Nottingham City Safeguarding Children Board
Annual Report 2017/18

"We want all the children and young people of Nottingham City to be safe from harm, inside their home, outside their home and online"

NOTTINGHAM CITY
Safeguarding
Children BOARD

Contents

1. Foreword by Independent Chair

2. Introduction

3. Local Data

4. Governance and Structure

5. Achievements against 2016/17 Priorities

6. Partnership Reports and Subgroup Reports

7. Future Priorities

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1. Foreword by Independent Chair

Welcome to the Nottingham City Safeguarding Children Board (NCSCB) Annual Report for 2017/18.

During 2017, the Government passed legislation which abolished Local Safeguarding Children Boards.

The duty to have a LSCB is replaced with a duty to plan and deliver a partnership between the three safeguarding partners' – the Local Authority, the Clinical Commissioning Groups (CCGs) and the Police. Planning for this has begun in Nottingham City and I shall undertake the 'independent scrutiny' role required by the new version of 'Working Together to Safeguard Children' from April 1st 2019 (Working Together to Safeguard Children 2018)
You can read more about this on page 7.

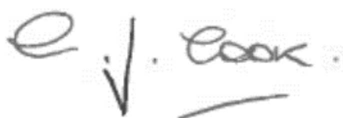
This annual report provides local people with an account of the LSCB's work over the past year to improve the safeguarding and wellbeing of children and young people across Nottingham City. The report reflects the activity of the LSCB and its sub groups against the agreed priorities for 2017/18. It also identifies the priorities and safeguarding work we will take forward into 2018/19.

As always, the children and young people of Nottingham are at the very heart of all we do and our vision that 'children and young people are safe from harm, inside their home, outside their home and online' motivates all that we do.
We do now have our own Twitter account and I would ask you to follow us as we promote learning and information sharing through this as well.

I would like to thank and recognise the contribution of our Lay Members and the Children and Young People Portfolio Holder who bring another layer of independent scrutiny to the work of the NCSCB.

Lastly I would like to thank the many partner agencies for their hard work and dedication during a time of huge demand and whose commitment and motivation helps deliver our shared priorities.

Chris Cook
Independent Chair
Nottingham City Safeguarding Children Board



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2. Introduction

Nottingham City Safeguarding Children Board has a statutory duty to prepare and publish an Annual Report, which describes how our partners safeguard vulnerable children and young people.

The role of the NCSCB is to:

- coordinate what is done by everyone on the NCSCB to safeguard and promote the welfare of children in the area
- provide scrutiny to and for ensuring the effectiveness of that work across the partnership
- publish policies and procedures for child protection in our area which are on the NCSCB website

Part 3 of the report highlights some local data about Nottingham and provides a local context for our work.

Part 4 describes the local governance arrangements and structure of the NCSCB and links to the strategic partnership across the city

Part 5 highlights some of the achievements and the progress that has been made in the last year.

Part 6 shows reports from agencies across the safeguarding partnership and provides an overview of sub-group activity.

Part 7 identifies the priorities the NCSCB will take forward into 2017/18.

The Annual Report 2017/18 demonstrates the extent to which the functions of the Nottingham City Safeguarding Children Board, as set out in the national statutory guidance 'Working Together to Safeguard Children' (March 2015) are being effectively fulfilled.

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3. Local data

- Nottingham City is a unitary authority comprising of 20 wards. It has a young and ethnically diverse population.
- The University of Nottingham and Nottingham Trent University are both located in the City.
- In 2017, there were an estimated 329,200 people living in Nottingham City of these 67,900 are aged under 18.
- Population projections suggest that this may rise to around 332,700 by 2024.International migration (recently from Eastern Europe) and an increase in student numbers are the main reasons for the population growth since 2001, together with the excess of births over deaths.
- There are an estimated 37,000 University Students in Nottingham.
- Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.
- Nottingham is ranked the eighth most deprived district in England out of 326 local authorities in the 2015 Indices of Multiple Deprivation (IMD), a relative fall from 20th in the 2010 IMD.
- 62.7% of children in Nottingham live in low-income/workless families (ONS).
- Nottingham City has a high level of child poverty, regardless of the definition used.
- Over 60% of City children live in families that receive financial support from the Government. This is significantly higher than the England average.
- 42,100 Nottingham City children live in families where no adults work or where the household income is low enough to receive tax credits. This is equivalent to 61.9% of children compared to rates of 46.3% in Greater Nottingham and 41.0% in England.
- 61 of the 182 City LSOAs fall amongst the 10% most deprived in the country. 110 fall in the 20% most deprived
- Here is the JSNA - which shows local assessments of current and future health and social care needs
- 19,300 (28.4%) of City children live in families where parents are claiming workless benefits, such as Jobseeker's Allowance, Incapacity Benefit and Lone Parent Income Support.
- Life expectancy at birth for females is 82 years
- Life expectancy at birth for males is 77 years.
- Here is the JSNA which shows local assessments of current and future health and social care needs

Local Safeguarding Data 2017/18

- 577 children were subject to a Child Protection Plan (85 per 10,000 population (Aged 0-18).
- 2.5%. The percentage of Child Protection Plans that lasted two years or more
- 94% of Child Protection reviews take place within timescales.
- Neglect continues to be the most frequent reason for children being placed on a Child Protection Plan in 2017/18.
- Domestic abuse continues to be the main parental risk factor leading to children becoming subject of a Child Protection Plan

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- 97% of practitioners are aware of how the NCSCB Safeguarding Children procedures relate to their work
- 618 children in care at the year-end, which is an increase of 2 from the previous year.

- 2200+ Taxi drivers in the city have now completed safeguarding training which will be revisited every 3 years.
- In excess of 350 practitioners from across the safeguarding partnership attended the second annual NCSCB "Every Colleague Matters" events on "Empowering the Workforce to deliver Excellence in Safeguarding Practice"
- 87% of practitioners are very confident/confident in using the signs of safety approach
- 550 cases discussed at a Multi-Agency Risk Assessment Conference (MARAC).
- 797 families successfully impacted by the Priority Families programme.
- 90.6% of our Children in Care benefited from placement stability.

4. Governance and Structure

Each local area is required by Law to have a Local Safeguarding Children Board. The LSCB is a statutory body established in legislation (Children Act 2004) and works according to national guidance 'Working Together to Safeguard Children 2015'.

The Nottingham City Safeguarding Children Board is chaired by an independent person and meets quarterly.
The Independent Chair also chairs the Business Management Group (BMG) and membership is comprised of the Local Authority, the Clinical Commissioning Group, and Police, chairs of the subgroups and board officers and meets quarterly.

The functions of the LSCB are:

- *To develop policies and procedures for safeguarding and promoting the welfare of children in the local area*
- *To establish a culture of learning and Improvement across the partnership.*
- *To monitor and evaluate the effectiveness and impact of services provided by the local authority and Board partners through the use of sub-groups of the Board and other mechanisms.*
- *To participate in the planning of services for children in the area of the authority*
- *To conduct reviews of serious cases and advising the local authority and their Board partners on lessons to be learned*

The governance arrangements form the formal agreement between the Board and all partner agencies. It outlines accountability; key purposes; functions and tasks; membership; and agreed standards and expectations of NCSCB members.

The Children and Social Work Act received Royal Accent in April 2017 and set out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. In Nottingham the Business Management Group monitor, develop, and progress local arrangements and future

safeguarding models throughout 2017/18.

Working across the Partnership

The NCSCB has arrangements in place in order to co-ordinate its work with other partnership Boards in the City including the Childrens Partnership Board, the Health & Wellbeing Board, the Safeguarding Assurance Forum and the Crime & Drugs Partnership, The Prevent Steering Group, the Domestic and Sexual Violence Strategy Group and Female Genital Mutilation Board report into the Safeguarding Children Board and also provides information to the Safeguarding Adults Board.

These are some examples of work across the partnership

- *Health and Wellbeing Board -Is a partnership bringing together key local leaders from the City Council, NHS and the wider community to improve the health and wellbeing of the population of Nottingham and reduce health inequalities.*
- *Childrens Partnership Board* – Is a partnership of local organisations working together to deliver a joint approach to improving outcomes for children, young people and families. Partners include the City Council, NHS bodies, Crime and Drugs Partnership, Nottinghamshire Police, Nottingham and Nottinghamshire Futures, Job Centre Plus, Probation Service, Nottingham Safeguarding Children Board, schools and young people. The Board is responsible for the development and implementation of the Children and Young People's Plan.
- *Nottingham Crime & Drugs Partnership - (CDP) is a multi-agency organisation responsible for tackling crime and substance misuse in Nottingham. It is made up of a number of statutory and non-statutory agencies including the Police, Nottingham City Council, the Fire and Rescue Service, the National Probation Service and the Community Rehabilitation Company, Public Health and the Clinical Commissioning Group, Nottingham Trent University and Nottingham City Homes.* – Tackles crime, disorder, substance misuse, anti-social behavior and to reduce re-offending.
- NCSCB will continue to engage and challenge these partnerships where appropriate to safeguard and promote the welfare of children in County Nottingham.

