Nottinghamshire
SAFEGUARDING
CHILDREN Board

Working in Partnership to Safeguard
Children & Young People

ANNUAL REPORT

2013 – 2014

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Essential information

This report has been compiled on behalf of the Nottinghamshire Safeguarding Children Board (NSCB) by Steve Baumber, NSCB Manager. The format and content has been guided by the Association of Independent LSCB Chairs suggested model for annual reports (May 2013). It has been produced in consultation with members of the NSCB Executive and approved by the NSCB. The content is drawn from the work of the NSCB and its sub groups including; reports presented to those groups; records of meetings; multi-agency audit findings; s.11 self-assessments; and the findings from serious case reviews and other forms of case review.

The report will be published in October 2014 and will be a public document.

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

FOREWORD FROM THE INDEPENDENT CHAIR

Foreword from the Independent Chair

Welcome to the 2013/14 Nottinghamshire Safeguarding Children Board (NSCB) Annual Report. The report provides an overview of the Board's work during 2013/14, our view of the effectiveness of local arrangements for safeguarding children and young people, the challenges we face and our priorities for meeting these over the coming year and beyond. I hope that you find it informative and interesting.

I would like to thank all members of the Board, its sub groups, staff and the many individuals who have assisted the Board over the last year for their commitment and valued contribution. Without this the achievements outlined in this report would not have been possible. Particular thanks to Val Simnett and Neville Hall who have recently stepped down from chairing two of the NSCB sub groups, and to Cathy Burke and John Slater for taking on new roles.

Chris Few
NSCB Independent Chair
April 30, 2014

LOCAL BACKGROUND AND CONTEXT

Local background and context

POPULATION AND DEMOGRAPHY

(taken from the Joint Strategic Needs Assessment, census for Nottinghamshire and other data sources)

- Approximately 162,144 children and young people under the age of 18 years live in Nottinghamshire. This is 20.5% of the total population in the area.
- Approximately 17.1% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14.2% (the national average is 18.1%)
  - in secondary schools is 12.1% (the national average is 15.1%)
- Children and young people from minority ethnic groups account for 7.2% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Any Other White Background, White and Black Caribbean and Any Other Mixed Background.
- According to the last available information the vast majority of children and young people have Christianity as their stated religion followed by of no religion or religion not stated. The largest religion after Christianity is the Muslim faith.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 5.5% (the national average is 18.1%).
  - in secondary schools is 4.2% (the national average is 13.6%).

There are estimated to be between 7,000 and 12,000 children and young people with some form of disability (aged 0-19) in the county. More than one in six Nottinghamshire pupils have some kind of special educational need (SEN). Districts with the highest percentage of children with SEN are Mansfield (20.4%), Ashfield (19.1%) and Gedling (18.0%).

Census data identifies 2% of the 0-15 population as having caring responsibilities for another person. More recent estimates suggest that nearer 8% of young people (equating to 12,400 in Nottinghamshire) provide care.

LOCAL BACKGROUND AND CONTEXT

Between October 2013 and February 2014, 2708 early help initiations were recorded as part of the early help dataset. These relate to requests for services or to log early help assessments. Over eighty-eight percent of early help initiations were requests for services from early help services (fifty per cent for Children's Centres and forty-two per cent for Targeted Support). The remaining eleven per cent of early help initiations were for the logging of early help assessments with the Early Help Unit (forty-seven cent were logged by schools). During the same period 826 early help (CAF) assessments were completed and 1797 cases closed by services.

In March 2013 there were 788 children in Nottinghamshire subject to a child protection plan which was much higher than the national average and our statistical neighbours. In response a significant amount of work including additional training and a multi agency audit of initial child protection conferences has taken place and at the end of March 2014 the number of children subject to a child protection plan had decreased to 587. Further details of work in this area are included later within this report.

There has been an overall decrease in numbers of looked after children during the year, from 892 at the beginning of April to 830 at the end of March 2014; the drop in numbers has been consistent since September 2013 when the number of looked after children stood at 906. Over the previous 4 years, Nottinghamshire's rater per 10,000 looked after children had increased from 36 to 53.9; as at the end of March 2014 this has dropped slightly to 51.2 and remains below that of statistical neighbours and England averages of 60.6 and 60 (figures as at end of 2012-13).

STRATEGIC PLANS AND STRATEGIES

The Health and Wellbeing Board produces the Joint Strategic Needs Assessment (JSNA) for local authorities and Clinical Commissioning Groups. The JSNA provides a picture of the current and future health and wellbeing needs of the local population and includes a chapter on Children and Young People with key messages. This chapter has recently been revised and will be available in September 2014 via http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx

The Health and Wellbeing Board then uses the JSNA to agree priorities in order to develop the Health and Wellbeing Strategy. The Strategy will, in turn, help to shape local health and social care commissioning plans. The NSCB uses the JSNA to inform its own priorities and during the year a breakout session of the NSCB was used to look in depth at the JSNA to ensure account was taken of the information contained within it. In due course the new Chapter on Children and Young People will be presented to the NSCB.

The new Children and Young People's Plan for 2014-16, was approved in March 2014. The plan guides the work of the Children's Trust and identifies the main activities that will be undertaken to improve the lives of children and young people. The plan was developed in collaboration with the

LOCAL BACKGROUND AND CONTEXT

NSCB and the Independent Chair took an active role in the identification of the priorities and delivery arrangements.

