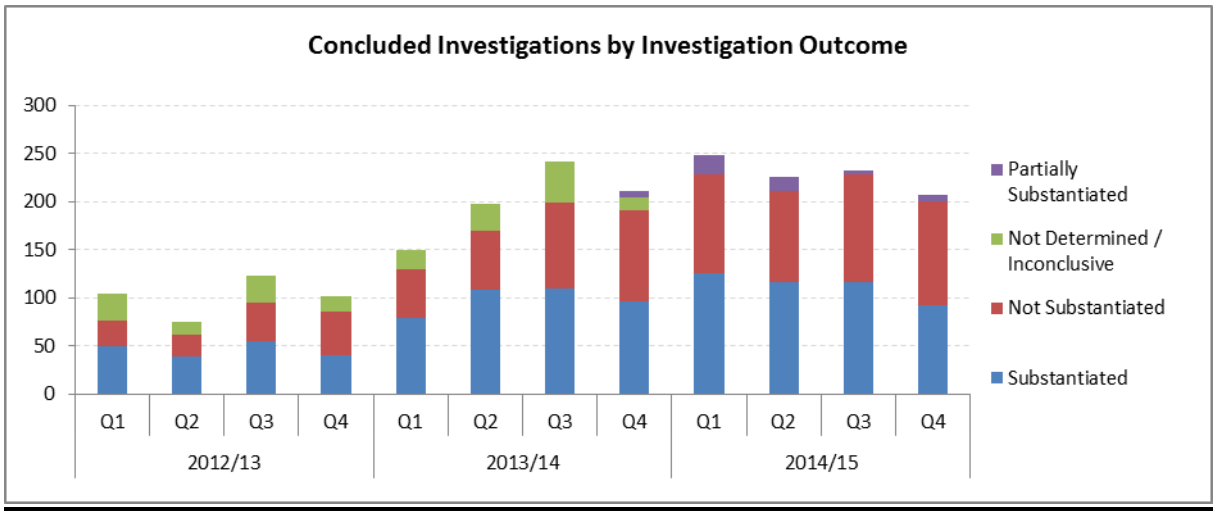


Chart 13: Opened & Concluded Investigations by Conclusion (Percentage)

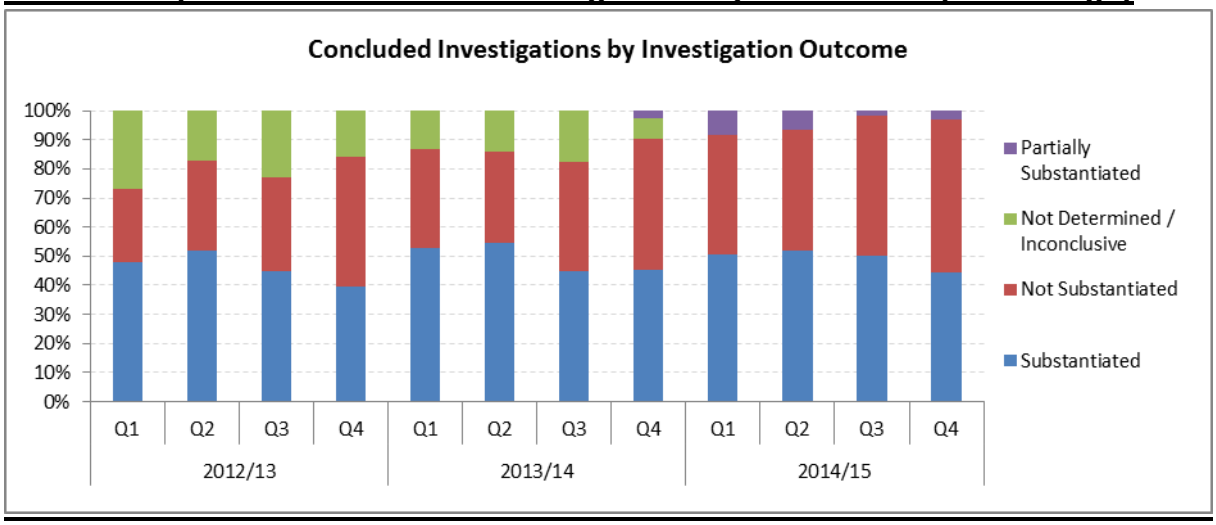
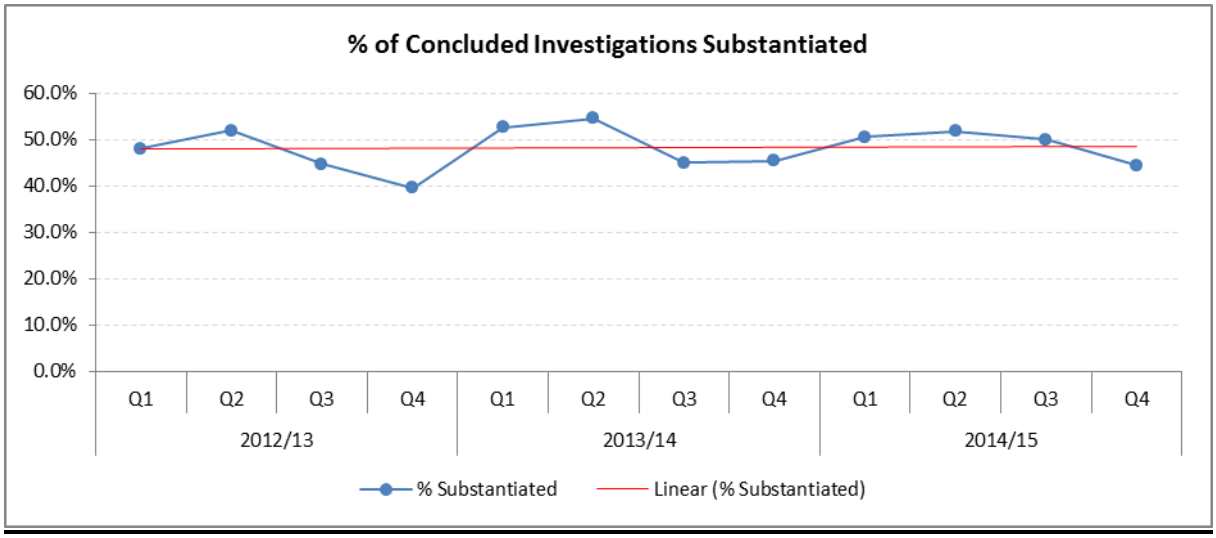


Chart 14: Percentage of Concluded Investigations Substantiated



Thresholds for safeguarding adults are clear, understood and consistently applied

3.4.11 Data as above in 2b.1 was received from adult social care to provide assurance that safeguarding alerts and referrals were dealt with as appropriate. However, the NCASPB agreed that this objective was no longer relevant once the Care Act became 'live' as there are no thresholds under the Care Act legislation.

Quality and impact of single agency and multi-agency provision to adults in need of safeguarding

3.4.12 It has not been possible to implement a programme of audits due to capacity issues and given the fact that implementation of the Care Act was a priority piece of work. However this has been remitted to the business plan for 2015-16 and a programme of audits based on the Care Act has been devised.

The followings groups that have been previously identified at risk are adequately safeguarded:

a. those receiving self-directed support and personal health budgets & those adults living with or receiving services from registered providers;
b. those affected by Mental Capacity Act/Deprivation of Liberty Safeguards
c. those experiencing domestic abuse

a) Those receiving self-directed support and personal health budgets & those adults living with or receiving services from registered providers

3.4.13 Issues regarding this are identified and addressed via SCRs and other learning reviews. See Chapter 4 for more details.

b) Those affected by MCA – Dols

3.4.14 Work in relation to MCA and DoLs has been led by the MCA/DoLs subgroup the chair of which has been Steve Oakley, previously Head of Quality and Efficiency and now Head of Contracting and Procurement. He has been chair since May 2013. The officer providing support to the group is Nicola McGrath, Adult Safeguarding Board Officer, and members are as follows:

- Head of Contracting and Procurement, Nottingham City Council
- Appropriate Head of Service, Nottingham City Council Adult Social Care
- Adult Safeguarding Coordinator, Safeguarding Adults Quality Assurance Team, Nottingham City Council
- Representative from NHS Nottingham City CCG

3.4.15 The MCA/Dols subgroup has met three times in 2014-15 due to one meeting being cancelled.

3.4.16 The MCA/Dols subgroup meets quarterly and it's aims are to identify appropriate assurance processes that enables NCASPB to be assured that the MCA in relation to safeguarding is being implemented in line with best practice and to provide oversight and strategic direction of the Mental Capacity Act in relation to safeguarding and Deprivation of Liberty Safeguards (DoLS).The MCA/Dols subgroup oversees the statutory returns for Dols data and has strategic oversight of the Mental Capacity Act in relation to safeguarding and Dols.

3.4.17 The key priorities outlined in the groups' work plan for 2014-15 were:

- To be assured that safeguarding is everyone's responsibility
- To be assured that adults in need of safeguarding are safe

3.4.18 Activity undertaken to support key objectives has been as follows:

- Regular Dols data presented to the group on a quarterly basis to be scrutinised by members, issues identified and action taken.
- Regular updates on the progress of updating the MCA policy and procedure from Adult Assessment who are the lead agency in completing this piece of work. Assurances were sought and received that practitioners are working to best practice.
- Coordination and responses to training needs to identify and feed into training subgroup.
- Monitoring of the action plan in response to Cheshire West.

- Challenge of areas for development and under performance.

3.4.19 At each meeting, data on Dols is presented to the group which is analysed and assessed for action to be taken. The staff survey specifically asks staff about their understanding of MCA and Dols.

3.4.20 A number of challenges have been presented in this area of work, not least the Cheshire West judgement, which has increased workload in Dols and created a situation where not all Dols assessment can be completed within timescales due to the volume of referrals. This is a national issue and has made it difficult to assess meaningful Dols data; however, the group monitors data relating to the triage system implemented as a result of Cheshire West.

3.4.21 The group took on MCA as requested by the Board and completed a scoping exercise. Based on the results, further assurance has been sought from the Police and the National Probation Service. Identified issues with Police and Probation with regards to MCA addressed leading to a change in process for provider investigations and the home closure process.

3.4.22 As a result of the above, there has been significant staffing issues across City that along with pending new national MCA guidance has resulted in a delay in completing the update of the MCA policy and procedure.