The Children and Social Work Act 2017

Following the Wood Review and the Children and Social Work Bill in 2016, new safeguarding arrangements were passed into law through the Children and Social Work Act 2017.
Provisions within the Children and Social Work Act 2017 will replace Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements, led by three Safeguarding Partners and supported by relevant agencies. It also places a duty on new Child Death Review partners to review the deaths of children normally resident in the local area.
In October 2017 the Department of Education (DfE) consulted on the draft 'Working Together to Safeguard Children 2018' guidance which lays down in much more

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detail the new safeguarding arrangements.
Nottingham City Safeguarding Children Board provided a full response to this consultation.
Alongside the 'Working Together' consultation documents, the DfE released statutory guidance on transitional arrangements.
This document for Local Authorities, Police, Health and LSCBs provides guidance on the arrangements that should operate as part of the transition from LSCB's to Safeguarding Partners and Child Death Review Partners.

Safeguarding Partners are identified as:

- Local Authorities
- Police
- Clinical Commissioning Groups

Child Death Review Partners are identified as:

- Local Authorities
- Clinical Commissions Groups

Safeguarding Partners will identify the relevant agencies required to support local safeguarding arrangements and this will include agencies that are currently members of the LSCB.

5. Achievements against 2016/17 Priorities

The priorities of the NCSCB were to;

- Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children and young people across the child's journey

- Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice with assurance that safeguarding is everyone's responsibility.

- To evidence the impact of NCSCB

Achievements;

- The SCR SP have continued to be instrumental in developing responses to reviews that actively seek to engage with the frontline workforce.

- Leading and promoting an Every Colleague Matters event dedicated to Safeguarding. The "Empowering the Workforce to deliver Excellence in Safeguarding Practice" event ran from the 12th to 16th February 2018. 358 places were attended on the face-to-face sessions during the week event. 98% of respondents to the evaluation rated the session as excellent/good. 98% of the respondents rated the overall event as Very good/good.

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❖ 96% of the respondents strongly agreed/agreed that they would attend similar sessions in the future.

❖ 96% of the respondents strongly agreed/agreed they felt confident cascading this information in their organisation/agency. This will increase the impact of the event to reaching thousands of colleagues across the partnership.

Feedback from the event included;

“These sessions have allowed me to update my skills and knowledge of services that have changed and also new services that available within Nottingham City. Also to liaise with and network with colleagues from a wide variety of agencies throughout the City”
“Being able to identify colleagues to follow up on referrals and queries and helped to clarify process and what we can do to intervene earlier”
“Improved partnership working and helps put faces to names”
“It has broadened my interventions skills as well my knowledge and skills in working with service users from diverse backgrounds”
“Given me up to date information so I feel more confident with giving advice or supporting children and their families. I can also feedback to colleagues to support them too”

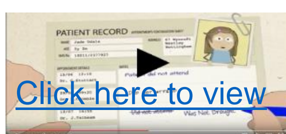
❖ We have a workforce with an increased understanding of and recognition of risk associated with medical neglect.

❖ Workforce survey issued to engage with wider workforce on their relationship with the Board, safeguarding issues and arrangements for supporting children and families

❖ Trained over 2200 taxi drivers in safeguarding.

❖ Missing Appointments Matter - NHS Nottingham City CCG have commissioned a video animation, which was co-produced with the NCSCB, aimed at citizens to encourage them to attend medical appointments, and to take children and adults they care for to their appointments. The animation is aimed at raising awareness about the consequences of missing appointments and to ensure that children and adults get the medical care that they need.

❖ Leading a change in culture nationally. This has continued to have been one of the most successful campaigns led by the NCSCB[1] in recent years receiving National and International recognition and has been viewed in excess of 30,000 times across a variety of platforms and it has been shortlisted for a national safeguarding award.



[1] Jointly funded by the NCSCB, Nottingham City Council and NHS Nottingham City Clinical Commissioning Group

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- The Quality Assurance Sub - Group completed audits on Child Sexual Exploitation, out of hour's referrals to Children's Social care, quality of plans for cases where the concern was physical abuse and medical neglect.
- Developed the use of newsletters from the NCSCB, which share important safeguarding information every two months with the partnership. Over 2700 people now subscribe to this.

- The NCSCB produces a bi-monthly newsletter which reaches in excess of 3300 people.

- Training and awareness raising sessions were delivered throughout the year in the following areas

- Emerging Themes in Safeguarding

- Staying Safe Online

- Learning from Reviews

- Effective engagement-Agreements, Contracts and Family Network Meetings

- Role of the LADO

- Having Difficult Conversations

- Low mood and Depression in Children and Young People

- Neglect: The individual impact on children and young people - What we can do

- Domestic Violence and Abuse Safeguarding: Your role working with Survivors, Perpetrators and Children

- 'Ending Female Genital Mutilation - our role and responsibilities'

- Making Safeguarding Personal

6. Partnership and Sub group Reports

Childrens Integrated Services

Children's Integrated Services was formally established in 2015. Our priorities are that we are;

1. A Learning City
2. Resilience in Children, Families and Communities
3. Healthy Minds, Bodies and Relationships

Our Early Help services are involved with 1000 children at any one time and engage with parents through group work and home visits. We delivered 6000 Children Centre sessions with 114,000 attendances and 2000 Play & Youth sessions with 32,500 attending. Following this period of intervention 82% of children engaged with Early Help did not require any further Social Care or Early Help engagement.

Childrens Duty and Targeted Services have continued to develop an integrated front-door, providing the right help at the right time in a proportionate response. We have further developed Children & Families Direct MASH leading to improved information sharing through the following initiatives.

- ❖ Good relationships with schools helped by the Consultation Line and Project Encompass
- ❖ Whole family working embedded within Targeted Family Support Teams
- ❖ Family Network Meetings pilot – supported by our Targeted Support Team
- ❖ Identification and response to complex, contextual safeguarding issues such as Child Sexual Exploitation, child criminal exploitation and knife crime.

Childrens Social work has benefitted through;

- ❖ High quality direct work with children and embedded use of Signs of Safety.
- ❖ Robust and timely assessment and planning for children.
- ❖ Locality hub arrangements supports collaborative working arrangements to step work across.
- ❖ Use of Public Law Outline and quality of work through care proceedings.
- ❖ Practice Improvement Days to drive consistent, high quality practice
- ❖ Extensive menu of edge of care services and Edge of Care Panel.
- ❖ Robust monitoring of caseloads

Children in Care

We are building strength into these services following the PILOT inspection in February 2017.

- ❖ Strong Corporate Parenting – apprenticeships, Big It Up events and our Christmas Stars initiative.
- ❖ The majority of our children are in high quality, stable placements, helped by our in-house foster carer recruitment
- ❖ High quality in-house residential provision on a small group homes model.
- ❖ Timely, child-focussed reviews of plans where children's views are heard.
- ❖ Participation of Children in Care (CiC) is strong as evidenced thorough the – CiC Council, Your Voice Group and the Mind Of My Own app (MOMO).
- ❖ We have seen Improvements across key statutory measures including offending and health measures.

Drivers for Improvement

- ❖ Learning & Improvement Framework – audit programme.
- ❖ Strong management information systems.
- ❖ Learning from feedback – Social Care Complaints, MOMO, service user

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feedback and our workforce engagement strategy.

- ❖ Participation leading to Co-production – ensuring children and families have a voice in service development.
- ❖ Integrated Workforce Development service have now moved into the Directorate.
- ❖ The work of the NCSCB - Learning from Reviews, Serious Case Reviews and multi-agency audits.

Nottingham City Clinical Commissioning Group

Summary of safeguarding activity 2017/18
This report is a summary of the Safeguarding Children arrangements within Nottingham City CCG. This demonstrates the mechanisms used to quality assure and oversee delivery of safeguarding standards within the services it commissions from provider organisations.
The report is an overview of the work during 2017/18 to safeguard children and young people.
During the year which the report is focused the CCG has been under a re-structure due to the emerging work of the STP working to align the health and social care of the local area.
It highlights risk, challenges and specific areas for development during 2018/19.
Summary of safeguarding activity –

1) What the agency planned to do and what we did

During 2017/18 the CCG planned to focus on the following risk and challenges:

- ❖ Discharge of Statutory Duties and Functions for Safeguarding

Nottingham City CCG has delivered its statutory functions in relation to safeguarding children as detailed within "Working Together to Safeguard Children" (March 2015) and "Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework" (April 2015) . Development of how the CCG gains its own assurance will be reflected in the summary of work achieved and described in the Safeguarding Assurance Tool (SAT) which was submitted to NHS England during a pilot in late 2017. The Safeguarding Leads also delivered the concept of this assurance giving extensive clarity to the Business Management Group Nottingham City Safeguarding Children Board. It was agreed that the SAT would be the alternative assurance to be submitted on receipt of a Section 11 request.