Children and Young People's Plan 2014-16 Priorities:

- *Work together to keep children and young people safe*
- *Improve children and young people's health outcomes through the integrated commissioning of services*
- *Close the gap in educational attainment between disadvantaged children and young people and their peers*
- *Provide children and young people with the early help support that they need*
- *Deliver integrated services for children and young people with complex needs or disabilities*

This work is underpinned by a new approach to the integrated delivery of the County Council children's services with an emphasis on locality working

The relationship between the Health and Wellbeing Board/Children's Trust and the NSCB is included within the governance and accountability section of this report but fundamentally exists to ensure that the strategies and plans developed by these bodies take full account of the need to safeguard and promote the welfare of children and young people.

The Safer Nottinghamshire Partnership has overall governance responsibilities for multiagency work to respond to and tackle domestic violence. Links have been established between the NSCB, Safer Nottinghamshire Partnership and Police and Crime Commissioner to ensure coordination of work to address the adverse impact that domestic violence has on children and young people as well as other public safety issues are likely to have on the safety and welfare of children. A number of NSCB members also sit on the Domestic Violence Executive, part of the Safer Nottinghamshire Partnership arrangements, providing direct lines of communication.

STATUTORY AND LEGISLATIVE CONTEXT

Statutory and legislative context

The NSCB was established in accordance with the Children Act 2004 and for the period covered by this report operated within the statutory guidance '*Working Together to Safeguard Children 2013'.* The NSCB is independent and provides the key statutory mechanism for agreeing how organisations within Nottinghamshire cooperate to safeguard and promote the welfare of children and for ensuring the effectiveness of what they do.

Core functions of the NSCB are:

- Developing policies and procedures for safeguarding and promoting the welfare of children in Nottinghamshire in particular:-
    - The action to take when there are concerns about a child's safety or welfare including thresholds for intervention
    - Training of persons who work with children or in services affecting the safety and welfare of children
    - Recruitment and supervision of persons who work with children
    - Investigation of allegations concerning persons who work with children
    - Safety and welfare of children who are privately fostered
    - Cooperation with neighbouring children's services authorities and their Board partners.
- Communicating to individuals and organisations in Nottinghamshire the need to safeguard and promote the welfare of children and raising awareness of how this can best be done.
- Monitoring and evaluating the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.
- Participating in the planning of services for children in Nottinghamshire.
- Undertaking reviews of serious cases and advising the local authority and their Board partners on lessons to be learned.
- Putting in place procedures to respond to unexpected child deaths and collecting and analysing information about all child deaths in Nottinghamshire.

The NSCB does not commission or deliver frontline services or have the power to direct other organisations but does have a role in making it clear where improvement is needed. Each Board partner retains their own lines of accountability for safeguarding. The NSCB continues to provide a full programme of multi-agency training.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

Governance and accountability arrangements

The NSCB has an independent chair, Chris Few, who was appointed to the role in 2009. His current tenure runs through to June 2015. The chair is responsible for making sure that the NSCB operates effectively and has a strong independent voice. The independent chair is accountable to the Chief Executive of the Local Authority for the effective operation of the NSCB and has regular meetings with the Chief Executive, the Lead Member of Children and Young People and the Principal Social Worker and with the Local Authority Corporate Director for Children, Families and Cultural Services, as part of scrutiny arrangements for the overall effectiveness of safeguarding arrangements in Nottinghamshire.

More widely, accountability for the effectiveness of the NSCB is through this annual report which is presented to the Local Authority Children and Young People's Committee, the Health and Wellbeing Board, the Police and Crime Commissioner. It is also published.

The NSCB is represented at the Nottinghamshire Children's Trust and the Health and Wellbeing Board ensuring that safeguarding children is a priority in their work. Members of the NSCB have contributed to the Children and Young People's Plan and the Health and Wellbeing Strategy. Regular meetings between the chairs, and relevant officers, of the NSCB and Nottinghamshire Safeguarding Adults Board have taken place recognising the connection between the two areas of work and providing the opportunity to share details of priorities and good practice.

A 'cross authority' group meets to coordinate the work of the NSCB and Nottingham City Safeguarding Children Board. This group has a work plan which identifies joint areas of work and agreed actions with the main objectives being to avoid any duplication of effort for those agencies that work across local authority boundaries and to work collaboratively on shared priorities. There is a continuing commitment to maintain joint inter-agency safeguarding children procedures and practice guidance.

The NSCB Manager has continued to link in with the Nottinghamshire Young People's Board attending as required. Members of the NSCB also sit on the Strategic Management Board of the Multi Agency Public Protection Arrangements (MAPPA) ensuring connectivity with public protection work.
The NSCB Chair, along with the chairs of other local partnership bodies, has regular meetings with the Police and Crime Commissioner.