<u>c) Those experiencing domestic abuse</u>

3.4.23 The DSVA Strategy Group is the overarching group which monitors the following working groups:

- Nottingham City Multi Agency Risk Assessment Conference (MARAC),
- Domestic Homicide Review Assurance and Learning Implementation Group,
- Children and Domestic Violence & Abuse group,
- Health and Domestic Violence & Abuse group,
- Local Criminal Justice Board (LCJB),
- Voluntary Sector Domestic and Sexual Violence Forum.

3.4.24 The MARAC Steering group focuses on the progression of the Risk Register and the merge of the MARAC Development Day action plan with the CAADA Self-Assessment feedback. The MARAC Steering Group will be reviewing the number of cases heard at the MARAC where the perpetrator is on the Police Domestic Abuse Investigation Team top ten list.

3.4.25 The work of the Domestic Abuse Referral Team (DART) and the MARAC continue to complement each other and the MARAC remains the most appropriate place to share high risk information across the wider partnership and identify actions for each agency to implement.

The workforce has capacity to deliver effective safeguarding

3.4.26 Partner agencies were requested to raise issues of capacity as and when required to do so. In 2014-15, no agency raised this issue. Although there is a recognition that shrinking resources will impact, safeguarding remains a priority for all agencies as it demonstrated by good multi-agency attendance at board, OMG and subgroup meetings.

What has been the impact?

MCA Dols

3.4.27 At the request of the subgroup, an Adult Social Care manager attended the care home manager's forum to address concerns regarding recording of restraint.

3.4.28 The group has ensured that practice has improved around signing off and authorising Dols. The group has successfully impacted on practice with a change in the process around signing off Dols authorisations and the group have completed an MCA scoping exercise which has identified and acted on areas of concern.

3.4.29 As a result of the work with Probation on MCA, they will be updating their vulnerable adults procedure to include MCA processes.

Domestic Abuse

3.4.30 In consultation with County colleagues the Domestic Abuse Stalking Harassment & Honour Based Violence Risk Identification Checklist (DASH RIC) has been revised making it more streamlined and clarified the referral process and action for referrers to take. The 27 risk assessment questions remain the same except the following four amendments:

- A note if the survivor would like to report the incident as a crime, for the survivor or agency worker to contact the police control room and report the incident.
- The classification grid which outlines referral points and action for the referrer to take has been streamlined.
- The MARAC referral form has been amended to highlight it is for high risk referrals only.
- The information sharing agreement without consent on the MARAC referral form has been amended to advise the process when consent has been provided.

3.4.31 It is proposed that a Safeguarding Group is established which will consider adults and children's safeguarding themes. The Children's Domestic and Sexual Violence Safeguarding Good Practice Guidance is currently being

refreshed. A strategic review of the response to adults at risk who experience domestic abuse will be undertaken in 2015/16.

3.4.32 A data and performance group will be established which will consider the data report ahead of the main meeting and provide headline information, identifying themes and trends which will be presented to the DSV Strategy Group for consideration as to whether further action is required.

3.5 Business Plan Priority 2c To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept

Adult services consistently to consider the safeguarding of children in households where they are working with an adult and make referrals for support and intervention where necessary

3.5.1 The NCSCB has an annual audit programme within which they consider the role of adult's workers and the quality of their joint working in respect of the child in the household. In July 2014, an audit of the Voice of the Child was completed and the following was identified in relation to adults in the household:

- NHCT checked the records of two adults in relation to one case and found good evidence of the children's needs being considered, and that the adult workers were part of the multi-agency team working with the child.

- Probation identified one case where adults in the house were known to them, and they reported that procedure in relation to children in the home had been followed.

3.5.2 An audit on referrals was completed in January 2015 and the final report noted:

- Evidence of adult services appropriately referring concerns in respect of the children of adults they were working with.

Children's services consistently to consider the safeguarding of adults in households where they are working with children and make referrals for support and intervention where necessary

3.5.3 This objective has been remitted to the business plan for 2015-16.

Services that work with “whole” families are effectively coordinated (e.g. Priority Families) and secure added value in ensuring and co-ordinating effective safeguarding

3.5.4 This objective has been remitted to the business plan 2015-16.

3.5.5 Work completed on this priority has been limited due to capacity issues. However, partners at the NCASPB development session were keen to ensure that this objective and joint working across the NCASPB and the NCSCB remained a priority for the future.

3.6 Business Plan Priority 3 To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults

Ensure learning from national, regional and local SCRs and other review/audit processes is incorporated into the practice of partner agencies and the partnership as a whole

3.6.1 The SCR subgroup considered learning from two national reviews The Overview report following the serious case review into the death of Gloria Foster was assessed at the SCR subgroup in December 2013. The case revolved around a self-funder who was left without care following the closure of the domiciliary care agency providing her with home care. The subgroup agreed that there was learning to be sought from the review around the following:

1) Home closure processes – does the current process cover domiciliary care providers?
2) Approved providers – does Nottingham City Council (NCC) have processes in place to provide citizens on personal budgets access to a list of providers they can appoint as carers?
3) Police involvement in strategy meetings

3.6.2 Assurance was sought from Adult Social Care (ASC) that the home closure process covered domiciliary agencies. It was confirmed that the process had been updated and covers both care homes and domiciliary agencies.

3.6.3 Assurance was sought from NCC Quality and Commissioning that citizens can access good quality homecare, and they confirmed that there is an approved provider list available for citizens. Providers have to meet a set criteria to confirm they are meeting certain standards before they are added to the list.

3.6.4 The Police confirmed that where they are invited to strategy meetings, they do their best to ensure attendance.

3.6.5 A small task and finish group was set up to look at the 34 recommendations made in the SCR into Orchid View, a care home in East Sussex that was closed due to concerns around neglect. An action plan was created based on the 34 recommendations and is currently being monitored by the Safeguarding Adults Review subgroup (previously SCR).

Review safeguarding procedures and practice guidance to ensure they are 'fit for purpose' and reflect current learning and best practice

3.6.6 A Transitions document was created as a cross authority document with Nottinghamshire County Council due to this being a common theme across a number of reviews. A small task and finish group was set up to focus on this piece of work and a good practice guidance document was created to be disseminated across the partnership. It was agreed that the document would be reviewed in 2015-16 in light of the Care Act.

Implement the communication and engagement strategy and ensure it is fit for purpose in order to secure awareness of safeguarding issues and the responsibilities of the Boards' partner agencies and the wider community in safeguarding

3.6.7 A Communication and Engagement Subgroup was established during 2014/15 primarily targeted at enhancing the' voice of the service' in the work of the NCASPB. It was agreed there should be representatives on this sub group from the following areas:

- Schools (teachers or support staff).
- Providers – Health & Wellbeing Board.
- Vulnerable Adults Provider Forum co-ordinated by Nottingham CVS
- Children & Young People Provider Network – also co-ordinated by Nottingham CVS
- Representative from Nottinghamshire Health Care Trust

3.6.8 Two meetings took place in 2014-15 and work undertaken included:

- Formulation and agreement of a revised communication and engagement strategy for the NCSCB and NCASPB
- An audit of existing engagement work across the partnership in relation to the three key engagement levels: strategic engagement; community of interest engagement; and engagement at service delivery level

- Commissioning of activity to secure feedback from adult service users on their safeguarding priorities through existing mainstream engagement initiatives

Establish a learning and improvement framework for adults

3.6.9 A learning and improvement process was created based on the model required for the Children's learning and improvement framework under Working Together 2013. The learning and improvement process ensures that learning from SCRs and other learning processes are fed into other subgroups, as appropriate, to inform future training and/or audit work.

3.6.10 The Learning and Improvement process sets out a framework for monitoring and evaluating the effectiveness of training and development in terms of the impact on the quality of safeguarding practice and outcomes for service users.

3.6.11 The co-ordination, monitoring and evaluation of safeguarding training and workforce development is undertaken by the Training Sub Group. The Chair of the sub group during the majority of 2014/15 was Janet Lewis, the Chief Executive Officer of Base 51 in the voluntary sector. The Board Officer supporting the work of the Sub Group is Paul Langley – Safeguarding Partnerships Training Officer. There are 15 agencies represented on the sub group

3.6.12 The Sub Group met 4 times in 2014-15 and the aims and objectives of the sub group were:

- To be assured that the workforce in Nottingham City are aware of their responsibilities in safeguarding vulnerable adults
- To be assured that the workforce have access to learning and improvement opportunities to support them to be competent in delivering appropriate services to protect and promote the welfare of vulnerable adults in the City
- To promote learning and improvement opportunities that respond to learning from Serious Case Reviews, Audits and other work of the Boards and their partners agencies
- To be assured of the quality of safeguarding training across the City and to monitor the effectiveness of learning and improvement opportunities, including training, delivered by partner agencies and the Boards

3.6.13 Achievements in 2014 / 15 against objectives included:

- All Board training materials and the criteria for the Quality Assurance Scheme (where appropriate) were updated in the light of the Care Act 2014.
- A short programme of 'Raising a Concern' and 'Referrer' courses was provided for the PVI sector.
- An adult safeguarding Learning and Improvement process was developed and agreed.
- The Training Quality Assurance Scheme was reviewed and improvements agreed to enable more effective ongoing validation of partner agency training materials, and the resulting annual review process started.

Workforce is safely recruited

3.6.14 The SAAF Organisational audit asks partner agencies on their recruitment practices and seeks assurance that all agencies have implemented safe recruitment practices. All agencies involved in the completion of the SAAF assessed themselves as meeting this objective.

Allegations made against people who work with adults are dealt with effectively

3.6.15 Under the Care Act, the role of the Designated Safeguarding Adults Manager (DASM) has been created to specifically address allegations made against people who work with adults. In 2014-15, work undertaken included ensuring that all partner agencies had identified a DASM and to update the governance arrangements with this information, as required by the Care Act. Work started on creating DASM procedures which were finalised in 2015-16.

What was the impact of work undertaken?

Attendance at 'Raising a Concern' and 'Referrer' adult safeguarding training commissioned by the NCASPB

3.6.16 There were two 'Raising a Concern' Courses and one 'Referrer' course, delivered in February and March 2015, and these were specifically for the Private, Voluntary and Independent (PVI) sectors. The late addition of these courses to the programme was a result of difficulties in finding someone to deliver them.

3.6.17 **41** people attended the 'Raising a Concern' courses and **24** attended the 'Referrer' course.