- ❖ Domestic Abuse and Sexual Violence

Domestic Abuse continues to be a risk feature in Nottingham City. The DART process continues to share information with key health providers particularly with Primary Care/GP practices. The CCG have continued to engage with the Domestic Abuse Referral Team (DART) and in relation to matters regarding the appropriate exchange of information to Primary care following incidents and subsequent assessments. Incidents of concern are raised by the DART specialist nurse and plans of action to resolve are made. The Designated Nurse with the Named GP have reviewed and agreed learning with the specific practices and then disseminated across all practices in the city. Subsequently a review of the information pathway was revised with the Adult Safeguarding Lead at the CCG. The CCG has continued to engage with key partners in the development of the Sexual Violence Action

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Network (SVAN) and the development of a strategy to address this harm. The revised service of the SARC has been supported and subsequently when the new service launched, this was cascaded via the team to all key providers including Primary Care.

- Child Sexual Exploitation (CSE)

The CCG's Designated Nurse Safeguarding Children continues to represent the City CCG at the cross authority sub group ensuring key messages and requests for details are disseminated across the health partnerships in the City Health Providers. This task is achieved through the Joint Nottingham /Nottinghamshire Safeguarding Group (health group for Named and Designated Professionals). Contributions were made to the regional profile for CSE, collated by the Police, with our key partners and subsequently shared with strategic leads for information but not openly disseminated.

- Female Genital Mutilation (FGM)

The CCG continues to support all areas of the Health Community required to report on FGM. The Designated and Associated Designated Nurse ensure resources and training materials are cascaded to relevant area and are members of FGM sub-group and relevant task and finish groups, of the Board. The CCG supported the cascade of pre and post letters, to key health areas in relation to the increased risk of FGM, during the defined summer period. Discussions have continued with Commissioners reviewing the need for a specialist provision due to the Specialist midwife noted in previous reports leaving post. Nottingham has continued to develop the messages of a Zero Tolerance city to FGM and the sub-group are planning an active campaign and request to promote through posting the message on websites and through communications.

- Information Systems

The Child Protection Information System (CP-IS) has continued to challenge the workforce to embed the system in Nottingham and Nottinghamshire. This remains a national challenge and locally NHS Nottingham City CCG continues to record this as a risk, which is gradually reducing due to the controls and actions in place. The cross-authority CP-IS group continue to progress the local action plans and have made revisions to incorporate the issues relating to a delay in "go live". The provision of having a Project Lead is invaluable and can remain available to the full implementation process.
NHS England produced guidance to support the Designated professionals Safeguarding Children in ensuring CP-IS is in the NHS Standard Contracts 2017/18 to 2018/19 ensuring the provision is promoted and implemented by the Providers who deliver the key services which require CP-IS on their systems.
The Local Authority CP-IS implementation groups have worked closely with health and the Designated Nurse in Nottingham has received regular communications from implementation groups. Regular reporting has been made to Nottingham City Safeguarding Children Board.

- Non-recent Sexual Abuse

The CCG have continued to request Primary Care and Health providers have responded to alerts on the retention of records as this enquiry has progressed. There has been no indication advised to the Safeguarding Team at the CCG of any Primary

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Care setting having had requests for information for the anticipated enquiry in Nottingham in the autumn of 2018. The CCG through senior management have engaged in the multi-professional process of dealing with cases of non-recent sexual abuse from the cases under Operation Equinox. Health pathways were devised for cases which present as requiring individual funding remains in place. There have been no requests received by the Designated Nurse Safeguarding Children in the last year as per the procedure implemented in 2015/16.This will be reviewed according to requests and to the need to consider a sustained provision.

- Prevent

The delivery of informing and training professionals in key areas of the health community in the WRAP3 training sessions has continued. During 2017/18 Health Providers have adapted PREVENT messages into mandatory training programmes to ensure maximum impact of awareness is achieved. The national Prevent returns as advised by national's guidance, with Nottingham classed as a Non-Priority area, continue to be submitted to the Designated Nurse Safeguarding Children on a quarterly basis. However the National Team within NHSE piloted a direct return system in Priority areas and in the last quarter of 2017/18 NHS-Trusts in non-priority areas are now required to submit to the National teams with copies advised to the CCG.

The reviewed returns contain details of staffing levels, staff trained, referrals made to channel and other relevant activity which is significant to the Prevent agenda. The reporting providers have over the year moved towards significant assurance of the level of trained staff and have developed creatively PREVENT champions in larger organisations available in clinical areas for direct advise and support when required.

The CCG also are represented on the Nottingham Strategic Prevent steering group. The representation enables further details being cascaded to advise and support the Leads in provider services. The CCG has further advised that health representation to CHANNEL panel should be from the mental health trust due to the input and services potentially required for cases heard at this meeting.

- Audit and Inspection 2017/18 – by maintaining and developing assurance processes

  a) Markers of Good Practice visits - Section 11 assurance tools using the Markers of Good Practice (MOGP) model were updated and shared with the LSCB in 2017/18. Actions plans were devised as necessary. The Designated Nurses Safeguarding Children, for both city and county when services and contracts cover the wider areas, participate in joint quality reviews of services specifically reviewing safeguarding practice. Services specifically delivered to the City are visited as above and some are in conjunction with the CGG Quality Governance Team.

  b) Safeguarding Children Board Multi-agency audit - the CCG in 2017/18 has continued to engage in the multi-agency audit programme for the NCSCB by reviewing GP records. Learning has subsequently been shared with the individual practice and

disseminated messages have been made through links with Practice Managers, presentations to the GP Safeguarding leads meetings and through Safeguarding newsletters. In the 2017/18 programme the Independent Chair of the NCSCB requested a mock-JTAI process. The aim was to test the anticipated process and establish how key partners would bring the wealth of information together into the multi-agency arena, within a specified time. The CCG safeguarding team co-ordinated the responses for Health Providers, supporting the submissions and with the details audited from Primary Care submitted a collated response within the timescales identified. The Designated Nurse has a working group with Named Professionals to consider preparation processors and collation of details for the potential themes of JTAI in the future.

c) GP Standards visits - A programme to review 10 GP practices in 2017/18 has been jointly managed by the Designated Nurse Safeguarding Children and the Adult Safeguarding Practitioner. In discussion with the Designated Nurse for Looked after Children visits included all three keys areas and the GP standards tool revised with LAC elements added prior to the visits. The findings were based on a combined audit tool incorporating both national and local requirements and at visits explored the individual practices processors and from this noted key learning requirements to be developed in 2018/19. The dip test of the practices in 2017/18 was reviewed in the CCG Safeguarding meeting and continues to be embedded into the GP offer and therefore will continue to be an annual requirement. The outcome of the visits noted significant assurance and all practices openly accepted suggestions and assistance to continue to improve practice where required.

d) CCG Assurances - The CCG's previously reported 360 degree audit of 2016/17 was updated and the outcome was noted outcome was of Significant Assurance. This review was based on previous details from the CCG responses to the sec11 return in 2016. As noted in the CCG's Discharge of Statutory Duties and Functions for Safeguarding the CCG has submitted to NHSE, as a second wave pilot, an assurance tool based on the reporting requirements in line with the statutory guidance to Safeguard Children including Looked after Children and Adult Safeguarding. The initial submission in October 2017 has been given assurance and the tool can be updated in live time. Following a presentation of the NHS England Safeguarding Assurance Tool (SAT) to the Business Management Group of the Nottingham City Safeguarding Children Board the tool will be the CCG submission to demonstrate assurance of section 11 requested in 2018/19.

- Learning and Development

GP/Primary Care learning and development continues through a variety of safeguarding forums. Significantly this is through the GP Safeguarding Leads

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meetings, which is predominantly children and young people based, but updates have included adult safeguarding and relevant themes. In 2017/18 the meetings have continued to be supported by the Designated Health Professionals with support from members of the multi-agency safeguarding partners.
During 2017/18 the following training opportunities has been delivered to Primary Care in Nottingham City - 1) Seminars on key themes 2) Bespoke packages to some surgeries when specific needs were identified, 3) GP Safeguarding Leads as per agenda and 4) PLT for Safeguarding Children. All of the sessions had significant attendance and learning was evident in the GP Standards visits undertaken in 10 practices in the 2017/18 period. Alternative training opportunities have been shared with all Primary Care teams in the city. During 2017/18 the anticipated development of the Practice Nurse Safeguarding forum had to cease due to the complexity on developing around the needs of the practice nurses release from practice, considering complex work patterns and pressures to the services. However there remains an appetite for this group and further consideration in new developments proposed by Greater Nottingham Clinical Commissioning partnership around the professional developmental requirements for Practice Nurses.