NSCB membership is drawn from agencies in Nottinghamshire that have a statutory duty to cooperate with the Local Authority in the establishment and operation of the board. In addition a representative

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

from the voluntary sector provides an invaluable link to the network of non-statutory organisations that provide services to children and families. During 2013/14 representation on the NSCB was strengthened by the inclusion of a senior manager from NCC Education and Inclusion Services. A representative from Public Health now attends the NSCB following the transfer of responsibility for public health commissioning to Nottinghamshire County Council. Two lay members sit on the Board and provide an important perspective to the NSCB on behalf of our communities and the lead member for Children's Social Care attends the Board as a participant observer. The contribution of designated health professionals advising the board and taking part in the activities of the sub groups continues to be a particular strength. A full list of members of the NSCB is attached as **Appendix A.** .

The District and Borough Council Safeguarding Group provides an effective link between the safeguarding leads within the District and Borough Councils and the NSCB. This group remit has been extended to include safeguarding adult issues as many of the members have dual responsibilities and the Nottinghamshire Safeguarding Adult Board are represented providing a further opportunity to coordinate work. The forum for designated persons in education led by the Safeguarding Children in Education Officer (SCIEO), meets once a term and facilitates direct communication between the NSCB and a wider representation from education services, complementing the work of the education representative on the board.

The NSCB is supported through funding contributions by key partner agencies which finance the services of the independent chair and a small number of staff that facilitate the work of the board including; NSCB Manager, NSCB Administrator, Development Manager, Training Coordinator and Training Administrator. Partnership funding also supports the resourcing of the Safeguarding Children Information Management Team (SCIMT) which facilitates the communication of safeguarding information between local authority areas as well as providing a means for initial checks regarding child protection plans and children's social care involvement with families. A summary of the financial arrangements is included in **Appendix B**.

The NSCB has explored new ways to more effectively carry out its functions. A development day took place in April 2013 and the NSCB Constitution (available at www.nottinghamshire.gov.uk/nscb) was revised to reflect new structures and responsibilities. The Constitution sets out how the NSCB operates, how decisions are made and details what inter-agency arrangements are in place to make sure that individuals and agencies effectively safeguard and promote the welfare of children and young people in Nottinghamshire. The role and expected performance of NSCB members is also defined

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

within the document. An accompanying organisational chart provides further detail on reporting arrangements.

The NSCB has met on four occasions during this year as part of its normal cycle of business meetings. A further extraordinary meeting was convened to consider the FN13 serious case review findings and approve the independent author's report.

An Executive group has delegated authority to deal with a range of issues on behalf of the full board including performance monitoring and overseeing the effective operation of the sub groups outlined below, this group also met on four occasions. The Executive is chaired by the Vice Chair of the NSCB who is the Assistant Director for Social Care at Nottinghamshire Healthcare NHS Trust. Its membership comprises the Chairs from each of the NSCB sub groups and senior decision makers from organisations represented on the Board. The NSCB has four sub groups to take forward specific areas of work and each one is chaired by a member of the board:-

LEARNING AND DEVELOPMENT

The work of this group was refocused during the year to take on a more strategic function with the Training Pool managing the delivery of multi-agency training. The group meets quarterly and is chaired by Joh Bryant (Head of Housing, Broxtowe Borough Council). It is responsible for evaluating learning from a range of sources and contributing to the dissemination of that learning; developing the NSCB multi-agency training programme and ensuring it is effectively delivered, evaluating the impact of NSCB training and quality assuring both multi-agency and single agency safeguarding training.

MULTI AGENCY AUDIT

A newly formed group created to strengthen the multi-agency audit work carried out by the NSCB under its Learning and Improvement Framework The group was chaired by Anthony May (Corporate Director NCC Children, Families and Cultural Services and met every 2 months). The group was responsible for setting the NSCB audit programme for the year, ensuring the effective delivery of that programme, contributing to the dissemination of learning and impact evaluation arising from audits

CHILD DEATH OVERVIEW PANEL

This panel meets every six weeks and until recently has been chaired by Val Simnett (Designated Nurse, Nottinghamshire Clinical Commissioning Groups (CCGs). The CDOP ensures that the NSCB gains a better understanding of how and why children in Nottinghamshire die and uses the collective

findings to take action to prevent deaths and improve the health and safety of all children in our communities. The panel is responsible for overseeing the immediate response to unexpected child deaths and for reviewing all child deaths

SERIOUS INCIDENT REVIEW

This group meets monthly and until recently was chaired by Neville Hall (Area Director CAFCASS). The group makes recommendations on whether there should be a review carried out in relation to the way a particular case was dealt with. Reviews recommended by the group could take the form of a Single Agency Review, a Multi-Agency Learning Review or a Serious Case Review. The NSCB Independent Chair decides when a SCR should be instigated. The Serious Incident Review group is responsible for formulating the scope and terms of reference for reviews, deciding on the appropriate methodology and then monitoring the completion of action plans arising from such reviews. The group ensures that the learning from reviews is disseminated through the appropriate mechanisms of the NSCB Learning and Improvement Framework.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