Qualitative evidence

3.6.18 All the courses offered were fully booked and attended by a wide range of largely voluntary sector organisations. Additional 'Raising a Concern' training targeted to private residential providers was introduced near the year end, but take up of this has been slow.

Analysis of course evaluation (adult safeguarding training)

3.6.19 There are two elements to the qualitative evidence we can provide this year:

- End of course evaluations for the training' delivered by NCASPB.
- Quality assurance of the adult safeguarding training materials used by Partner agencies.

3.6.20 Although the number of courses provided on behalf of the NCASPB was small the evaluations confirmed they were well received. The Raising a Concern course increased confidence from an average of 45.6% to 97%. The Referrer's course increased confidence on average from 64.6 to 88.8%.

Quality Assurance of Adult Safeguarding Training Materials

3.6.21 At the end of the previous year (2013 / 14), we were able to assure the NCASPB that the content of any introductory level adult training being delivered by the Partner agencies was accurate, up-to-date and fit-for-purpose. During 2014 / 15, the scheme has been reviewed to include a more robust Annual Review Process to assure the Boards that any training having been validated through this process continues to meet the required standards and has been appropriately updated. This process happens at the end of each financial year.

3.6.22 It has also been agreed to publish the annual checklists of content so that other organisations are able to 'self-assess' their content to assure themselves they are providing fit-for-purpose and up-to-date content, and so those commissioning training can require this of their providers.

CHAPTER 4 SERIOUS CASE REVIEWS

4.1 Introduction

4.1.1 During 2014/15 the chair of the SCR subgroup for NCASPB has been Bella Furse, the Designated Adult Safeguarding Nurse for NUH and Adult Safeguarding Lead for Nottingham City CCG.

4.1.2 The following agencies are represented on the subgroup:

- Nottinghamshire Police
- Nottingham University Hospitals
- Children & Adults Legal Team Nottingham City Council
- National Probation Service
- Derbyshire, Nottinghamshire, Lincolnshire and Rutland Community Rehabilitation Service
- Nottingham CityCare Partnership
- Nottinghamshire Healthcare NHS Trust
- Nottingham City Council – Adult Social Care
- Nottingham City Council – Adult Safeguarding Board
- Nottingham City CCG
- Adult Social Care Quality Assurance Lead

4.1.3 The SCR subgroup has met on a bi-monthly basis and meetings are two hours in duration. The aims and objectives of the group are to:

- ensure the multi-agency protocol for the commissioning and undertaking of a Serious Case Review is fit for purpose;
- discharge the Serious Case Review functions on behalf of the NCASPB;
- manage Serious Case Review processes and provide information and support to panel members and overview authors;
- receive and consider reports on Serious Case Reviews and ensure that action plans from the findings and recommendations of reviews and audits are implemented;

- create or contribute to revised and or new policies and procedures following the recommendations of a Serious Case Review from either Nottingham or from other Local Authorities;
- consider the impact of local and national Serious Case Reviews and ensure robust media management protocols are in place;
- explore the funding implications of Serious Case Reviews and report these findings to OMG;
- share findings of Serious Case Reviews conducted in Nottingham as appropriate.

4.2 What we did in 2014/15

4.2.1 Until April 2015 there was no statutory requirement for the work of the subgroup. However from 1st April 2015 the Care Act 2014 came into force which made it a statutory requirement that SABs conduct safeguarding adults reviews (SARs). It has always been the practice in Nottingham City to undertake serious case reviews and other types of review in adult cases from which learning and improvement could be secured. This has been a core part of our learning and improvement process.

4.2.2 As stated above the key priorities of the group have been to assess SCR referrals appropriately, identify and disseminate learning from local and national reviews and to update the SAR policy and process. During 2014-15 the SCR subgroup had three referrals for consideration. One of these has been taken forward in the SCR process and the others were felt not to meet the criteria and appropriate feedback was given to the referrers. The SCR that was undertaken did not conclude in the year that we are reporting so will be included in our annual report 2015/16.

4.2.3 The SCR subgroup considered learning from two national Serious Case Reviews. One of these pieces of work involved the creation of a small task and finish group to look at recommendations from a care home closure which proved to be a very valuable piece of work. (See chapter 3, business priority 3 for more information).

4.2.4 The SCR subgroup published the Executive Summary for an SCR completed in June 2014 and a multi-agency review report that was completed in May 2014. The group also published a newsletter with key learning from reviews which was circulated to all agency representatives and disseminated to frontline practitioners.

4.2.5 The Nottingham City and Nottinghamshire County cross authority working group on transitions submitted a Transitions Best Practice Guidance' to the subgroup and this was approved. The SCR subgroup also approved the best

practice guidance on working with adults that 'do not attend' appointments. This has been made available to both the City and County Board and was written by the SCR subgroup Chair. The SAR policy and procedures have been re written to reflect changes in the Care Act 2014- this work was delayed at the end of last year in anticipation of the Care Act coming into force.

4.2.6 It was agreed that the SCR subgroup will act as the decision making forum for Domestic Homicide review referrals. Additional members from the Crime and Drug Partnership (CDP) attend when a referral is received and this process has demonstrated better multi-agency working and use of agencies representatives' time. One referral was received and considered in 2014-15 and a Domestic Homicide review commissioned by the CDP.

4.2.7 The SCR subgroup encountered some challenges in completing its programme of work. For example, the ongoing Police investigation and delayed CPS decision into a care home that was closed in the city has created a significant barrier to the completion of the Serious Case Review commissioned in 2013. This work will now proceed in a different format with a report being pulled together reviewing all the information that is available to date. Learning from this review has already been implemented in individual organisations as Individual Management Reviews were completed and signed off by agencies some time ago. The CPS made a decision to move forward with a criminal prosecution which is currently underway in the court system.

4.2.8 The SCR subgroup is an effective group that has good attendance and meets on a regular basis. There is always good interaction and challenge by members. One serious case review has been initiated this year. National reviews have been considered and best practice guidance produced as a result of this.

4.3 Learning from reviews

<u>EW Multi-agency learning event - Summary of lessons learned and how these have translated into recommendations</u>

4.3.1 The multi-agency learning event aims to identify lessons learned and then translate the learning into recommendations that are relevant for the multi-agency partnership. At the event, safeguarding leads, case summary authors and practitioners directly involved in the case discuss the case openly and critically.

4.3.2 EW was an individual well known to staff at the GP surgery and at LIFE, a supported living service. Although she had a mild to moderate learning difficulty, EW lived an independent life and took on a caring role for her mother and brother. EW was eligible for services and as such, had an

appropriate care package in place which she accessed. When her mother died, EW continued to access that care. Appropriate referrals were made at the time of her mother's death, but EW declined additional support.

4.3.3 Adult Social Care identified that they could have been more robust in assessing EW's capacity to make the decision to refuse additional support; however, ASC representatives believed it was unlikely that her package of care would have increased greatly as she was accessing the care already in place. This was supporting her to live independently and her health needs were being addressed. The Police described EW's flat at the time of her death as 'squalid'; however, this description was surprising to the agencies involved, as practitioners entering her flat described it as cluttered and no concerns were raised by tradesmen entering the flat. Tradesmen would not have entered the flat had it been in the state described by the Police at point of death.

4.3.4 This appears to be a tragic case of someone's health deteriorating rapidly. The analysis of the case showed that EW had an appropriate care package in place and access to support networks through LIFE and her GP, which EW accessed when she required. Members at the Multi-Agency Learning Event concluded that as there was no evidence of significant harm attributed to any agency, the case did not meet the threshold for safeguarding interventions.

4.3.5 The multi-agency learning event did not determine a need for multi-agency action, but a number of individual agency actions were identified which formed part of an action plan monitored by the SCR subgroup. This included:

- ASC will develop a comprehensive record-keeping policy ensuring intervention in cases is based upon key historical and chronological factors.
- When citizens make unwise decisions that impact upon their health and wellbeing, ASC will ensure practitioners consider the Mental Capacity Act.
- LIFE will access further training and support on the Mental Capacity Act to improve their awareness and understanding.

<u>Adult A SCR Recommendations</u>

4.3.6 The learning points from the SCR highlighted several areas for improvement. The following recommendations were aimed at improving the safeguarding process and to avoid a similar situation from arising in the future:

4.3.7 Clarity on 1) the purpose of a carer's assessment to be shared with partner agencies, 2) with a clear outline of what to do if safeguarding concerns are raised about the carer's suitability and 3) what action should be taken if a carer refuses an assessment where there are known safeguarding concerns.

Action:

- Assurance that carer's strategy includes a communication strategy and educational materials about the purpose of carers' assessments
- Assurance to be sought that safeguarding is embedded in carer's strategy and guidance
- Review of carer's assessment in Adult Social Care

4.3.8 Practice guidance in respect of managing the behaviours and impact of carers' who obstruct care.

Action:

- Practice guidance on working with carer's who obstruct care
- Training audit to ensure obstruction of care is covered in Adult Safeguarding training
- Be assured that domiciliary care provision understand what action to take when access is denied through contracting arrangements

4.3.9 The NCASPB requires that staff in partner agencies are confident in recognising indicators of financial abuse and raising it as a concern within their assessments and in supervision.

Action:

- Training audit to ensure indicators of financial abuse is covered in Adult Safeguarding training.

4.3.10 Supervision for those assessing or working with vulnerable adults should consider safeguarding concerns and challenge practice where necessary.

Action:

- Assurance from partner agencies that safeguarding is covered in supervision with staff

4.3.11 The safeguarding investigation should include the production of a safeguarding protection plan when the person remains at risk. The plan should outline all the agencies involved in that person's care (including the landlord and any homecare), what their role is and what action they have undertaken/will undertake. This plan should be shared with all agencies and should:

- strengthen the role of the lead professional to help them coordinate agency involvement.
- aid agencies to escalate and track escalation of concerns.
- support agency ownership of actions
- be reviewed at an agreed frequency
- have clear contingency plans when it cannot be implemented and /or is not wielding the desired change

Action:

- Review existing multi-agency procedures
- Develop Adult Social Care policies and procedure in relation to safeguarding protection plans.
- Training on protection plans to appropriate Adult Social Care staff

4.3.12 The NCASPB requires assurance that staff in partner agencies are 1) knowledgeable about the purpose of the Mental Capacity Act, 2) understand their role in Mental Capacity assessments and that 3) capacity assessments are completed appropriately and effectively.