There remains a positive response from GP practices when details are requested for potential Serious Case and/or Learning reviews conducted in 2017/18. The GP practices have fully engaged in sharing information by interviews and further participating in multi-agency Practitioner events when arranged by the NCSCB as part of the review process. The Safeguarding Team at the CCG recognise this valuable input and acknowledge learning time for the continuing professional development and revalidation of these professionals involved.
CCG staff continue to use the agreed e-learning package for Safeguarding matters relevant to the required training matrix. Specialist professionals working in the CCG have been given the appropriate support to undertake the required level of professional development as identified in the Intercollegiate Guidance (2014)
Local learning from reviews in Nottingham City are shared through the cascade of internal newsletters for the CCG and Primary care staff and to all safeguarding leads within organisations commissioned for the resident population of Nottingham City. These have been multiagency bitesize learning briefings. The CCG has proactively engaged in the promotion of alternative learning with the animation “Was Not Brought” (WNB) and in conjunction with the Board Office have promoted to a significant number of CCG’s and other local and national health partners.
Following the recognition and positive response to the WNB animation consideration was given to being transparent with the public around encouraging rescheduling appointments for health care across the health communities. Not taking away the positive rethinking of the professional’s message from WNB, the Designated Nurse Safeguarding Children applied for a non-recurrent grant from NHSE. On the successful receipt of the grant the CCG has developed a powerful message to encourage citizens to reschedule health care via a powerful message called “Missing Appointments Matters”. This has been in conjunction with colleagues involved in the WNB and additional members of the wider safeguarding networks. Following the cascade of this animation locally there will be an evaluation report made. Anyone requesting details of the animation from the wider networks will be asked to share any responses from using the animation within settings.

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2) What has been the impact of that work?

The CCG and all services reviewed through quality monitoring and safeguarding visits as noted in this report continue to demonstrate a high priority in recognising the need to keep children and young people safe when in contact with health agencies. In primary care this continues to be achieved by the Safeguarding Leads meetings and the dissemination of learning resources and training relevant to needs being identified. It has been identified in 2017/18 this continues to be a challenge as resource constraints, service redesign versus the need to ensure the productive development of professionals remains constant. The continued review of how to deliver messages has been noted, but due to redesign new approaches will have to be developed to ensure staff are trained and prepared for situations presented in everyday practice. As noted this will be considered for the Practice Nurse forum.
A further key development is the pilot of the “Multiagency GP information exchange” (MAGPIE) meeting previously known as “Red Card”, which links Primary Care with key community health practitioners. The pilot process and development of the SOP took some considerable consultations but the pilot has highlighted a need to appropriate information exchanges with other professionals significantly education colleagues and a further piece of work has emerged in links with DSL’s to work in conjunction with the MAGPIE. The evaluation report requires further review for cascade of the projects success considering the support required for the professionals to deliver meaningful discussions to plan to support and safeguard children.
The CCG will continue to gain assurance from quality monitoring and safeguarding is reflected in visits with specific questions for all reviews and visits. When considered appropriate this will also include the designated professionals with services that have significant contacts with children and young people. The development of the GP Safeguarding tool has enhanced the monitoring and support in primary care and became part of the Primary Care offer as standard.
The CCG Safeguarding team continued to report on activity to the organisations Quality Improvement Committee. Reviews and audits are managed within activity and can be raised within the CCG Safeguarding Steering group for further discussion and actions to be considered. Following the aligning to the Greater Nottingham Clinical Commissioning partnership the Safeguarding team will report to the reconfigured meetings structures where the needs of commissioning appropriate health services for children can be highlighted and also continue to discharge the CCG statutory function.

3) 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 in conjunction with the restructuring of the commissioning arrangements. The CCG will continue to develop professionals and particularly with Primary Care in exercising their safeguarding roles and responsibilities as noted in the developments in 2017/18. This will be enhanced with the Designated Safeguarding teams working to a more cohesive working relationship continuing to drive forward the Safeguarding Agenda. The anticipated appointment of a Named Professional for Primary Care will further support developing forums and reacting to themes and enabling a knowledgeable and responsive workforce.
The CCG will continue to embed agendas of the key areas specifically related to

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safeguarding on the local and national agendas. This will be the changes which have been proposed through the Wood review 2016 and will become fully embedded in 2018/19. The anticipation of the new Working Together to Safeguard Children (2018) will support the preliminary changes made by the key stakeholders driving the safeguarding children agenda in Nottingham.
The CCG will continue to participate in local and national reviews and ensure that the health community are engaged in the process.
The CCG will react to the key developments and participate in consultations as deemed necessary to the work undertaken in prevention, safety, quality and protection.

Nottingham CityCare

Nottingham CityCare is a community health services provider, dedicated to improving long-term health and wellbeing. Our vision is building healthier communities. We are a staff-led social enterprise delivering a range of healthcare services tailored to the needs of local people and free at the point of delivery.
We are a provider of NHS services, but we're not the NHS. We build on the best NHS principles and support growth and regeneration.
At CityCare we provide a range of nursing and healthcare services shaped and developed by the needs of and wishes of the communities we serve.

Summary of Activity

- Our new Safeguarding Supervision Strategy has been implemented within the past year. This new strategy enables transference of learning and improved reflection in complex safeguarding cases. The new model promotes the embedding of learning into practice, ensuring practitioners analyse and problem solve together, promoting a shared learning environment. The model promotes group supervision to the majority of practitioners, however to enhance the learning and enable targeted practitioners additional support 1 to 1 supervision is also available. The new model stipulates that newly qualified practitioners, student practitioners (during their consolidation of practice), Safeguarding Champions and others who require additional support receive 1 to 1 Safeguarding Supervision.

- CityCare are active participants of the Multiagency Safeguarding Hub (MASH). We provide a practitioner, on a full time basis, who is located, within the MASH to contribute to the safeguarding process. Our practitioners have access to the SystmOne records of children. Our practitioners actively participate in Strategy Discussions utilising information from SystmOne as well as communicating with the CityCare caseload holder. The rota for the MASH constitutes Safeguarding Team members and qualified practitioners with broad experience in safeguarding. The Nurse Specialist for Domestic Abuse provides management oversight of our activity in the MASH and the Domestic Abuse Referral Unit (DART).

- CityCare continues to actively contribute to the DART, we have a full time Assistant Practitioner who is based within the DART supporting the DART process. Our Nurse Specialist for Domestic Abuse continues to drive the

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Domestic Abuse agenda and actively participate in the MARAC.

- Safeguarding Champions have been introduced across the children's services workforce. The Champions are qualified practitioners with a broad knowledge base and experience in safeguarding practice. They provide safeguarding supervision and/or support the MASH or Domestic Abuse agenda in addition to managing a caseload.

- The Safeguarding Training Strategy has been reviewed and changes implemented in recognition of the need to streamline face to face learning, ensuring compliance is met through achievable measures. Current training compliance figures:

Safeguarding Children Level 1-	82%
Safeguarding Children Level 2-	90%
Safeguarding Children Level 3-	93%
Domestic Abuse-	91%
Safeguarding Adults Level 1-	91%
Safeguarding Adults Level 2-	93%
MCA-	78%
Prevent-	95%

We have made significant progress in improving compliance in all areas of safeguarding training. Safeguarding training remains on the risk register for the organisation, whilst improvements are recognised we are implementing measures to ensure that all safeguarding training meets a minimum of 90% compliance.

- The Safeguarding Team's duty service remains a key priority for the service ensuring our workforce have access to expert advice and support which is readily available. The team's capacity has been reduced over the last 6 months however the duty service has been prioritised to ensure our staff receive support in a timely and accessible manner, and ultimately safeguarding practice requirements are met to ensure all people our staff comes into contact with are safeguarded to the best of our ability. In addition we offer an out of hour's advice and support telephone service, this runs from 5pm-8pm on each working day.

- The safeguarding team continue to share quarterly safeguarding updates across the organisation, to embed key learning from significant events. These are delivered to all practitioners attending the Safeguarding Champions forum and/or receiving safeguarding supervision, and are available for all staff to access online via the safeguarding intranet pages.

- In partnership with CityCare's Children's Services and NUH, the Safeguarding Team have developed and implemented a Child Death Policy. This policy ensures a consistent approach to managing child deaths and working in partnership with agencies. In addition CityCare continue to actively monitor all untoward incidents and seek learning where necessary. CityCare are active members of the Serious Case Review Standing Panel and we are a key agency with involvement in a number of Serious Case Reviews.