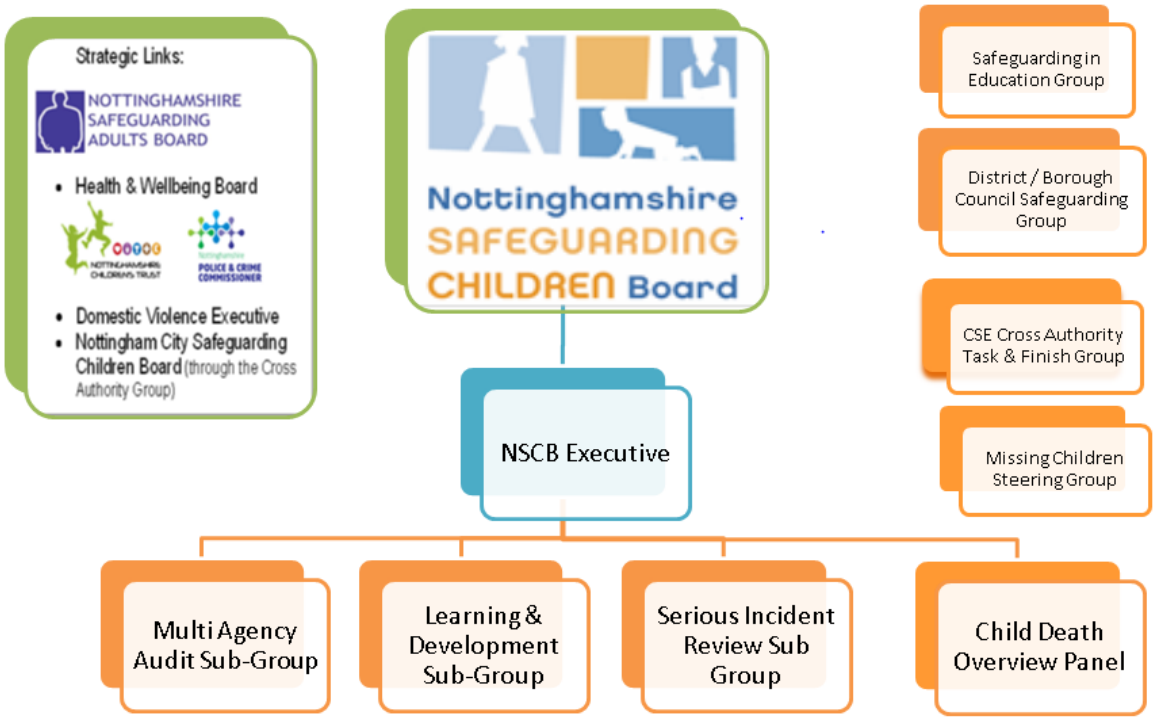
LEARNING AND IMPROVEMENT

The NSCB Learning and Improvement Framework was developed and implemented during 2013-14 and is set out within the new interagency procedures. The purpose of the framework is to enable organisations to be clear about their responsibilities to learn from experience, act and secure improvement as a result.

The NSCB Learning and Improvement Framework components include gathering information from children and families, analysis of performance data on a range of activity from early help through a child's journey in the child protection process, feedback from frontline staff, section 11 audits (further detail later), reports on agencies' critical issues and learning from inspections and thematic reviews. The framework describes the way audit, serious case reviews, learning reviews and child death reviews contribute to developing learning, improving practice and the setting of priorities for the work of the Board.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

NSCB ORGANISATIONAL CHART AND STRATEGIC LINKS – 31 MARCH 2014



PROVISION OF POLICIES, PROCEDURES AND GUIDANCE

Provision of policies, procedures and guidance

A new set of inter-agency safeguarding children procedures have been jointly developed with Nottingham City Safeguarding Children Board in collaboration with Tri X, a company specialising in web based safeguarding procedures. A wide ranging consultation process took place to develop the procedures which included workshops involving practitioners and managers from partner agencies. The new procedures provide clear advice, and where appropriate instruction, about the actions which need to be carried out whilst being concise enough to be practically useful to staff. They reflect the changes to practice implicit within Working Together 2013 and take on board the recommendations of the Munro review into social work. Learning from local serious case reviews, learning reviews, audit and performance monitoring work have been incorporated into the procedures and guidance.

The core procedures section provides the frame of reference for multi-agency practice in Nottinghamshire and Nottingham City with key new or updated content including:

- *A greater emphasis on early help.*
- *An expanded and updated section on medical examinations.*
- *Updated material on bruising to babies and bite marks.*
- *A new chapter on assessment principles with links to more specific assessment processes.*
- *Re-written content in the child protection conference chapter.*
- *A new organised and complex abuse chapter.*
- *An updated and strengthened chapter on information sharing.*

Safeguarding and Practice Guides provide further guidance for practitioners and include new or updated content on the following:

Bullying

Children of parents with learning difficulties or mental health problems

Historical abuse

Effective core groups

Sexual abuse

Emotional abuse

PROVISION OF POLICIES, PROCEDURES AND GUIDANCE

The impact the new inter-agency safeguarding children procedures and guidance have had will be evaluated through follow up workshops in September 2014 where information will be gathered from practitioners on how the procedures have supported frontline work. Early feedback has been positive with reports of improvements in correct procedures being followed. Systems to analyse the level of access to the procedures and practice guidance have been incorporated into the procedures and dip sampling will take place to get further direct evaluation from staff and inform future priorities.

Early Evidence of the New Interagency Safeguarding Procedures Taking Effect

A number of recent cases where there have been suspected bite marks to children have demonstrated improvements in practice through following the new procedures. The Police and forensic odentologists have been informed prior to medical assessments of the children and this has ensured that the correct expertise is available at the time of the assessment reducing the need for further examinations and therefore providing a better outcome for the children concerned.