Action:

- Audit of cases where capacity has been assessed to address the quality and effectiveness of the capacity assessment.
- Outcome of assessment is shared appropriately and the outcome impacts on action taken.

4.3.13 Contracting arrangements with homecare providers need to make clear that care workers should receive training on recognising those individuals who are at high risk of developing pressure ulcers and should feedback concerns to Adult Assessment to aid in the prevention of ulcers developing.

Action:

- NCC Quality and Commissioning to update their contract to ensure care workers working with high risk individuals understand tissue viability and are trained to recognise risk factors.

4.4 What was the impact of work undertaken?

4.4.1 The SCR subgroup has had many achievements this year aligned to the agreed work plan as outlined above. As a direct result of one review, a seminar based on working with carers who obstruct care is planned for 2015-16. Impact evaluation of this seminar will take place and results will be fed back to the SAR subgroup.

CHAPTER 5 INDIVIDUAL AGENCY PERFORMANCE

5.1 Introduction

5.1.1 Whilst the Annual Report focuses on multi-agency priorities set out in the Business Plan, safeguarding effectiveness in individual agencies is an important facet of performance. Indeed effective partnership working to secure effective safeguarding relies heavily on the quality of safeguarding practice and performance in individual agencies that form the Board partnerships.

5.1.2 This section of the Annual Report draws on the annual reports of constituent agencies and headlines key safeguarding achievements and issues that have arisen in 2013/14.

5.2 NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP (CCG)

What we did:

5.2.1 With regards to training, during 2014/15 money was secured from NHS England to help with the embedding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards 2009. With this money an app was devised for smart phones in conjunction with Derbyshire CCG's This is now live for health professionals to access free of charge. An e learning package was also designed. This is complete and due to go live by the end of May 2015.

5.2.2 Training events were held for GP's, community health professionals and care home managers across Nottingham and Nottinghamshire. These were well attended and in total circa GP 23 practices were represented at these events out of a possible total of 59 and there are still events planned during 2015/16.

5.2.3 All CCG staff are up to date with their Safeguarding training.

5.2.4 The CCG has been represented at learning events following adult safeguarding reviews and GP's have been part of this process.

5.2.5 With regards to DOLS, all managing authorities in the City were written to by the CCG to inform them of the Supreme Court judgement and highlighting their responsibilities under this change.

5.2.6 The CCG has also scoped the number of citizens living in their own homes who may require application to the court of protection for a deprivation of

liberty authorisation. This work continues and applications are starting to be made.

5.2.7 Work with the Coroner's office took place to devise guidance for staff when a city resident dies under a DOLS and is living in a care home or in their own home. This work will be complete by end of May 2015.

5.2.8 In terms of the Care Act, the CCG has been well presented on the multi-agency groups in relation to the implementation of the Care Act. The CCG internal adult safeguarding policy has been updated to reflect the changes and training content reviewed appropriately.

5.2.9 Communication around Duty of Candour has been communicated to providers.

5.2.10 The CCG continues to be well represented at the Local Safeguarding Boards and subgroups and members of the CCG chair two of the associated subgroups.

5.2.11 The CCG is a key stakeholder in provider investigations supporting the mantra that we will not accept substandard care in our nursing and residential homes.

5.2.12 The CCG has been a key stakeholder in safeguarding adults reviews and domestic homicide reviews.

5.2.13 The CCG provides assurance to the local safeguarding board in the form of the completion of the safeguarding adult's assurance framework (SAAF).

5.2.14 Internally there are robust governance arrangements within the CCG. The CCG has a regular Safeguarding forum and safeguarding health overview group. These are fed into the CCG Quality improvement committee.

What has been the impact of that work?

5.2.15 The biggest impact of the last year is the training to GP's, community health professionals and care home managers. The training events were evaluated by an external company to ensure that the impact of these events was captured. Set out below are some examples given by GP's of how the training has helped them provide better patient care.

- GP's reported that the training clarified the law and provided them with the confidence to undertake capacity assessments. One GP reported that he was asked to assess the mental capacity of a patient with learning difficulties and specifically his capacity to look after his finances. He reported that 'going into the detail of day to day capacity helped reinforce my decision.' Another GP explained how it has helped her when undertaking on the spot capacity assessments on hospital wards, saying

she feels ‘so much more confident’ and that the ‘training gave me the confidence to make the decision’. Another GP also provided an example of where she was asked to comment on a dementia patient’s deprivation of liberty. Normally, this would have concerned the GP, but she was able to assess the patient effectively following the training.

- Surgeries reported that they have ‘revamped’ their MCA templates which have especially helped with assessing dementia patients’ capacity. GP’s have also updated their adult safeguarding cards and policies. They have held meetings within their practices to discuss the training with staff and to ensure that any queries are answered.

- The training has also had positive impact on patient care. One GP used the example of her 80 year old dementia patient. As part of the lady’s care package she was seen 4 times a day by carers from a private healthcare company. The carers believed that because the lady had dementia she was unable to make any decisions for herself. This had made the relationship strained. After the training the GP explained to the carers that just because the lady has dementia this does not necessarily mean that she is unable to make any decisions. After she had relayed the principles of the training, the carers were extremely grateful and changed the way they cared for the lady, who is now a lot happier.

- The training has also helped strengthen relationships between GPs and patients. One example is a GP whose patient is a lady in her late 70’s with a personality disorder. The GP explained that she is highly suspicious of the care team entering the property. The training on assessing capacity helped her change her approach to her patient which has meant the woman is no longer suspicious of her intentions.

- Feedback demonstrates that GPs are now taking a more active role in care homes. For example, one practice has now implemented a system of asking the care home managers when a patient with dementia dies in the home whether a DoLs Authorisation was in place.

- It was also reported that the training helped provide clarity on a patient’s capacity to refuse treatment. One example given was one of the GP’s patients was mentally ill and diagnosed with cancer, they refused treatment and had regular reviews of their capacity. The GP helped review her capacity and found that she did have the capacity to make this decision. The training meant that the GP decided this confidently and they also commented that it helped clarify his role alongside the psychiatrist.

5.3 NOTTINGHAM CITY COUNCIL,DIRECTORATE OF ADULT SOCIAL CARE

5.3.1 Adult Social Care Adult Safeguarding Annual Report 2014 -15

The Adult Social Care Directorate is responsible for assessing and commissioning services to some of the City's most vulnerable adults. The Council must make sure that the services provided, are consistently safe and of high quality and that customers, carers and residents can rely upon this

What we did.

5.3.2 **Restructure** In anticipation of the new statutory duties placed upon the local authority in relation to Safeguarding we created the new position of Head of Adult Safeguarding and Quality Assurance responsible for the City Safeguarding Team, Adult Safeguarding Quality Assurance Team, Placement Review, Deputyship and Safeguarding Training and Development.

5.3.2 **Care Act training** We ensured that social workers and their managers were fully briefed through a training programme to ensure that they were prepared for the changes in Safeguarding Policy and Procedure as a result of the Care Act 2014.

5.3.3 **Internal Procedures** April 2015 saw Safeguarding become a statutory responsibility through the Care Act, which meant that our procedures were reviewed and appropriate changes made to our Electronic Social Care records to ensure that we could monitor and report upon our new reporting requirements for the Department of Health

5.3.4 **Reflective Practice** We continued to run a bi-monthly Safeguarding Manager Forum facilitated by the Head of Safeguarding, and a Practitioner forum facilitated by the Safeguarding Training and Development manager to allow managers and practitioners to meet and reflect upon their practice and learn from one another's experiences

5.3.5 **'Smarter Safer Stronger' Networking Events** Adult Social Care led a project team, kindly funded by Nottingham Clinical Commissioning group and held several events aimed to improve front line practitioners' knowledge of the services available to citizens in care settings in order to improve their health and wellbeing.

5.3.6 **Making Safeguarding Personal & Nottingham Trent University** We utilised the links with NTU and a small research project was initiated by an academic colleague to benchmark where Adult Social Care were in the implementation of Making Safeguarding Personal.

5.3.7 **Peer Review** A team of specialist Safeguarding Managers alongside the two senior managers and the Director of Adult Social Services participated in a 3 day peer review of another Local Authority which included case file audit, and consultation and interviews with Local authority staff, partners from the Private, Voluntary and Independent Sector and Users and Carers. Such work

is extremely helpful in bringing back good practice and learning to the Directorate.

5.3.8 **Quality Assurance** We continued to undertake monthly audits of Safeguarding Investigations across our Directorate, the findings of this feed into the development of training and procedural revision and in tackling poor practice should this be identified as a result of the audit process.

5.3.9 **Board responsibilities** Adult Social Care continues to be well represented at the Board and within subgroups, and the Adult Safeguarding Training & Development Officer chairs the Training subgroup. We also are represented on the East Midland Adult Safeguarding Board.

What has been the impact of that work?

5.3.10 **Care Act Training** We evaluated our training and over 84 % of staff who replied stated they understood the new forms and the concept of the Care Act. A rolling programme has now been implemented to embed in practice the Care Act changes.

5.3.11 **Smarter Safer Stronger** The events were attended by over 300 practitioners over six sessions held at the Council House. Each session examined different aspects of elderly care ranging from Dementia, Falls, medication management, incontinence and other subjects. Feedback was very positive. Over 98% of attendees scored the event as very good or excellent. 85% of attendees felt their knowledge of other specialist services available had increased and gave them confidence to contact safeguarding services if required.

5.3.12 **Early Intervention Strategy** As a result of the success of the Networking events, Nottingham City Council collaborated to develop 2 projects which will come into fruition in 2015. A virtual Dashboard will be developed with the aim of holding all monitoring and regulatory information from the City Council and partners in relation to registered care homes, and two Early Intervention Officers will be appointed in a year long pilot.

5.3.13 **Making Safeguarding Personal & Nottingham Trent University** The findings of the research concluded that in most cases, vulnerable adults were involved and consulted during Safeguarding investigations. The report also indicated that involvement could be strengthened, and therefore a training programme in relation to Making Safeguarding Personal was agreed to be designed and implemented, and monitoring of Outcomes and advocacy were added to our performance management framework.

5.3.14 **Internal Procedures** Our internal procedures are now Care Act compliant in relation to our Safeguarding duties becoming statutory in April 2015, and we have ensured that Citizen involvement and the principles of Making Safeguarding Personal are embedded both in our procedures and performance management reporting.