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- In January 2018 CityCare received a Section 11 Assurance Visit from Nottingham City CCG, the findings from this visit provided CityCare with positive assurances across the board in relation to our arrangements to safeguarding children. Although this visit was facilitated by the safeguarding team the CCG were able to talk to a variety of practitioners and managers across a number of both adult and children's services to seek this assurance. The overall summary set out that there had been a positive review of the safeguarding arrangements across CityCare's services. Training compliance was identified as a challenge for CityCare; however since this visit training compliance has increased considerably.

- The safeguarding service continues to work in partnership with multi-agency groups, having membership of the strategic boards and sub groups to ensure joined up working and embedded learning for practitioners. This includes Nottingham City Safeguarding Children's Board (NCSCB) Multi-agency Quality Assurance and Audit Sub Group, Serious Case Review Standing Panel and Local Safeguarding Children's Board.

- The Safeguarding team take an active role in the multi-agency audit led by the NCSCB quarterly. The learning from these audits comes from a true multi-agency view and is invaluable in identifying how we can work and learn better together across the partnership. This learning is cascaded throughout the workforce through our communication strategy.

Impact of Activity

- There is a planned audit for October 2018, whereby an array of aspects relating to safeguarding practice will be audited and actions implemented to promote safeguarding.
- CityCare are achieving improved levels of compliance for both safeguarding training and safeguarding supervision.
- Our activity in the MASH and DART have strengthened partnership working, ensuring robust working arrangements with partner agencies
- Our activity has provided positive assessment through the Section 11 Quality Visit that we have robust safeguarding arrangements in place.

Plans for the Future

- The Safeguarding Children's Policy is currently being updated to account for the recently published Working Together to Safeguarding Children (2018).
- The Safeguarding Team will facilitated the development of a 0-19 Safeguarding Standard Operating Procedure (SOP) for practitioners to utilise, supporting them identify their role and responsibility in safeguarding. The 0-19 Safeguarding SOP will provide consistency in practice across the workforce. This SOP will be utilised in addition to the Safeguarding Children's Policy.
- Training compliance will continue to be monitored with a view to ensuring 90% compliance is met across all areas of safeguarding training.
- A review of the current Masterclasses and Bitesize learning events is underway to establish different ways of reaching practitioners when they are

DRAFT

not able to attend these face to face training sessions. We will achieve this through a training needs analysis and findings from the safeguarding audit planned for autumn 2018.

Lead for Safeguarding.

Together they have joint responsibility for ensuring the Trust's key statutory responsibilities (e.g. supervision and training) are discharged.
Key areas of activity during 2017/18 include:

Domestic violence:

This year has seen the start of an 18 month focus on domestic violence and the impact upon families. The Trust's DV subgroup has focused on the use of routine enquiry, which will lead to earlier interventions when an adult is experiencing or at risk of domestic violence. A new DV training package has been developed to further enhance understanding in this challenging area. In November 2017 the Trust made an active contribution to the 16 Days of Activism campaign coordinated by Equation. This included a number of events, displays and the wearing of white ribbons by senior male managers. This coming November, we aim to develop this with a domestic violence conference for staff and partner agencies to launch the 16 Days of Activism 2018.

Communications:

The safeguarding team continue to run a number of events throughout the year. From January 2018 there has been a monthly focus on different safeguarding topics, including making safeguarding personal, eating disorders, 'was not brought' and self-neglect. A series of seminars were delivered to staff across the trust around the learning from multi-agency reviews.

Research and development:

The Trust has completed a research project in partnership with the University of Nottingham aimed at improving the sexual safety of patients which had been identified by the CQC as an area for improvement at a national level. Funding has been secured to develop this work further and it is hoped that we will be able to make a national contribution to the prevention of this emerging risk.

The Independent Inquiry into Child Sexual Abuse:

This year the Trust has continued to be represented at the Strategic Management Group meetings to ensure a proactive response. The Trust continues to play a key role in the Inquiry locally by supporting survivors via the survivors group, ensuring appropriate services are in place for survivors and supporting the multi-agency partnership in the preparation of information for survivors.

Internally, we have worked on ensuring that staff are kept up to date with the

DRAFT

progress of the Inquiry and we have provided assurance around our current safeguarding policies and processes. A suite of leaflets for staff and service users related to historic abuse disclosures can be found on our website.

Learning and improvement:

The Trust has a specialised safeguarding training team who deliver safeguarding training across the Trust. Training is reviewed on an annual basis and specific areas of need are identified and addressed as necessary. Evaluations of training (by both attendees and observers) are consistently high. The Named Nurse for Safeguarding continues to lead this work in line with her statutory responsibilities. During 2017/18 the Trust has developed a safeguarding leadership programme for senior clinical leaders, led by the Safeguarding Clinical Lead and this will be launched in 2018/19.

In order to ensure that learning is embedded across the Trust, we have recently introduced the framing of action plans into Quality Improvement Plans and these plans are revised on a regular basis to reflect accomplishments, changing priorities and the impact of lessons learned and changing priorities.

Compliance:

This year has seen the introduction of a Compliance Framework which can be used by individual services to measure their safeguarding compliance against the CQC standards for safeguarding. This has begun to be used across both divisions, supported by the safeguarding divisional teams. If areas of improvement are identified, a quality improvement plan is developed and monitored by the corporate safeguarding leads. Initial feedback is that this is a useful tool for staff to use to reflect on the quality of their safeguarding practice.

The Trust continues to review and update compliance using the section 11 audit tool to ensure safeguarding arrangements remain robust. In February 2018 the CCG (Clinical Commissioning Group) undertook a safeguarding quality assurance visit around children and adults. The outcome was positive in all respects and provided significant assurance that the safety and welfare of children and adults is a priority within the organisation.

Supervision:

This year the safeguarding supervision framework has been introduced to ensure that all relevant staff are receiving appropriate safeguarding supervision. The revised system includes a central database which collates data around the level of compliance with this requirement. The framework is being independently evaluated by the University of Nottingham and we will report on the outcomes next year.
We have a significant amount of development work which we wish to complete over the next 12 months, including a restructure of our team and further work on domestic violence: we look forward to updating you again next year.

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NUH

The safeguarding of all our patients remains a high priority for Nottingham University Hospital Trust. Safeguarding is a fundamental component of all care provided. NUH have recently submitted an update of trust activity to the Board and the paper below summarises this activity.

Summary of Safeguarding Activity

- Safe recruitment and managing allegations against staff NUH continues to operate a safe system of recruitment which is in line with the NHS employment check standards. A cross check against new starters entered onto our electronic staff records takes place monthly to ensure that a centrally held record of the DBS check has been retained.

- Effective staff training. The approach to delivering training changed in 2017-18. All staff view podcasts (in their birthday month) with clinical staff receiving additional safeguarding training. Level 3 children's safeguarding training continues to be delivered at face to face sessions for relevant staff. Training content remains compliant with the Intercollegiate Competency Framework 2014 and has been quality assured by the local safeguarding Boards. All mandatory safeguarding training for the year focused on Prevent. Targeted Level 3 training to staff in the Emergency Department continues with 14 sessions delivered between April 2017 and March 2018. These combined with the roll call briefings ensure staff at the front door are kept up to date with current safeguarding topics, for example; self-harm in primary school age children, professional curiosity, working with children where there are continence issues, trilogy of risk, FGM,CSE, modern slavery, child sexual exploitation, female genital mutilation and domestic abuse. All sessions evaluate well. The domestic abuse specialist nurse delivers domestic abuse training across the Trust.

- Effective supervision arrangements The Safeguarding Children Supervision Policy forms part of the NUH generic Clinical Supervision Policy. Safeguarding supervision is provided on an ad-hoc basis to members of staff when requested and as a formal debrief after a complex case. There are also specific safeguarding supervision sessions provided for specialist nurses such as the cleft lip and palate team, burns and plastics and Integrated Sexual Health Services. Where staff require specialist safeguarding support 100% of requests are met.

- Working in partnership with other agencies The Trust continues to be represented on Nottingham City Safeguarding Children's Boards and their relevant sub-groups.

- Performance management NUH provides CQC, Ofsted, and LSCB's (as required by Section 11 of The Children Act) with evidence that it is discharging its safeguarding and child death reporting duties. In May 2018 the

DRAFT

self-assessment ‘Markers of Good Practice’ were submitted to Nottingham City and Nottinghamshire County Clinical Commissioning Groups and the Local Safeguarding Children’s Boards, in order to comply with their statutory function to gain assurance from provider organisations regarding the robustness of safeguarding systems.