The new interagency safeguarding procedures link to associated key documents and processes including the Pathway to Provision which sets out guidance for practitioners in identifying a child, young person and/or family's level of need, and referral pathways to the most appropriate service to provide support. In October 2013 the NSCB took responsibility for the approval of the revised Pathway to Provision in line with Working Together 2013 which requires Local Safeguarding Children Boards to provide policies and procedures on thresholds for intervention.

Pathway to Provision – Clear Thresholds for Accessing Services

As part of the approval process Board members took part in an exercise to review real life case studies taken from the Multi Agency Safeguarding Hub (MASH). The application of the Pathway to Provision Guidance was tested and found to be effective overall. The decision taken by the MASH in one case was referred back for further consideration.

The NSCB website has been revised to improve accessibility to information. The site provides a source of information for the public on identification and responding to concerns for children and includes links to further advice, such as the Child Sexual Exploitation (CSE) E learning module for parents and carers. It also provides information for professionals in support of their work. Further improvements are planned as part of the Business Plan 2014-16 **(Appendix C)**.

LEARNING AND DEVELOPMENT

Learning and Development

During this period learning and developmental activities were supported by NCC Workforce and Development staff and the NSCB Manager until the appointment of an NSCB Training Coordinator in January 2014. A full NSCB training programme has been delivered during 2013/14 and since her appointment the new Training Coordinator has taken a lead role in refocussing the work of the Learning and Development Sub group and developing a new training strategy. The NSCB Training Pool, with an enthusiastic and committed membership drawn from partner agencies, delivers much of the NSCB Training Programme and their contributions are greatly appreciated.

Key Achievements

- Established and developed the new Learning and Development Sub group, with a clearer strategic focus. Members of the sub group reviewed and revised the terms of reference for the group to ensure compliance with Working Together to Safeguard Children 2013 and devised its yearly work plan ensuring that the group contributes to the effective implementation of the Nottinghamshire Learning and Improvement Framework and the key priorities of the NSCB.

- The 2013/14 Training Programme was agreed and delivered. All of the courses went ahead with the exception of two half day seminars on CSE, which were cancelled and replaced with full day courses following evaluation. In addition, as a result of a need identified through links with frontline practitioners additional training courses regarding child protection medical examinations were added to the programme and delivered.

- Links with the Child Death Overview Panel, Serious Case Review Sub group and Multi Agency Audit Sub group have been strengthened to ensure that learning gathered through these processes is effectively incorporated within the training programme and disseminated.

- The evaluation process for NSCB multi agency training has been strengthened and further developed. In addition to the immediate post course evaluation, a follow up process has been implemented to gather information about the impact training courses have made on practice and therefore the outcomes for children and young people.

LEARNING AND DEVELOPMENT

TRAINING DELIVERY

The Training Programme delivered comprised: E Learning, core safeguarding training events, and subject specific trainings events on key safeguarding issues identified throughout the year. The programme included a series of 'What's New in Safeguarding' seminars that were used to disseminate the learning from reviews and case audit as well as providing updates and new information on a range of other issues including; Female Genital Mutilation (FGM), Missing Children, E Safety, Managing Allegations and Private Fostering. A specific 'Learning from Case Reviews' seminar was held jointly with Nottingham City Safeguarding Children Board and this addressed learning from local and regional reviews. Other methods of disseminating learning include briefings to specific staff groups by NSCB officers, the NSCB Newsletter, briefing papers to Board members and new 'Learning and Improvement Bulletins'. See **Appendix D** for details of training events delivered and take up by organisations. Attendance has remained consistent across all agencies but there has been a slight reduction in attendance as a whole which may be a consequence of the organisational change taking place in agencies over this period.

E learning continued to be offered to all partner agencies. The principal course, 'Awareness of Child Abuse and Neglect' was available to staff from all partner agencies alongside specific versions for police staff and those who work with young people in an education setting. A total of 1,749 licences were allocated to users between the period of 1 April 2013 to 31 March 2014, in comparison to 4668 the previous year. The allocation of licences was much higher during the previous year due to Nottinghamshire Police issuing 3206 licences as part of an initiative to bring all frontline staffs' basic awareness of Child Protection up to date and the majority of them completed the course by November 2012. The completion rate (licences issued against courses completed) was 69% for this year (1331) and course completion reminders are sent out to encourage full completion of the modules.

In February 2014 a significant number of the NSCB members attended a two day Multi-Agency Critical Incident Exercise (MACIE) simulation exercise where senior and front line managers worked together on several real time child protection scenarios.

TRAINING IMPACT EVALUATION

Initial course evaluation and subsequent impact evaluation has been on-going throughout this period ensuring that all learning events are of a high quality, that any feedback is monitored and course content reviewed regularly. One of the key questions asked of participants attending the core safeguarding courses is whether they were satisfied with the course as a whole. The satisfaction levels with both core courses were very positive with 96% of course participants rating the 'Introduction to Safeguarding' course as either good or very good and 80 % rating the 'Working Together' course as good or very good, indicating that the courses met their intended learning outcomes.