5.3.15 **Lessons Learned** Adult Social Care has been a key stakeholder in safeguarding adult reviews and Significant Incident Learning sessions and we have ensured that the learning from these processes is disseminated across the workforce. We have also ensured that following any large scale safeguarding investigation a stakeholder "Lessons Learned" session has been led by the Directorate. The most recent impact of this was a multi-agency improvement plan for Early Intervention and Provider Investigations.

5.4 NOTTINGHAMSHIRE POLICE

WHAT WE DID

5.4.1 The Nottinghamshire Police completed several areas of work as described below:

- Conducted a self-assessment for the HMIC and a series of audits
- Secured assistance with other teams outside of Public Protection to assist with crime recording compliance.
- Implemented daily domestic violence meetings in the County and assisted with the implementation of Operation Encompass (schools project).
- Rolled out awareness sessions to all control room operatives to reinforce the need to 'flag' incidents where children reside or frequent domestic abuse households.
- Created a specialise cadre of on-call Detective Inspectors available 24/7 from Public Protection to take primacy for dealing with child deaths and associated investigations.
- Implemented the victim's code throughout the force. Mandatory e-learning to be completed by all officers.
- The Force commissioned a peer review which was undertaken by the College of Policing on 1st-3rd December 2014.
- The force has established and maintained productive relations with CEOP/NCA who have lead on a number of national operations.
- The staffing establishment for Public Protection has increased with the creation of an additional Detective Sergeant and 4 full time equivalent officers for SEIU alone.

What has been the impact?

5.4.2 The impact of the work has been as follows:

- HMIC identified areas of vulnerability for the organisation and this has enabled a targeted action plan to be developed.
- Robust and accurate recording in line with NCRS, ensuring victims of abuse are afforded all of the rights with victim code.
- Op Encompass - improved communication between police, social care and health
- Investigations receive increased internal scrutiny so as to ensure that all reasonable opportunities for disruption/prosecution are pursued. The department can now attribute the officers with the correct skill set to the most appropriate investigation type.

5.5 NOTTINGHAM UNIVERSITY HOSPITALS TRUST

What we did

5.5.1 Training was reviewed at NUH and updated to include Prevent.

5.5.2 The number of potential deprivation of liberty authorisations was scoped during June and July 2014. The results of this scoping exercise were reported to the Trust Board. The scoping exercise predicted that approximately 22% of inpatients at NUH would meet the 'acid test' on any day.

5.5.3 Work was done with the local authority and a triage system was agreed for referrals of deprivation of liberty authorisations, with the Trust Board agreeing a measured approach to reflect the average length of stay.

5.5.4 Training was updated to ensure the 'acid test' was communicated to staff at NUH and guidance in the form of printed posters and flowcharts was designed by the adult safeguarding team and distributed to inpatient wards.

5.5.5 NUH has been well presented on the multi-agency groups in relation to the implementation of the Care Act. The NUH internal adult safeguarding policy and procedures have been updated to reflect the changes and training content reviewed appropriately.

5.5.6 NUH continues to be well represented at the Local Safeguarding Boards and subgroups and the Designated Adult safeguarding nurse chairs the Safeguarding Adults Review subgroup.

5.5.7 NUH has been a key stakeholder in safeguarding adults reviews and domestic homicide reviews and has a subgroup of the safeguarding adults and children's committee which monitors NUH action plans from safeguarding reviews and domestic homicide reviews.

5.5.8 As a result of reviews during 2014-15, training has been reviewed to include a focus on 'think family' and of ascertaining carers and those with caring responsibilities.

5.5.9 NUH provides assurance to the local safeguarding board in the form of the completion of the safeguarding adult's assurance framework. This is due to be submitted at the end of May 2015. NUH also provides assurance to Nottinghamshire County CCG.

5.5.10 Internally NUH has a regular Safeguarding Adults Committee and an annual report is submitted to the Trust Board, with a half annual report submitted to the Quality Assurance Committee. NUH has robust internal governance arrangements.

What has been the impact of that work?

5.5.11 Each year during November and December NUH completed the Safety of the Vulnerable Patients benchmark. Year on year this demonstrates improvement and this year has been no exception.

5.5.12 Every November and December all wards and departments score the essence of care safety of the vulnerable patient's benchmark. In order to gain a better understanding of staff knowledge across the trust, minimal changes were made to the benchmark since it was last scored in 2013.The indicators that are used are:

	Indicator
1.	Staff are aware of types of abuse and potential indicators of abuse
2.	Staff are aware of how to make a safeguarding children or adults referral
3.	Staff are aware of the NUH restraint policy and have an understanding of what constitutes proportional restraint
4.	The ward/department has a safeguarding folder, which is accessible to all staff OR staff are aware of how to access information in the virtual folder on the safeguarding vulnerable adults or children's intranet sites
5.	Staff are aware of who the safeguarding leads are for both: • The clinical area • The Trust
6.	Staff know how to access the mental capacity act/deprivation of liberty safeguards policies
7.	Staff know how to perform a mental capacity assessment and in what circumstance they should perform one
8.	Staff are able to describe what should be considered and who should be consulted when making a best interests decision for a patient who lacks

	capacity
9.	Staff are aware how to access the advocacy service for patients who are vulnerable e.g. Independent Mental capacity Advocate Service (IMCA)
10.	Staff are aware of which consent form should be used if a patient lacks capacity

5.5.13 To attain Gold, general areas needed to achieve all 9 indicators (10 indicators for inpatient areas); green was attained in general areas if 7-8 indicators were achieved (8-9 inpatient areas); and red was scored if 6 or less indicators were achieved (7 or less inpatient areas)

5.5.14 For those areas using the benchmark, 8 of the 10 indicators of best practice were achieved by at least 90% of wards and depts.

5.5.15 There are two indicators that are not consistently scored at 90%. The first isIndicator 7: **"**Staff know how to perform a mental capacity assessment and in what circumstances they should perform one." Action taken is as follows:

- The safeguarding team will engage with clinical area safeguarding champions, specifically looking at the application of the Mental Capacity Act in their area
- The MCA is legislation and as such, clinical teams have a responsivity to follow this. The adult safeguarding team has delivered multiple sessions on its usage. Non-compliance with this will be escalated to directorate meetings for action

5.5.16 The second indicator is Indicator 9**:** "Staff are aware how to access the advocacy service for patients who are vulnerable e.g. Independent Mental Capacity Advocate Service (IMCA)." Action taken is as follows:

- The adult safeguarding team will provide information during the 2015-16 Mandatory Training programme on the role of the IMCA

5.5.17 Four areas scored red for this benchmark but these areas were all individually supported by the NUH Adult Safeguarding team and were all rescored as Green.

5.5.18 Comparison of scores 2011-2014:

Nov/Dec 2011	Nov/ Dec 2012	Nov/Dec 2013	Nov/Dec 2014
177 areas scored	**168 areas scored**	183 areas that scored:	170 areas that scored:
20 (11%) areas scored GOLD	61 (36%) areas scored GOLD	94 (51.4%) scored GOLD	110 (65%) scored GOLD
24 (14%) areas scored GREEN	33 (20%) areas scored GREEN	80 (43.7%) scored GREEN	55 (32.5%) scored GREEN
119 (67%) areas scored AMBER	72 (43%) areas scored AMBER	9 (4.9%) scored RED	
14 (8%) areas scored RED	2 (1%) areas scored RED		4 (2.3%) scored RED
25% of areas scoring GREEN/GOLD	**56% of areas scoring GREEN/GOLD**	**95.1% of areas scoring GREEN/GOLD**	**97.5% of areas scoring GREEN/GOLD**

5.5.19 Between April 2015 and March 2015 NUH submitted 90 deprivation of liberty applications to the local authority only 19 of these were granted Standard Authorisations this was largely due to the patient being discharged from NUH prior to assessment.

5.6 CityCare Partnership

5.6.1 **Safeguarding Adults**

- During 2014/15 CityCare prepared for the implementation of the Care Act (2014) which resulted in the review and re-writing of the safeguarding adults policy and procedures to ensure that the organisation is commensurate with the requirements of the Act.
- The Lead Practitioner for Safeguarding Adults is an active participant of the NCSAPB Care Act task and finish group; reviewing the multi-agency response to the implementation of the Care Act.
- A Care Act briefing which outlined both the requirements of the Act and the new roles and responsibilities of staff has been cascaded to staff and

delivered via face to face sessions with clinical teams as part of a targeted roll out plan. This will continue over the forthcoming year.

- Development of a Vulnerable Adults Risk Management (VARM) tool to support staff with decision making and the recording of concerns in a consistent and robust way.
- A comprehensive review of Safeguarding Adults activity within CityCare has been completed which informed capacity mapping and shaped the basis of the proposal for a new Safeguarding Adults service which was submitted to the CCG for consideration. A decision regarding the service development is expected shortly.
- CityCare completed Individual Management Reviews for a substantial Serious Case Review.
- CityCare also developed an internal information sharing meeting to capture and analyse the data and soft intelligence regarding concerns raised by staff in relation to Care Homes (QUIF).
- CityCare have had significant involvement in the Care Home closure process to ensure that the safety, dignity and well-being of residents remains paramount, once a decision to close a Care Home has been made.
- The Lead Practitioner for Safeguarding Adults has also reviewed the internal process for CityCare attendance at multi-agency safeguarding adults meetings to provide clarity both internally and to external organisations regarding roles and responsibilities.
- Development of specific advice recording sheets for Care Homes
    - Care Home Equipment Prescription Process
    - Care Home Concern Sheet

5.6.2 **PREVENT**

- Following the completion of the PREVENT 'Train the Trainer' course, the accredited trainers have delivered PREVENT training to over 300 staff since July 2014. A rolling programme of PREVENT training is in place as part of the safeguarding 'Think Family' training matrix.
- The PREVENT lead has supported practitioners with managing a number of PREVENT concerns that have been raised by frontline staff, liaising with statutory organisations to ensure a co-ordinated multi-agency response is in place.

5.6.3 **Mental Capacity Act**

- Citycare achieved 91% compliance with Mental Capacity Act training.
- 2 further staff have been supported by CityCare to undertake 'Best Interest' assessors training.

- Development of an MCA / Best interests aide memoire card for clinical staff which is currently in printing process and will be provided to staff at induction and training.
- Review and rewrite of the CityCare Mental Capacity Act Policy and Consent to Treatment Policy.
- Completion of an MCA clinical audit to inform practice and demonstrate compliance with MCA legislation. Report on audit findings due to be completed Spring 2015.