- Essence of Care Every November and December all wards score the Essence of Care Safety of Vulnerable Patient’s benchmark. In the children’s areas nine of the ten indicators were achieved in 90% of all areas.

- CCG Visit In October 2017 the CCG carried out its annual safeguarding quality visit to discuss and review safeguarding children arrangements in the adult and paediatric emergency departments, labour suite and one of the maternity wards. The visiting team gained significant assurance that the Trust was prioritising the safety and welfare of children and meeting its contractual safeguarding responsibilities. Staff were able to demonstrate the application of ‘Think Family’ principles.

- Child Sexual Exploitation (CSE) NUH has an identified lead as per the NHS Quality Standard Contract supported by a newly formed NUH steering group. The CSE risk assessment tool for staff has been fully implemented and is well established in the Emergency Department.

- Child Protection Information-Sharing Systems (CP- IS) Project Work continues in conjunction with NUH Information Governance and the Nottinghamshire Project Team in regards to the implementation of CP-IS. This system allows staff working in unscheduled health care settings, for example ED, to access information as to whether a child is cared for by the Local Authority or is subject to a Child Protection Plan. NUH is CP-IS ready and has been using the summary care record in the Emergency Department to check for CP-IS alerts in out of area children since April 2018. Unscheduled maternity services and Eye Casualty will be live by the end of June.

- Safeguarding Champions. The Trust has 70 safeguarding champions, with coverage in each Division, including community services. There are two safeguarding champion forum days scheduled for the coming year and champions continue to receive support via regular meetings with one of the safeguarding children’s nurses or the Named Midwife for maternity staff.

Support for Local Safeguarding Systems and Processes

- Self-harm remains a significant problem for the under 18s and this reflects the national picture in this challenging area. The significant increase in the level of activity of self-harm in under 18s is reported through Family Health governance. It is a concern that an increasing percentage of self-harm is being seen in children aged eleven years and younger. The Children’s

DRAFT

Hospital is now utilising a validated risk assessment tool for children with self-harm in the ward environment. There is on-going work and liaison with the local authority to reduce delayed discharges and ensure safe discharge planning. This includes current work between the CCG, Local Authority, CAMHS and the children's safeguarding team in the production of a pathway for children presenting to hospital with self-harm. Since April 2018 CAMHS workers have been located within QMC with the aim to improve access and support for these young people.

- Safeguarding Midwifery Update - Midwifery safeguarding activity continues to rise in both numbers and complexity (9% increase from 2016/17). Most cases the midwifery safeguarding team are involved with have multiple risk factors, the most frequent being domestic violence followed by mental health, drug and alcohol misuse. There is a corresponding increase of referrals to children social care. Safeguarding midwifery supervision continues to be delivered by the team.

- Section 47 Enquiries and Medicals are embedded within the Children Act 1989 and are led by Children's Social Care Services. NUH provide this service. Data is collated as part of quarterly returns.

- Female Genital Mutilation (FGM) FGM Prevalence Standards have been established and this data now forms part of the quarterly data collection and submission to commissioners and national sources.

Impact

- Training Safeguarding training is mandatory at a compliance level from April 2017 – March 2018 of 76% for level 1, 66.6% for levels 2 and 3. The safeguarding teams in combination with Learning and Organisational Development agreed that all level 2/3 staff should receive the WRAP training and additional training capacity was provided and is being extended into the coming year in order for the Trust to reach the 85% compliance rate expected by NHS England by the end of Q2 2018/19 Management are being asked to ensure staff book onto the relevant level of safeguarding training.

- Safeguarding Supervision Currently where staff require specialist input 100% of the requests are being met. Paediatrician supervision to review specific cases is available via a safeguarding peer review session coordinated via the Named Doctor. In 2018/19 the children's safeguarding team are rolling out safeguarding supervision for the Emergency Department and Children's Hospital Staff.

- Section 47 Medicals - The number of requests for medicals has only slightly increased from 2016/17 and 17% of these did not progress to an NAI medical

DRAFT

following consultation with the Paediatrician.

- Markers of Good Practice (Section 11) Overall NUH compliance was good (submission rated green).There are two areas rated amber and these will be reviewed and monitored via the Safeguarding Children's Committee.

- The amber items are:
  - Can NUH evidence the impact of SCR recommendations on current practice? This remains amber as this is an on-going process.
  -To ensure the organisation takes into account the views of fathers - this was a new measure following a serious case review recommendation and will be audited in quarter 2 - 2018.

- Essence of Care (Internal benchmarking) The February 2018 assessment as reported to the Quality Assurance Committee in March 2018 achieved nine of the ten indicators for good practice in 90% of wards and departments. This demonstrated a good knowledge of safeguarding processes across the Trust. No children's areas scored Red.

- Initial Health Assessments – Children Looked After NUH provides the medical input and function for this statutory service. Doctors have been made aware of the requirement to provide basic health information to care leavers who are also signposted to appropriate services.

- Child Sexual Exploitation (CSE) NUH has an identified CSE lead as per the NHS Quality Standard Contract supported by a newly formed NUH steering group. A new CSE risk assessment tool for staff has been implemented in sexual health services and ED since January 2017. This tool is to assist in more accurate identification of possible CSE and is now available on the Trust intranet for all staff to access.

- CP-IS NUH is now live with CP-IS via the summary care route and is working closely with the Nottinghamshire Local Authorities, Commissioners and other health providers to ensure implementation.

- Safeguarding Champions - In 2018/19 the Safeguarding Champions will receive additional training in current topics, yet to be decided. These will be identified via recommendations from serious case reviews and other learning.

Plans for the Future

Maintain compliance and assurance for all Safeguarding standards

- Completed markers of good practice and section 11 self-assessment tool. All

DRAFT

current deadlines are being adhered to.

Continue to improve and develop training methods and compliance

- ❖ Plans to achieve the NHS England target of 85% for Prevent training.
- ❖ Achieve Trust Mandatory training compliance of 90% for 2018/19

Work on self-harm pathways and processes with partners

- ❖ CAMHS Hospital Discharge Pathway being developed

Assurance that NUH takes into account the views of fathers

- ❖ Audit in quarter 2018/19

Priorities for 2018/19

Continue to embed learning from serious case reviews.

Work on improving the quality of the children's safeguarding referrals to the local authority. The Named Nurse Safeguarding Children is undertaking a review of the referral process and forms used.

Continue with the roll out of CP-IS in line with the local authorities 'going live'.

Nottinghamshire Police

2017/2018 has seen the embedding of the new Public Protection department following its restructure in June 2017. The force was recently subject to the HMICFRS inspection and although the report isn't due until spring 2019, the feedback shows positive improvement in how the force deals with vulnerability. A further HMICFRS Inspection is expected on 'Children' in 2018/2019.

The force has updated its Child Abuse and Child Sexual exploitation (CSE) problem profiles which include multi-agency data. These will assist multi-agency activity via the identification of gaps in delivery and focus on groups and locations, which appear statistically vulnerable.

The force has introduced a Child Centred Impact Log as a local response to the National Child Centred Policing Action Plan. This local impact log has strategic oversight at Command Officer Level and is a wide ranging benchmarking and action plan in terms of effects of policing on children in its widest sense. This includes areas such as effects on children whilst in police custody, stop search, non-criminalisation, and work with children's homes with particular reference to misisng, schools engagement and criminal exploitation of children.

The effects of domestic abuse on children continues to receive focus from Nottinghamshire Police, working closely in partnership through the MASH and particularly via Operation Encompass, a daily multi-agency information sharing meeting solely in respect to children experiencing domestic abuse. We have

DRAFT

improved our efficiency in the City MASH with the introduction of video conference facilities for Encompass.

Knife crime is the focus of concerted partnership activity in Nottingham City. Increased information sharing, via our Public Protection Notice (PPN), has been introduced highlighting children who are vulnerable as victims of, or perpetrators to, knife crime. These PPNs are now processed through the MASH and appropriately shared with partners.

The Paedophile Online Investigation Team continues to pro-actively pursue offenders of indecent images of children (IIOC). Methodology exists which assists the Police identify suspects currently using the internet to procure and/or distribute IIOC. This department has received increased resources this year and investment in IT to provide efficiencies in tackling peer-to-peer image sharing.

Nottinghamshire Police continues to respond to intelligence from the public relating to child exploitation, including Online Child Sexual Abuse Activist Groups OCAGs (aka Paedophile hunter groups). The profiles of OCAGs continue to increase nationally and locally.

With regard to child exploitation, the MASE (Multi-agency Sexual Exploitation) arrangement is now well established in the City. It is supported by the Police through the maintenance of the Children at Risk of Sexual Exploitation (CaROSE) data set, which defines the case list at each MASE panel.