LEARNING AND DEVELOPMENT

Comments from Working Together Course Attendees

"As a health visitor I will use the learning in every aspect of my role. Particularly found the fact that the training was multi-agency useful, as allowed me to consider factors from other agencies perspectives and their role within safeguarding"

"I now feel much clearer on the child protection procedures and am more aware of my responsibilities in a core group"·

"I know now what is expected of me if I was asked to attend a child protection meeting. I feel confident in carrying out my responsibilities in Safeguarding children and know where to go for advice such as early help, Mash etc."

The initial course evaluations include questions that are used to ascertain how attendees judged the benefit to them from attending the training. The data below is taken as an overall average from the Working Together courses over the year and indicates the difference in confidence levels pre and post course.

Question: Please rate your level of confidence in your knowledge and understanding of the child protection process?

	None	Limited	Some	Good	Very Good
Before	0.7%	6.7%	40.2%	45.7%	8%
After	0%	0%	4.6%	48%	41.9%

This indicates that there were a significant proportion of attendees who felt they had a good base knowledge before attending the course. Prior to the course 53.7 % of participants reported either good or very good levels of confidence in their knowledge and understanding and following the course this increased to 89.9%, demonstrating a positive shift in participant's levels of confidence. The additional comments provided by participants indicated that both the training input and opportunity to network and share information with other agencies contributed to the value of the course. Similar levels of increased confidence have been evident in further questions and data collated for the courses.

LEARNING AND DEVELOPMENT

Training Evaluation Case Study

As members of the NSCB the Nottinghamshire CCGs are committed to ensuring that NHS organisations prioritise the needs of vulnerable children and families and safeguard their welfare. An example of a positive outcome from the NSCB child exploitation strategy during 2013-14 resulted in over 50 health staff from priority areas such as school nursing and sexual health services receiving training around recognising and responding to sexual exploitation.

A child in school made a disclosure raising concerns about sexual exploitation to a school nurse. As a result of the training that the school nurse had received, she responded appropriately resulting in the child and family receiving the right support and a subsequent police investigation leading to criminal prosecutions for sexual offences.

Those completing E Learning modules report high levels of satisfaction with 97% of learners saying they felt that the learning outcomes were either completely or mostly achieved.

QUALITY ASSURANCE

A Quality Assurance scheme was developed in 2012 in conjunction with Nottinghamshire Safeguarding Adults Board and the Nottingham City Safeguarding Children and Adults Board, in order to assure the quality of single agency training. Some initial work has taken place, in particular around gathering information about the suitability and experience of trainers and reviewing some introductory course materials, however further work needs to be completed to ensure this is fully implemented. The quality assurance process is currently being reviewed with the aim for a revised methodology to be fully implemented over the forthcoming year.

LEARNING AND DEVELOPMENT

Learning and Development Priorities for 2014/15

- The Learning and Development Sub group will continue to develop its role within the NSCB Leaning and Improvement Framework to ensure that learning identified from Serious Case Reviews, Child Death Reviews, multi-agency audit and other sources is consistently disseminated and built into the training programme.

- Review and revise the training quality assurance scheme and ensure it is fully implemented.

- E learning opportunities will be expanded with the introduction of a CSE module and a self-registration system to accommodate greater numbers of users.

- Continue to strengthen the NSCB multi-agency training impact evaluation process, to ensure the impact of training is analysed on a more frequent basis and that evidence is collated on the impact the learning has on the outcomes for children and young people.

QUALITY AND EFFECTIVENESS OF ARRANGEMENTS AND PRACTICE

Quality and effectiveness of arrangements and practice

The quality and effectiveness of safeguarding is tracked and monitored by the NSCB in a number of ways. A key element is the Performance Information Report (PIR) which is prepared each quarter and provides information and analysis on priority areas of performance including; early help; information sharing; section 47 enquiries; child protection conferences and plans; looked after reviews and youth justice data.

The PIR is presented to each NSCB Executive meeting and is supplemented with additional reports as required. The report is used on an ongoing basis to inform priorities for further exploration and challenge – for example the re-referrals audit by the local authority in February 2014 and the participation by agencies in child protection conferences which was examined in greater depth through the multi-agency Initial Child Protection Conference (ICPC) audit (see section later in this report). The Performance Information Report for 2013/14 is included in **Appendix E**.

EARLY HELP

Nottinghamshire Early Help Services are arranged in three locality areas, each with an early help offer and support services. The core early help offer comprises a number of children centres, youth centres and targetted support services which deliver across the 0 – 19 age range as well as supporting their parents, carers and families. Children and young people with an identified early help need will have an allocated lead professional either in one of these services or in a school, health setting or voluntary agency.

In September 2013 the Early Help Unit was established to work alongside the Multi Agency Safeguarding Hub (MASH) and provide a single access point for referral of children in need of targetted early help services.

During the year the dataset regarding early help has been refined. To supplement this the NSCB commissioned a multi agency audit of referrals to the Early Help Unit. An internal review of the early help processes was also commissioned. Both of these pieces of work will report to the Board in 2014/15.

QUALITY AND EFFECTIVENESS OF ARRANGEMENTS AND PRACTICE

CHILDREN SUBJECT TO CHILD PROTECTION PLANS

The Independent Chair Service, provided by Nottinghamshire County Council, includes Child Protection Coordinators (CPC) who chair Child Protection Conferences and complex strategy meetings. They have a central role in promoting quality in child protection practice, including ensuring that thresholds are applied consistently, and effective implementation of departmental and interagency policies and procedures.