5.6.4 **Domestic Abuse**

- Review of Domestic Abuse Referral Team Pathways and procedures
- Implementation of the Domestic Violence Disclosure process (DVDS – previously referred to as Claire's Law)
- Domestic Abuse Nurse Specialist gained accreditation as a trainer for Honour based Violence and Forced marriage.

5.6.5 **Strategic work**

- Introduction of the Serious Incident Review Group (SIRG) which is a sub group to the Safeguarding Group, tasked with reviewing and implementing recommendations from serious safeguarding incidents (including SCR / SILP).
- Development of the CityCare safeguarding intranet pages – a one stop shop for policy and guidance documents (internal, local and national documents) relating to safeguarding.
- Development of a Carers strategy and 'Supporting Carers' factsheet for frontline staff
- Development of the 'Think Family' factsheet for frontline staff

5.6.6 **Key Priorities for 2015/16**

- Development of level 2 Safeguarding Adults and Safeguarding Children training for identified Adult Services staff
- Safeguarding Conference for CityCare staff
- Safeguarding Champions Network
- Completion of Safeguarding Adults Self-Assessment Framework
- Appointment of designated MCA Lead Practitioner role
- Development and Implementation of Safeguarding Adults service
- Audit of 'Think Family' group supervision model

5.7 Nottinghamshire Healthcare NHS Foundation Trust

The Nottinghamshire Healthcare NHS Foundation Trust sees an effective safeguarding service as one that ensures that vulnerable people, whether our patients, their carers, or our staff and their relatives, are kept safe and have the best possible experience whilst in our care.

5.7.1 **What NHCT planned to do?**

Nottinghamshire Healthcare's Business Plan was developed to cover a three year period 2012 – 2015.

What we did this year:

- Review the recommendations that have emerged from reviews, reports and other national enquiries
- Embed and consolidate our approach to domestic violence and abuse by ensuring that it is aligned to that of our partners in order to avoid duplication of effort and maximise our effectiveness.
- Ensure organisational learning from internal and external issues, Serious Case Reviews, Domestic Homicide Reviews, alternative reviews and audit is embedded and evaluated against impact and sustainability
- Develop new, imaginative and innovative ways of extending learning and development.
- Refresh our approach to Think Family 'in order to support the implementation of the Trust's first 'Think Family Strategy'.
- Improve our involvement with members, service users and carers to guide our development and measure our effectiveness
- Align our programme to the Strategic Objectives of the Trust and the identified priorities of the Local Safeguarding Adults and Children's Boards.
- Deliver a robust governance system and continue to develop our methods of reporting to reflect the quality of the service we deliver.
- Provide a greater focus on the quality of safeguarding leadership and integration to ensure that all our staff are supported, confident and well-equipped to meet the demanding challenges of the safeguarding responsibilities they undertake on behalf of users of our services and their families

5.7.2 **What has been the impact?**

The plan between 2012 and 2015 has been reviewed and established that all the actions planned for completion by the end of 2015 have been achieved on time or have been embedded into our longer term and ongoing activities.

Highlights this year include

- Our active participation on Safeguarding Boards / DV multi – agency executive Groups and sub structures

- Robustly responding and adapting National, regional , local changes and emerging themes - including , e safety , modern slavery , child sexual exploitation
- Delivering a Trustwide Think family approach in everything we do
- The delivery of high quality accessible training , supervision and support
- Consolidation of our approach to Domestic Violence & Abuse including sexual violence
- Engagement in safeguarding research
- Development of the first Trustwide Quality and Performance framework
- Producing high quality individual and multi - agency investigation reports such as SCRs and DHRs to ensure learning is timely , effective and respectful to the Service user, their family and our staff

5.7.3 **What we need to do in the future**

The year ahead sees the launch a new phase in our work , a refreshed 5 year plan with an emphasis on leadership , learning and improvement and a commitment to strengthen of our ability to evidence we are making a difference,

Priority 1: To demonstrate Nottinghamshire Healthcare has a strong integrated and sustainable culture of both safeguarding leadership and strategic and operational working across the Trust.

Priority 2: To demonstrate that we are assured that safeguarding is everyone's responsibility and we are able to evidence that we are making a difference.

Priority 3: To demonstrate that we are assured that learning and improvement is raising the awareness and the quality of safeguarding practice and ensure that training, procedures and guidance support improvements in safeguarding children and adults.

This approach is in line with the POSITVE values and vision of Nottinghamshire Healthcare Foundation Trust. Furthermore it encompasses a clear overarching message and framework for all staff which ensures safeguarding is

'**Everyone's business.**'

CHAPTER 6 FUTURE CHALLENGES: OUR BUSINESS PLAN FOR 2014/15

6.1. This year's plan is intended to deliver more than "business as usual" and take a more transformational approach. To be effective the “Making Safeguarding Personal" agenda requires leadership that supports less risk averse practice where this will ensure better outcomes for the citizen. Sharing the risk as a partnership provides a more resilient and robust approach. Our approach also recognises that social isolation can increase the risk of harm and focuses on addressing this as a method for reducing incidence of harm and neglect. Maximising partnership resources to deal with social isolation in our city will result in more deliverable outcomes than individual agency effort. Finally the Board recognises that by working in partnership and sharing information more effectively we can maximise the opportunity to intervene earlier to prevent harm occurring.

6.2. In setting our NCASPB Business Plan for 2015/16 we have elected initially to focus our objectives around the Care Act 2014 and from a Board perspective this will mean ensuring that we are Care Act compliant and targeted on the safeguarding related developments of this key piece of legislation.

6.3 As set out earlier in this section of our Annual Report the Care Act 2014 requires that all local authorities must have established a SAB as set out in the Act and the accompanying statutory guidance. Partners will find themselves more accountable for their actions and there will be higher public expectations. The statutory guidance encourages all three of the core partners to make a resource contribution to recognise the corporate partnership accountability and to ensure the SAB can carry out its functions.

6.4 The Care Act (schedule 2) gives the local SAB three specific duties it must:

6.4.1 Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community.

6.4.2 Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any Safeguarding Adults Reviews (SAR) including any ongoing reviews.

6.4.3 Decide when a Safeguarding Adult Review (SAR) is necessary, arrange for its conduct and if it so decides, to implement the findings. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report. Boards

will need to agree clear policy and procedures, membership, governance structure and communication plan, including how to obtain feedback from the local community. The local training and workforce development strategy will need updating in light of the Act; it should be competency based to ensure that workers' practice meets the Act's new requirements including the latest guidance on the Mental Capacity Act, undertaking MCA assessments, and Deprivation of Liberty Safeguards. The Care Act says that if a SAB requests information from an organisation or individual who is likely to have information which is relevant to the SAB's functions, then they must share it with the Board. Additionally agencies should have drawn up a common agreement relating to confidentiality and the sharing of information between themselves based on the well-being of the adult at risk of abuse or neglect. It should also set out in what circumstances information will be shared without the agreement of the individual. The Act introduces statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews) and gives Boards flexibility to choose a proportionate methodology. The purpose of an SAR must be to learn lessons and improve practice and inter-agency working. It defines the circumstances under which a SAB must conduct a SAR as "there is reasonable cause for concern about how the SAB, members of it or others worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse." It expects agencies to cooperate with the review but also gives Boards the power to request information from relevant agencies. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from "near misses" and situations where the arrangements worked especially well.

6.5 The detail of the NCASPB Business Plan is set out at appendix 1.

The Care Act

6.6 The NCASPB was in a good starting position prior to the Act coming into force. A SAB was in existence with good partnership attendance, Serious Case Reviews were commissioned as appropriate and the Board completed an annual report based on its business plan. It has been the role of the Care Act task and finish group to ensure that existing processes and structures are compliant, and this has been the focus of the work of the group.

6.7 The Business Plan for 2015/16 is, in essence, designed to continue the implementation of Care Act requirements both in relation to the Board itself but also to the wider development of adult safeguarding provision across the City.

6.8 Priority areas of work for 15-16 are as follows:

- The creation of a performance framework
- To consider the implications of DV as a type of abuse
- Ratification of information sharing protocol and implementation
- Updated information for publication
- Completion of the SAAF
- Self-assessment of the Board's compliance with the Care Act
- Audit of partner agencies compliance with the Care and Making Safeguarding Personal

MCA DoIs

6.9 Concerns have been noted around the focus of the MCA DoLs subgroup group and discussions have taken place as to whether the NCASPB requires an MCA/DoIs subgroup. The group was set up prior to the shift in responsibilities from NHS to local authorities and the remit was oversight of the implementation of DoLS to ensure compliance with legislation. To oversee the implementation of MCA would require a significant change in membership with resource implications for all partners. MCA is just one Act that partner agencies need to comply with that has an impact upon citizens. Given the implementation of MCA is the responsibility of individual agencies the Board could seek assurance of implementation via OMG as part of the overall quality assurance process. The implementation and oversight of DoLs is now the responsibility of the LA social care so multi-agency working is limited. Actions from Serious Case Reviews relating to MCA should be implemented by all agencies and monitored through the SCR sub-group in line with other actions arising from SCRs.

6.10 It has been agreed that we will assess the relevance of continuing to operate an MCA/DoLS subgroup and to decide whether to continue the group. If it is recommended that the group continues then clear direction and objectives will need to be set and if extended to oversee MCA then partner agencies will need to agree to the increased resource implications for the Board and their agency.

Training and Workforce Development

6.11 Key areas for development identifies for 2015/16 include:

- A review of membership of the Training Sub group to ensure the right representation of partner agencies and improved attendance.
- Increased participation of Sub Group members in leading on particular work streams.

- Board partners to be challenged to ensure staff co-operate with requests for evidence of the impact of training and other work of the sub group.
- The establishment of an adult safeguarding training pool, to ensure sustainable delivery of a programme of training for the PVI sector.
- To effectively implement the Learning & Improvement Process.
- To finalise and agree Competence / Capability frameworks for both Adult and Children Safeguarding and collect information from partner agencies regarding competence levels of their staff teams.

6.12 Safeguarding Adults Reviews (previously known as Serious Case Reviews)

The key focus for 2015/16 will continue to be the implementation of the Care Act 2014 to ensure that our SAR and other review processes reflect the expectations of the Act and that we continue to maximise the impact of the learning that is drawn from these and other reviews of practice that are undertaken.