The CSE Disruption Team continues, staffed by colleagues from the Special Constabulary. This team compliments the work of investigators by responding to CSE intelligence, which might not have previously attracted a Police response. The team visit suspected perpetrators or adults of concern, visit suspected hotspots, issue CAWNS and undertake follow visits on persons CAWNS have been issued to. This team has been recognised as good practice both locally and nationally, including recognition at the national awards for Special Constable of the Year.

We have delivered CSE education/awareness to selected City schools, targeting the vulnerable age range of 13-15 year olds; and their parents.
Topics included online stranger danger and grooming, particularly via social media. Evening sessions were provided to parents about healthy conversations and social media awareness. A media campaign was delivered alongside this project which reached 115,000 on Facebook and 3.8 million on Twitter.
Maintaining momentum, Nottinghamshire Police have recently released a CSE awareness video via its social media pages.

NPS Midlands, Nottinghamshire Cluster

Summary of safeguarding activity

During 2017 to 2018 Nottinghamshire National Probation Service added to our safeguarding commitment by dedicating a Senior Probation Officer to the city MASH. Additionally, all staff were mandated to attend safeguarding children training to

DRAFT

achieve their end of year appraisal. This was regardless of how recently they had attended similar training.

Impact of that activity

The first measure has led to an improvement in the sharing of safeguarding information with other agencies; an increase in confidence that more safeguarding information is being received by NPS, alongside an improvement in the quality and timeliness of this. This contributes to risk assessments / reviews being more informed and risk management more robust, and, where appropriate, immediate enforcement action taken.

The second measure provides an assurance to NPS Midlands that all staff have had safeguarding training over the past year to increase awareness and improve practice.

Plans for the future regarding safeguarding

Clearly safeguarding remains core work for Nottinghamshire National Probation Service in accordance with national policy, procedures and practice guidance. Middle managers continue to audit cases and safeguarding children has been identified as one of the themes for the next staff conference.

<u>Child Death Overview Panel</u>

CDOP is a subgroup of the Nottingham City Safeguarding Children's Board.
The Nottingham CDOP has the responsibility of undertaking a review of all deaths (under 18 years) within the City of Nottingham under Working Together to Safeguard Children 2015.

CDOP functions as set out in working together 2015:

- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- Identifying patterns or trends in local data and reporting these to the LSCB;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- Agreeing local procedures for responding to unexpected deaths of children; and
- Cooperating with regional and national initiatives - for example, with the National Clinical Outcome Review Programme - to identify lessons on the

DRAFT

prevention of child deaths.

- In reviewing the death of each child, the CDOP should consider modifiable factors, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.
- The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area.

Overview:

CDOP has met regularly throughout 2017/18 with planned monthly meetings to ensure that cases are reviewed as swiftly as possible; however not all meetings have been required due to the reduced number of deaths during this year.

- 8 Panels have taken place
- 25 reviews were conducted
- 12 (48%) of the reviews identified modifiable factors.
- Timescales for review are significantly above the national average.
- 10 (40%) of cases were reviewed within 3 months of death
- A further 6 were completed within 6 months of death
- Making a total of 64% of cases reviewed within 6 months of death

The quality of case preparation and presentation remains consistently high, with all cases being ratified on presentation. The only exceptions being those cases pending inquest, which cannot be formally ratified until after inquest.

Membership & Attendance

- The Panel includes all key partner agencies, with appropriate health and local authority representation. Partnership attendance has been good overall, capacity challenges effecting attendance last year appear to have been resolved.
- Our Lay member continues to attend regularly, and we have welcomed a new Children's Integrated Services representative for early help and targeted family support.
- New members of the NUH Trust child death team have attended as appropriate for individual cases.

Data

During 2017/18 there were 30 child deaths in Nottingham City:

- This is an increase of 7 (30%) on the previous year, and the first increase since the 2014/15 year.
- 13 neonatal deaths, slightly up on last year, but not considered significant.
- 12 (40%) of the 30 deaths were classified as unexpected. Despite a concentrated peak at the beginning of the year this is a 12% decrease on the previous year but still higher that the 20% seen in 2015/16.
- There was an increase in the older age range during this year, a total of 8

DRAFT

deaths between 5 and 17 years, double from the previous year's total of 4.

- 6 of these 8 cases were classified as unexpected
- 1 was a young person with complex disabilities and life limiting conditions
- 1 child died of Acute Myeloid Leukemia
- Two of the deaths were referred to the Serious Case Review Standing Panel for consideration of a Serious Case Review, one case was agreed as meeting the criteria and a SCR was commissioned.

In October 2017 the LeDeR programme (Learning Disabilities Mortality Review) became live in Nottingham.

- Since then we have notified the programme of two deaths, one of which we have been informed will be subject to an LeDeR.

Deaths reviewed by CDOP

- 25 cases have been reviewed and ratified during 2017/18
- 14 (56%) were classified as unexpected deaths, requiring a rapid response process. This is up from 8 (38%) in the previous year, and a 26% increase on 2015/16 year of 7(30%)
- 9 were neonatal events – minimal change from the previous year.
- 20 (80%) were aged 4 years or under – the same percentage as the previous year and consistent
- Modifiable factors were found in 12 (48%) of cases, a very slight decrease on last year. Examples of modifiable factors:
  Risks associated with unsafe sleeping practice present
  Physical abuse / non accidental injury
  Smoking in pregnancy
  Consanguinity

- Gender breakdown - 9 Male, 16 female; this is a much higher proportion of females than previously seen
- One child reviewed was subject to a Child Protection Plan at point of death
- One case had been subject to a Serious Case Review

Serious Case Review Standing Panel (SCRSP)

The Serious Case Review Standing Panel (SCRSP) supports the statutory functions of the NCSCB as set out in Chapter four of Working Together 2015; and regulation 5 of the Local Safeguarding Children Boards Regulations

- The overall aim of the SCRSP is to ensure that Serious Case Reviews (SCR) are commissioned where they meet the criteria
- That lessons learned from SCRs and other types of review are; shared with agencies and individuals to positively influence practice, and improve the way in which they work, both individually and collectively, 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 SCRSP is a critical contributor to the NCSCB Learning and Improvement Framework

DRAFT

NATIONAL AND LOCAL CONTEXT

- The Standing Panel have contributed to the national consultation for Working Together 2018. They have reviewed their membership after considering the draft version of Working Together, and made the decision to maintain the current membership. This decision is made on the basis that all partner organisations make a valuable contribution to the work of the Standing Panel and that they offer professional challenge and scrutiny to decision making.
- It is anticipated that further development work will be undertaken to review and agree future process, once Working Together 2018 is published.

MEETINGS AND MEMBERSHIP

- The Standing Panel have continued to schedule monthly meetings, and review agendas dependent on workflow. In the 12 months up to 31st March 2018, they have met on nine occasions.
- Commitment to and attendance by members' remains positive.

SUBGROUP ACTIVITY / KEY PIECES OF WORK

- Reflecting on the previous very busy year the SCR Standing Panel are reporting positively on the reduced activity of the panel during the year 2017/18.
- During the 2017/18 year the SCR Standing Panel has considered four referrals and reviewed one case from the previous year following a single agency review. Only one of these referrals resulted in the commissioning of a SCR. This Review is near completion and anticipated to be ratified at the June Board Meeting.
- Two Serious Case Reviews have been published this year Child J in April 2017 and Child C in October 2017. Child C was commissioned by East Riding LSCB, involving Nottingham City and Hull.
- The SCR for Child L commissioned in early 2017 was completed on time and signed off by the SCR Standing Panel in June 2017. This was initially commissioned as a Serious Case Review. However following the outcome of further expert medical examination, and communication with the National Panel; this review was reclassified as a multi-agency learning review.
- The review concluded that whilst there were some areas where practice could have been enhanced, service delivery and contact with the family was of a professional standard, in line with organisational procedure and practice guidelines. A learning briefing has been produced and circulated through Board and Subgroup members, the NCSCB newsletter and the NCSCB website. It highlights learning in the following areas:
- Meaningful engagement with families, including having difficult conversations
- Effective responses to anonymous referrals
- Collaborative working with housing providers
- The SCR Standing Panel will continue to monitor the Action Plan arising from this review until completion.

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LEARNING AND IMPROVEMENT

- ❖ SCR Standing Panel Colleagues supported the delivery of the Every Colleague Matters safeguarding event run in February 2018. This is an opportunity for the safeguarding board to disseminate key learning from completed or current reviews. Two national independent reviewers commissioned by the NCSCB took part in one of the sessions, receiving very positive evaluation.
- ❖ Other sessions included a focus on having difficult conversations, and meaningful engagement with families, both key learning points from the Child L Review.