The CPC is responsible for considering whether advocacy is required in order for the child's voice to be heard, and whether all possible has been done for the child to participate in the conference.

CPCs have been identified to take lead roles in specific areas, for example Child Sexual Exploitation, Fabricated and Induced Illness and the participation of children and young people in child protection processes.

CHILD PROTECTION PLANS

At the end of March 2014 there were 587 children subject to a child protection plan in Nottinghamshire, which was a marked decrease from the number of 788 children in March 2013. Work has been undertaken throughout the year due to awareness that the numbers of children on child protection plans in Nottinghamshire was so much higher than the national average and our statistical neighbours. There has been a sustained attention to thresholds by social work teams and CPCs, and children have only been made subject to a child protection plan, or remained subject to a plan if they have met the threshold for this.

There has been a small increase in numbers of complex multi-agency meetings chaired throughout the year, being 419 to the end of March 2014, compared to 384 in the previous year. 289 of these were as a result of allegations against professionals and 86 were as a result of concerns regarding child sexual exploitation.

CHILD PROTECTION REVIEWS

The timely review of child protection plans and distribution of the record of the meetings within the agreed timescale is an important aspect of child protection work. The year-end figure for Child Protection cases reviewed within timescale (NI 67) was 97.4%. This was slightly below the target of 98%. No reviews have been held out of timescale since October 2013. Due to sustained efforts by both business support staff and CPCs, the percentage of minutes distributed in timescale in the last

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quarter has averaged 97% a month. On the occasions when minutes are not distributed within 20 days of the conference the reasons for this are subject to management challenge.

QUALITY OF OUTLINE CHILD PROTECTION PLANS

Considerable work has been done to improve the quality of outline child protection plans, and Nottinghamshire County Council audits have found that the recommendations have become smarter. However in response to the awareness that the outline plans are too detailed further training is planned for CPCs and children's social work team managers which will explore the interface between outline and detailed child protection plans.

As part of their quality assurance role CPCs gather information and offer feedback in terms of what is being done well and what requires improvement in the child protection process. Certain information is passed to Children's Service Managers (CSMs) through the management information reports following each conference or meeting.

For ICPCs this includes comment on:

- The quality of reports
- Whether there has been any drift or delay in progressing the plan
- The engagement and participation of the young person and parents
- The quality of multi-agency working

For Review Child Protection Conferences (RCPCs) further comments are made on:

- Whether 'my protection plan' is completed (a questionnaire to gather children's views).
- Whether visits have been made to the child in timescale.
- Whether the core groups have been held in time.

In addition CPCs use the Independent Chair Service's dispute resolution process to bring urgent issues to the attention of team managers, and managers in external agencies. One hundred and forty-five alerts were raised in the reporting year, which was the first full year of this process being in use.

The following themes were identified through collation of management information forms and the alerts for the year:

- Engagement with parents and children by social workers was very good in the majority of cases.

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- The quality of multi-agency work at RCPCs and complex multi-agency meetings was noted to be overwhelmingly positive.
- The vast majority of core groups were held in the correct time scales.

Some areas for improvement were also identified as follows:

- Some social worker's assessments and risk analyses.
- Delay in a few cases in bringing children to ICPC.
- Some drift due to delay in assessments being completed or planned work not being actioned.
- Some problems in ensuring external organisations were invited in a timely way, which led to a few conferences not being quorate and unable to go ahead.
- Social workers not always visiting children at the frequency set out in the child protection plan.

There were 604 ICPCs, and 1285 RCPCs held in the reporting year, and it is notable that alerts were therefore raised following a very small proportion of conferences. Alerts were sent following 35 conferences raising the concern that drift was occurring, and following 29 conferences raising concerns that the plan was not adequately safeguarding the child.

Regarding the issues identified with the process of notifying external organisations of the need to attend conferences, CPCs raised 10 alerts for conferences when the invitations had not been sent out, and management information reports were sent through for 13 other conferences when chairs had identified that invitations were not sent out to key professionals. Although this is a small number of the total conferences, and only 8 in the year were reported as unable to go ahead due to being non-quorate, consideration is currently being given to how arrangements for the sending out of invitations could be improved. Issues with the non-attendance of external organisations were identified on only four occasions in the year. This is a strong indicator that in the vast majority of cases external organisations were invited and attended.

Nottinghamshire County Council's procedure and practice guidance (PPG) on child protection was revised and agreed in November 2013. The new guidance includes tools to assist staff in securing children's participation as well as updated versions of the agenda template and the agency checklist for social workers, which is used to help identify which organisations to invite to conferences. At the request of Nottinghamshire Healthcare NHS Trust, invitations to ICPCs to various health professionals are copied to the safeguarding teams in order for attendance to be monitored and this requirement is included in the new PPG.

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COMPLAINTS REGARDING CHILD PROTECTION CONFERENCES

In the reporting period 7 complaints were responded to by the service managers responsible for the CPC service, 2 of these related to the same family. On 2 occasions complaints made were regarding the decision to make a child subject to a child protection plan, and 2 complaints were made related to information sharing. Other complaints related to the management of the meetings by the chairs. A specific outcome from the complaints received in this reported year was that business support staff and CPCs were reminded of the complaints procedure and a revised leaflet was supplied to CPCs to be given to parents should they enquire.