Paul Burnett
Independent Chair, Nottingham City Safeguarding Children Board and Nottingham City Adult Safeguarding Partnership Board

APPENDICES

Appendix A Results of Peer review

Appendix 1: NCASPB Business Plan 2015/16

Appendix 2: Joint Business Plan for NCASPB and NCSCB

Appendix A PEER CHALLENGE OF NOTTINGHAM CITY SAFEGUARDING BOARD

During 2014/15 a Peer Challenge of our safeguarding arrangements was carried out as part of the East Midlands Network improvement framework. The Peer Challenge provided an external, objective judgement of our performance.

Key positives identified in the report included:

- Comprehensive senior level representation
- Very clear commitment to work in partnership
- Consistent attendance and representation
- All members feel able to contribute and provide challenge
- SCR sub-group is strong and works well
- Partners felt resources followed risk
- Good practice around safeguarding adult networking events

However a number of issues were raised by the peer reviewers notably

- An overall view was that adult safeguarding issues are being squeezed out by primacy of children's safeguarding
- The aspiration to support a Think Family approach through Board integration has yet to be realised
- Very little knowledge of Board's priorities across the workforce
- Business plan is more focused on business as usual rather than evidenced areas that require step change
- Combined infrastructure underneath also contributes to diminution of focus on adult safeguarding
- Too little opportunity for interagency learning and review

Recommendations for consideration were as follows:

- Consider 'splitting out' the Board and OMG
- Consider 'splitting out' Board sub-groups, particularly quality assurance and training
- Adult Safeguarding Board has a separate business plan
- Level 3 and 4 training should be multiagency
- Multiagency case file auditing
- Targeted work with BME communities to raise awareness of adult abuse and how to make a referral
- Board's analysis of safeguarding issues needs be informed by partners' data

Appendix 1

NOTTINGHAM CITY SAFEGUARDING ADULTS PARTNERSHIP BOARD

BUSINESS PLAN 2015/16

Nottingham City Adult Safeguarding Partnership Board

Priority: **Adults are able to protect themselves from harm with appropriate support.**

- Provide leadership to support less risk averse practice where this will ensure citizens' outcomes are better met.
- An early intervention approach that reduces preventable incidences of harm.
- Develop supportive communities and ensure people are befriended and have friends.

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating

1.1	The Board and partner agencies are fully compliant with the Care Act.	Delivery of phase 2 of the Care Act task and finish work plan including self-assessment of Board compliance	Care Act task and finish group	Care Act task and finish reports to OMG	April 15 July 15 Oct 15 Dec 15 Feb 15		
		Audit partner's implementation of the Care Act (SAAF).		Report received by Care Act task and finish group	June 15		
				Report to OMG	July 15		
1.2	Provide leadership to	Scoping of the MSP principles		Care Act task and finish	April 15		

	support less risk averse practice where this will ensure citizens' outcomes are better met.	in relation to ○ Their impact on cultural change in workforce interventions ○ Safeguarding board practice such as quality assurance ○ Leadership at safeguarding partnership level	Board manager/Care Act task and finish group	reports to OMG	July 15 Oct 15 Dec 15 Feb 15		
1.3	An early intervention approach that reduces preventable incidences of harm.	Develop a multi-agency early intervention strategy in homecare and residential care Conduct a review of the early intervention approach in relation to homecare and residential care providers, and determine if we can improve. Map local profile to determine	Early Intervention Subgroup	Early intervention subgroup reports to OMG	**Oct 15** **Feb 16**		

		where we have low levels of safeguarding referrals to focus safeguarding awareness raising.					
1.4	Develop supportive communities and ensure people are befriended and have friends.	To determine how the Looking After Each Other project led by the LA and CCG might impact on keeping people safe from harm and what more we might need to do to address this objective. Determine whether the wellbeing vision for the City and the workforce change implicit in that could include a focus on social isolation and friendship.	Board manager Helen Jones, Director of Adult Social Care	Assurance report to OMG Assurance report to NCASPB	Oct 15 Sept 15		

RAG Rating key

Clear	Work is underway and, in the judgement of the lead individual/subgroup, is expected to be completed within the agreed timescale
Red	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by more than 3 months and/or • The impact of missing this deadline is likely to be significant
Amber	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by less than 3 months and • The impact of missing this deadline is unlikely to be significant
Green	Action completed
Blue	Impact of the action has been evaluated and found to have addressed the issue identified

NOTTINGHAM CITY SAFEGUARDING CHILDREN BOARD AND ADULT SAFEGUARGING PARTNERSHIP BOARD

JOINT BUSINESS PLAN 2015/16

Nottingham City Children's and Adults Safeguarding Board

Priority 1: **To be assured that safeguarding services are effectively coordinated across children and adult services ('Think Family')**

- DV, modern slavery and FGM
- Priority Families
- Transitions
- Information sharing

Priority 2: **To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults**

- To be assured that the workforce across all partner agencies has adequate basic knowledge and that this has been effective in improving practice, responding to areas of improvement identified.
- Ensure learning is identified and disseminated from and between partner agencies, including how this will be embedded into practice.
- Measuring the impact on practice and outcomes for children, young people and adults, basic and improved knowledge, demonstrated through a mechanism with clear outcomes identified.
- Improvement of citizen awareness of their responsibility for the welfare of children and adults.

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating
1.1	Effective safeguarding arrangements in relation to domestic abuse are in place across the partnership.	Delivery of the domestic violence strategic group and action plan.	DVSG chair	DV strategic group reports to OMG	**Oct 15** **Feb 16**		
		Delivery of the domestic abuse and children subgroup's work plan.	DA Children's subgroup chair	DV children's subgroup reports to OMG	**Oct 15** **Feb 16**		
		Establish effective lines of connectivity with adult safeguarding board to reflect the requirements of the Care Act.	Care Act task and finish group	Care Act task and finish group reports to OMG	**July 15** **Dec 15**		

1.2	The Boards receive a report on current intelligence in relation to modern slavery and identify further action that may be required in response.	Liaise with DVSG chair to add indicators to DV data regarding how many case of modern slavery there are and what action was taken.	DVSG/Board manager	DV strategic group reports to OMG	**Oct 15** **Feb 16**		
1.3	The Boards are assured that work in relation to FGM is addressing key expectations in relation to awareness raising, identification and response.	Delivery of the FGM board work plan.	Chair of the FGM board	FGM update to Board	**April 15** **Oct 15**	**Green**	

1.4	The Priority Families programme incorporates robust safeguarding arrangements and coordinates effectively with formal safeguarding processes where appropriate.	The board will receive a report from Vulnerable Children and Families Services evaluating the impact of the Priority Families service against the four quadrants of the Quality Assurance Framework. This report should provide a comparative analysis of the impact of the service in working with adults at risk.	Children's QA subgroup	Report received by Children's QA subgroup Children's QA subgroup report to OMG	**Jan 16** **Feb 16**		
			Care Act task and finish group	Report received by Care Act task and finish group Care Act task and finish group report to OMG	**Dec 15** **Feb 16**		

1.5	The Board is assured that agencies are successfully transitioning individuals from children's to adult's services, applying best practice principles.	Health, social care and education provide evidence that SEND forms are being completed and are effective.	Children's QA subgroup	Report received by Children's QA subgroup Children's QA report to OMG	**Oct 15** **Dec 16**		
		The transitions document is updated in line with the Care Act.	Care Act task and finish group	Care Act task and finish group report to OMG	**July 15**		
		The transitions document in publicised.	Comms& Engagement task and finish	Comms and Engagement report to OMG	**Oct 15**		
		Boards receive reports from Children's social care setting out the efficacy of local arrangements to support care	OMG/Head of Safeguarding	Report to NCSCB	**Jan 15**		

		leavers. The Board will then formally communicate its views regarding these arrangements to the Corporate Parenting Panel.					
1.6	Information sharing protocols are fit for purpose	Information sharing protocol for children's amended in light of revised statutory guidance required in line with TriX updates.	Board Service Manager	Report on TriX updates to OMG	**July 15**		
		Information sharing protocol for adults benchmarked against requirements of the Care Act and amended if necessary.	Care Act task and finish group	Care Act report to OMG	**July 15**		

1.7	The Boards are assured that work in relation to children and vulnerable adults at risk of radicalisation is robust and effect in diverting and supporting the individuals and their families	The board will receive a report from local Prevent Leads evaluating the impact of local practice against the four quadrants of the Quality Assurance Framework. This report should provide analysis of the efficacy of local Chanel Panel arrangements	OMG/Head of Safeguarding	Report to NCSCB	**Oct 15**		

Priority 2: **To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults**

No.	What do we want to achieve?	How are we going to do it?	Who will lead?	How will we know we have achieved our goal?	When are we going to achieve this?	Comment on Progress	RAG rating
1.8	The Board is assured that the learning and Improvement Framework enables staff and volunteers to identify safeguarding risks for both children and	Embed the function of the Learning and Improvement process.	Training subgroup	Training subgroup report to OMG	**Oct 15**		
		Test that the training and development programme reflects key Business plan priorities and the recommendations arising from SCRs, SILPs and other	Training subgroup	Training subgroup report to OMG	**Oct 15**		

	adults, and act accordingly	reviews.					
		Strengthen the training and development evaluation process to test impact on service quality and safeguarding outcomes for children, young people and adults at risk including a safeguarding competence framework.	Training subgroup	Training subgroup report to OMG	**July 15** **Oct 15** **Feb 16**		
		Ascertain numbers of referrals from children's services to adult services.	Children's QA subgroup	Children's QA subgroup report to OMG	**Oct 15**		
		Ascertain number of referrals from adult services to children's services.	Care Act task and finish group	Care Act task and finish group report to OMG	**Oct 15**		
RAG Rating key							

Clear	Work is underway and, in the judgement of the lead individual/subgroup, is expected to be completed within the agreed timescale
Red	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by more than 3 months and/or • The impact of missing this deadline is likely to be significant
Amber	Work is underway however, is not expected to be completed within the agreed timescale. In the judgement of the lead individual/subgroup either • The deadline will be missed by less than 3 months and • The impact of missing this deadline is unlikely to be significant
Green	Action completed
Blue	Impact of the action has been evaluated and found to have addressed the issue identified

OVERVIEW AND SCRUTINY COMMITTEE
4 NOVEMBER 2015
UPDATE ON COUNCIL PROGRESS FOLLOWING THE OFSTED INSPECTION IN 2014
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider and review progress of the action plan in response to the Ofsted inspection in 2014.