IMPACT

- ❖ The “Was Not Brought” agenda has maintained traction throughout 2017. The animation has now been viewed over 30,000 times.
- ❖ Furthermore the NCSCB has continued to receive evidence of a cultural change, a clear shift in thinking and language used in relation to children not being brought for appointments. This has included, feedback from frontline practitioners sharing cases examples, audit evidence, language used across multi-agency forums such as MARAC, and information submitted in safeguarding referrals.
- ❖ Through a task and finish group CityCare have completed work on developing a pathway for engaging with fathers. This work was initiated follow the Child K review. In addition they have developed learning tools for CityCare staff in relation to purposeful visiting.
- ❖ Nottingham City Children’s Integrated Services have progressed the implementation of Family Network Meetings. This supports the learning from reviews highlighting the need for meaningful engagement with families. Family Network meetings seek to achieve a plan for the family that is devised by the family / for the family / owned by the family.
- ❖ Learning from both Child K and Child L has been instrumental in shaping the development of GP practice safeguarding meetings. Previously known as Red Card Meetings the new process MAGPIE was piloted from Sept 2017. This new process is supported by a clear framework of expectations and guidance including templates for recording.
- ❖ NHS Nottingham City CCG have also developed a Practice Nurse forum as a result of accumulated learning from reviews, most noticeably Child J and the joint review with East Ridings.
- ❖ The SCR Standing Panel has also identified issues of confirmatory bias in relation to CSE risk associated with boys, it has raised these and as a result work has been undertaken with the Children’s Social Care Duty Teams.
- ❖ The Child L Review called for greater collaboration and joint working between housing providers and the children’s workforce. This challenge has been comprehensively addressed through programmes of work within the Local Authority, and CityCare. We have seen evidence of new joint forums effectivity supporting families to avoid eviction. Care levers in receipt of better support, and collaboration between strategic safeguarding leads.
- ❖ Nottinghamshire Healthcare NHS Trust have been instrumental communicating to the wider workforce, information in respect of Special

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Guardianship Orders; both internally and externally. This has included the development of a fact sheet which has been included in the NCSCB Newsletter and on the NCSCB webpages.

FUTURE PLANS

- In addition to fulfilling the statutory functions the main focus of the SCR Standing Panel for 2018/19 will be the implementation of Working Together 2018. This will include:
- A review of current referral processes for SCR consideration
- Develop a local procedure for completing Local child safeguarding practice reviews.
- Development of a process for engaging in National child safeguarding practice reviews.
- Review engagement in learning and improvement function of the NCSCB
- SCR Standing Panel will continue to maintain an impact log.

<u>Quality Assurance Sub Group</u>

Its role and function is to -

- Provide assurance to the NCSCB on the quality of safeguarding intervention for children and young people and the performance of agencies in carrying out their safeguarding function. This will include a focus on improving outcomes. Sub group members are expected to disseminate learning within their own organisations and ensure participation in quality assurance measures and learning events.

In order to deliver its purpose the sub group will-

- Monitor and evaluate trends and profiling for safeguarding data and report this to individual agencies and the Board.
- Develop and oversee a programme of multi -agency audits to assess and report on the quality of safeguarding interventions across Children's Services.
- To conduct an agreed quality assurance process of partner agencies safeguarding activity set against national standards. This will be undertaken through completion of the Sec 11 for the NCSCB. To analyse and report the outcomes of this to the Boards and partner agencies.
- To review the impact of the implementation of Action Plans resulting from review processes commissioned by the NCSCB.
- The Chair of the group reports to the Business Management Group and Board.

Membership & Attendance

- Membership of the subgroup is representative of the partnership and attendance at meetings has been consistent throughout the year. We have worked with DLNR CRC colleagues to secure support and involvement in audits where parents are known to their service. Where appropriate we have invited additional colleagues to attend meetings, present reports or be involved in audits.

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Summary of safeguarding activity

- The Subgroup has met as planned eight times during the year; four QA meetings and four audit meetings.
- The audit programme included the following subjects
  Interfamilial Sexual abuse (joint audit with Nottinghamshire)
  Children subject to Special Guardianship Orders
  Neglect
  Missing children
  Child Sexual Exploitation (Toolkit compliance)

In addition the group have

- Commissioned and received a report in relation to the application of thresholds and changes to the Children and Families Direct / Duty Service.
- Received a Priority Families Performance Report
- Received an overview report of the workforce survey that included a Safeguarding Board specific section. As a result of this information the QA subgroup commissioned a further comparison report with historical data to help support analysis.
- Joined a county led piece of work examining cases where children have been subject to s136 of the metal Health Act 1983
- Received an Allegations Management Performance Report (LADO)
- As a result of an audit in the previous year; commissioned through the Head of Service (children's social care) an internal audit on the quality of Child Protection Plans.
- Continued to work with the local authority to produce the agreed performance report; this has been a challenge given the implementation of a new case management system that reports are drawn from.
- Championed the development of a service/ support pathway for young people who have been sexually abused. Task group to be set up within Public Health.
- Monitored and signed off action plans resulting from audits undertaken.

Impact

- The Quality Assurance Group has maintained an impact log throughout the year and examples of positive impact include
  a) Development of case file audit tool for schools which provides a useful reference point.
  b) Evidence of the positive impact of the Was Not Brought message (medical neglect audit)
  c) Improvement in CSC CP plans noted (second audit of plans)
  d) Evidence of the impact of the dissemination of the learning from SCR Child J. (SGO audit)
  e) Improvement in the use of CSE Toolkit across agencies (Dip test audit following earlier CSE audit)

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Challenges

- ❖ The introduction of Liquid Logic within Nottingham City Children's services did present some challenges for the Quality Assurance Group as performance data was not readily available for a significant period of time. This is currently being given priority by the Nottingham Safeguarding Children's Board with the aim of multi -agency performance data being made available by all agencies.

Future Plans 2018/19

During this year the QA subgroup will also

- ❖ Continue to support the Nottinghamshire lead with the implementation of the s136 audit action plan.
- ❖ Oversee the section 11 audit findings and report these to BMG / Board as appropriate.
- ❖ Support Public Health colleagues in the development of a pathway of support for children who have been sexually abused
- ❖ Review and agree amendments /additions to the multi-agency performance framework.

7. NCSCB priorities for 2018/19

The NCSCB is enhancing its focus on responding to the priorities of children and young people that live in Nottingham, what they have specifically told us matters most to them and what needs to happen to make them feel safer and be safer.

These priorities will remain flexible for the duration of the Boards business plan and will be sharpened through the NCSCB/NCSCP's ongoing engagement with children and young people. Annually, the NCSCP will identify the specific actions required against each of these priorities with the detail being set out in the specific work plans of the Partnerships' sub groups and working groups.

The NCSCB/P has the responsibility of ensuring that all agencies have a focus on safeguarding children and ensuring that effective safeguarding arrangements are in place. This involves safeguarding children at all levels of our partner organisations and identifying those children who need early help, as well those in need of statutory intervention and protection.
Our vision is that children and young people are safe from harm, inside their home, outside their home and online. This is about providing help to all children and families by access to strong universal services which are available to everyone. The aim is to provide help at the earliest point so that help is provided quickly and children and families receive the support they need to become independent of services.

The NCSCB will ensure it focuses its attention on the following groups during the timeframe of its 3 year business plan:

- ➢ Children at risk of Neglect
- ➢ Children at risk of exploitation and abuse in all forms including knife crime and county lines

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- Children at risk of domestic abuse
- Children in Care
- Young adults leaving Care
- Child at risk of exclusion from education and those that have been excluded
- Privately fostered children
- Children with emotional health and wellbeing needs
- Children with disabilities
- Unaccompanied children
- Children in custody
- Children at risk of radicalisation
- Children at risk of Female Genital Mutilation
- Children at risk of Forced Marriage/ Honour Based Violence
- All other identified safeguarding themes that may emerge and be identified

The NCSCB shall, through a variety of means including self-assessment, management of the performance framework, audit, peer review and external inspection progress these priorities. The NCSCB recognizes that continual improvement is required so that it fulfils its statutory functions as set out in Working Together 2015.

The NCSCB shall ensure that it is effective in discharging its responsibility by:

- Use of performance data to regularly and effectively monitor front line practice
- Listening to, hearing and acting on the voice of the child
- Use of multi-agency audit to improve safeguarding practice
- Ensuring that learning from child deaths and significant incidents is central to the NCSCP work
- Evidence of challenge including section11 audits to improve safeguarding practice
- Embedding learning and improvement activity so that impact may be captured
- Monitoring the application of locally agreed thresholds.
- Engagement with children, parents/carers and front line staff as well as the wider community

The NCSCB would like to thank all partners for their dedication hard work and commitment and is looking forward to continuing to work as a partnership in 2017/18 in order to strive to improve outcomes for children, young people and their families.

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