2. Action required

2.1 To scrutinise the Council's performance in meeting actions arising from the Ofsted inspection in 2014.

2.2 In the future, the Committee might consider referring progress reports to the Children and Young People Scrutiny Committee.

3. Background information

3.1 In the January 2015, Overview and Scrutiny reviewed progress made by Nottingham City Council in its action plan developed in response to the Ofsted inspection in 2014.

3.2 In March 2014 Ofsted inspected Nottingham City Council's services for children in need of help and protection; children looked after and care leavers (also known as the Single Inspection). The inspection was unannounced and lasted for four weeks; inspectors met with managers, frontline workers and partners and they sampled a large number of case files to judge the quality of safeguarding practice in the City. The inspection also included a review of the Nottingham City Safeguarding Children's Board (NCSCB).

3.3 Their main findings were that, across all elements of the inspection framework, we 'required improvement' but they found no children to be 'unsafe' in the City. The inspection did not find any areas for priority and immediate action; however key areas for improvement were identified. The full Ofsted report is available here http://www.ofsted.gov.uk/local-authorities/nottingham.

3.4 In response to the key findings Nottingham City Council was asked to produce an Improvement Action Plan identifying each action and detailing what will be done to address it and by whom. This Improvement Action Plan was submitted to Ofsted in August 2014. Since the inspection Nottingham City Council has actively engaged with Ofsted

and we have worked with them to pilot ‘Challenge Seminars’ designed to help local authorities develop their improvement plans.

3.5 Since April 2014 we have worked to put in place strong qualitative and quantitative monitoring of the Improvement Action Plan and its impact on frontline practice.

4. List of attached information

None.

5. Background papers, other than published works or those disclosing exempt or confidential information

None.

6. Published documents referred to in compiling this report

Overview and Scrutiny Committee minutes 7 January 2015.

7. Wards affected

City-wide.

8. Contact information

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OVERVIEW AND SCRUTINY COMMITTEE
4 NOVEMBER 2015
PROGRAMME FOR SCRUTINY
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

To consider and set the overall programme and timetable for scrutiny activity for the forthcoming year.

2. Action required

The Committee is asked to

2.1 note the items scheduled on the work programme for the Overview and Scrutiny Committee and Scrutiny Review Panels for 2015/16.

3. Background information

3.1 One of the main roles of the Overview and Scrutiny Committee is setting, managing and co-ordinating the overall programme of scrutiny work. This includes:

- mapping out an initial programme for scrutiny at the start of the municipal year
- monitoring progress against the programme throughout the year, and making amendments as required
- evaluating the impact of scrutiny activity and using lessons learnt to inform future decisions about scrutiny activity.

3.4 In setting the programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and is matched against the resources available to deliver the programme. It is intended to hold fewer, but more in depth reviews which will enable panels to explore and challenge more.

Commissioning scrutiny reviews

3.5 Delivery of the programme will primarily be through the commissioning of time-limited (2 to 3 meetings maximum) review panels to carry out reviews into specific, focused topics. All reviews must have the potential to make a positive impact on improving the wellbeing of local communities and people who live and/or work in Nottingham; and to ensure resources are used to their full potential, reviews must have a clear and tight focus and be set a realistic but challenging timetable for their completion.

3.6 In setting the programme of scrutiny reviews, it is important that the programme has flexibility to incorporate unplanned scrutiny work requested in-year. However, the Committee will only be able to schedule unplanned work after it has reassessed priorities across the scrutiny programme and considered the impact on existing reviews of the diversion of resources. When the Committee monitors the overall programme for scrutiny at each meeting there will be opportunity to do this.

3.7 The Committee held a workshop session in March 2015 and identified a number of areas for consideration during 2015/16. These topics have been identified and are listed in Appendix 1 to this report.

3.8 When establishing a review panel, the Committee needs to decide on:

- a clear and tight remit for the review
- a timescale within which the review should be carried out
- size of review panel, including whether any co-opted members should be involved
- chair of the review panel (to be appointed from the pool of five scrutiny chairs)

and should have regard to the need over the year to engage as many councillors as possible in the scrutiny process.

Policy briefings

3.9 Through the process of developing the programme for scrutiny, the Committee may identify issues which call for a policy briefing. The purpose of these briefings is to inform councillors about a current key issue or to prepare councillors for review work that has been commissioned. These informal briefings will not be occasions for scrutiny to be carried out, although they may result in a suggestion for a new scrutiny topic, which would need to be considered by this Committee against the current programme for scrutiny and available resource.

3.10 Policy briefings will not form part of the Overview and Scrutiny Committee's agenda but will be held separately and be open to all councillors to attend.

Monitoring programme for scrutiny

3.11 On an ongoing basis the Committee will be responsible for managing and co-ordinating the programme for scrutiny and assessing the impact of scrutiny activity. At all future meetings the Committee will monitor the progress of the programme, making amendments as appropriate.

4. List of attached information

The following information can be found in the appendices to this report:

Appendix 1 – Feasibility criteria for topics
Appendix 2 – Long list of main scrutiny topics
Appendix 3 – Policy Briefing topics
Appendix 4 - Long-list of potential future OSC/SRP topics

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

None

7. Wards affected

Citywide

8. Contact information

Contact Colleagues

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Senior Governance Officer
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Appendix 1 - feasibility criteria includes:

Decision making and being a critical friend	**Is it a topic/key decision which requires consultation with Overview and Scrutiny <u>prior</u> to the decision being taken.**	Yes – include. No – apply other criteria and consider removing
Public Interest and relevance	**Is the topic still relevant in terms of it still being an issue for citizens, partners or the council in terms of performance, delivery or cancellation of services?**	Yes – apply other criteria and consider inclusion No – apply other criteria and consider removing
Ability to change or influence	**Can the Committee actively influence the council or its partners to accept recommendations and ensure positive outcomes for citizens and therefore be able to demonstrate the value and impact that scrutiny can have?**	Yes – apply other criteria and consider inclusion No – apply other criteria and consider removing
Range and scope of impact	**Is this a large topic area impacting on significant areas of the population and the council's partners <u>or significant impact on minority groups</u>.** **Is there interest from partners and colleagues to undertake and support this review and will it be beneficial?**	Yes – apply other criteria and consider inclusion No – apply other criteria and consider removing
Avoidance of duplication of effort	**Is this topic area very similar to one already being scrutinised in another arena or has it already been investigated in the recent past?**	Yes – consider involvement in the existing activity or consider removing No – apply other criteria and consider inclusion.

Appendix 2

4 November 2015	• **Nottingham City Safeguarding Children Board Annual Report and Nottingham City Safeguarding Adults Partnership Board** To consider the NCSCB's annual report and progress against the actions arising from the Ofsted inspection in May 2014. (NCSCB Independent Chairs) • **Progress report on actions arising from Ofsted inspection in 2014** To consider a progress report on actions made following the Ofsted inspection in 2014. • **Work Programme** To agree a draft work programme for 2015/16
9 December 2015	• **Nottingham Growth Plan** To consider an update from the Portfolio Holder for Job, Growth and Transport on the progress of the Growth Plan in Nottingham. (Economic Development, Portfolio Holder for Jobs, Growth and Transport) • **Council Plan and Priorities** To consider an update from the Leader of the Council on his Council plans and priorities (Leader of the Council) • **Work Programme** To agree a draft work programme for 2015/16
6 January 2016	• **Good to Great Operating Model** To consider an update from the Chief Executive on the Council's transition from 'Good to Great' and the resulting changes to the Council's operating model.

	(Chief Executive, Nottingham City Council) • **Housing Strategy in Nottingham** To consider the development of the housing sector in the city of Nottingham (Major Programmes, Nottingham City Council) • **Work Programme** To agree a draft work programme for 2015/16
3 February 2016	• **Adoption of Children with complex needs, disabilities or from minority/ethnic backgrounds** To consider the process for the adoption of children. (Children in Care, Nottingham City Council) • **Combined Authority** To consider the process and plans for the formation of a combined authority in Nottingham. (Development and Growth, Nottingham City Council) • **CDP Plan and report from the Police and Crime Commissioner, Paddy Tipping** To consider the process for the adoption of children. (Crime and Drugs Partnership) • **Work Programme** To agree a draft work programme for 2015/16
9 March 2016	• **CDP Annual Partnership Plan** To consider an update on the CDP's partnership plan. (Crime and Drugs Partnership) • **Commercialisation of Council Services** To consider an update on the commercialism agenda, with a view to identifying a number of topics

	requiring closer scrutiny. (Commercial and Neighbourhood Services, Nottingham City Council)
5 April 2016	

APPENDIX 2

List of potential policy briefings

The Committee can identify any topics to be put forward as ideas for potential policy briefing sessions at this stage – this process can be ongoing throughout the year.

Date	Topic	Comments

Appendix 4

Scrutiny Review Topics 2015/16

	Topic	Comments
1	**To review school attendance for children with disabilities or special education needs and the support mechanisms in place to support them to improve attendance and the progress of the transition from the Statement of Special Educational Needs or 323 assessments to the new Educational Health and Care Plans arising from the Children and Families Act 2014 Act**	**Status – to be scheduled** Proposed by Beverly Denby, 3rd Sector Advocate • Chair and membership needs appointing at OSC • Panel will include the co-opted representatives for educational issues • Scope to be finalised and submitted for approval to OSC
2	**NOTTINGHAM CITIZEN'S SURVEY** **To review the responses of sub-groups of the population, including the differing views by area and demographic factors such as age, ethnicity and disability**	**Status – to be scheduled** CHAIR: To be determined • Identified as a review at the Overview and Scrutiny workshop held in March 2014 • Scope needs to finalised with chair and submitted for approval to OSC • Membership needs to be appointed
3	**Equalities within the Commissioning and Procurement process**	First review held in December 2014, follow up review planned for June 2016 with Cllr Jenkins to chair
4	**Kin fostering regulations**	
5	**The changing landscape of demographics of children in care**	
6	**The specialist skills required for adoption and foster families**	
7	**The wider impact of commercialism on services and the balance between delivering outcomes for citizens**	
8	**The commercialisation of garage services**	
9	**The commercialisation of cemeteries and crematoriums**	
10	**Term time holidays**	

11	**Correlation between school attendance and behaviour and the impact on attainment**	

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