PARTICIPATION AND ENGAGEMENT OF CHILDREN AND YOUNG PEOPLE WHO HAVE CHILD PROTECTION PLANS

My Protection Plan (MPP) was completed by two thirds of children over the age of 4. These are questionnaires which the social worker uses as a tool to gather the child's views at the time they are subject to a plan. This is a significant improvement from the previous year.

A sample of MPPs has been collated from the second and third quarter, and half of those who completed a questionnaire at the end of the child protection plan said that they thought the plan had made things better for them. The sample of plans looked at emphasised the importance of the child's relationship with their social worker, as 91% of the MPPs completed at the review of a plan said the child intended to use their social worker to express their views at the conference.

A range of comments were made by children on the MPP forms in the sample. These reflect the mixed views of children. Two such comments are as follows:

"…having a social worker made a difference…mum and dad got on better and it was nicer at home."

"We don't need protection, we're safe, happy and healthy".

In order to build a fuller picture this year a series of interviews have taken place with a sample of children, and their parents, whose plans have ended The interviews were arranged and led by Children's Social Care Practice Support Service and was independent from the social workers involved with the children. Questions asked included;

- How well the child's social worker had explained the reasons for the Child Protection Conference?
- Did the social worker help the child to get their views across to the meeting? and

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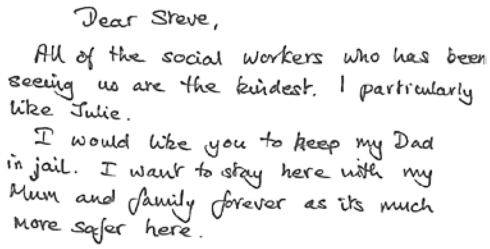
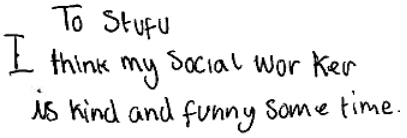
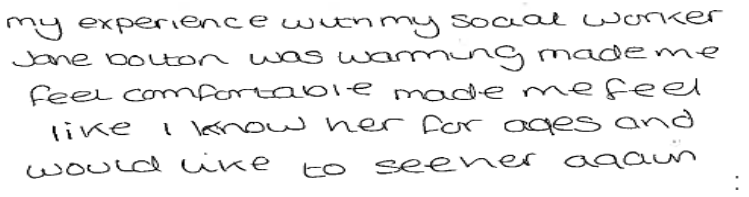
- If they attended what their experience of the meeting was.

Children who took part in the interviews were also encouraged to send a 'message in a bottle' to the Service Director for Children's Social Care who in turn has replied to each message. The following are some examples of the messages sent


Dear Steve,
All of the social workers who has been seeing us are the kindest. I particularly like Julie.
I would like you to keep my Dad in jail. I want to stay here with my Mum and family forever as its much more safer here.


To Stufu
I think my Social Worker is kind and funny some time.


my experience with my social worker Jane bolton was warming made me feel comfortable made me feel like I know her for ages and would like to seener again

A report outlining the findings from this work was presented to the NSCB Executive to support participation data within the PIR. The report noted an increase in the percentage of MPPs completed and an increase in the amount of comments made by children. This is a positive sign that children are engaging more with social workers in order to give their views. Directly relevant to the work of the CPCs is the positive conclusion that children's understanding of child protection processes is generally satisfactory. However children's participation in child protection processes was less clear. Out of the children interviewed, "some had attended, some had contributed and a small minority did not appear to have a clear (age appropriate) understanding".

NSCB leaflets for children and parents designed to explain what a child protection conference is, and what child protection is, have been revised and distributed this year.

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Data recorded by CPCs following each conference is that the views of the child were presented to 87.1% of RCPCs and to 76.5% of ICPCs in the reporting year. This is a positive picture, However the service is committed to reaching a position where voices of all children in the child protection process are heard and this remains therefore an area for further work. CPCs routinely consider whether an advocate should be considered for children to enable their views to be put across in the child protection process. As chairs, CPCs have a key role in championing the views of the child at child protection conferences.

Child Protection Conference Priorities for 2014-15

In order to develop the service further the following work is planned in the year ahead:

- Strengthening service user feedback from those attending meetings, children, parents and carers
    - Further work planned by practice support unit designed to gather the views of children and parents who have been subject to child protection plans
    - Feedback to be sought from attendees from conferences observed by Service Managers as part of ongoing QA process.
- Evaluation of the impact of the chairing of Supervision Order reviews by CPCs from 1st April. The aim of this was to provide more robust oversight of supervision orders.
- Evaluation of the impact of developing the CSE lead into a CSE coordinator role pilot, being 0.5 of a post.
- Evaluation of the effectiveness of the work currently undertaken by CPCs under their lead roles, in order to ensure knowledge base of CPCs is fully utilised in contributing to development of services to children in Nottinghamshire.
- Quality of outline plans to be further improved.

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SECTION 11 SELF-ASSESSMENT

Section 11 of the Children Act 2004 places a duty on key people and bodies to ensure that in discharging their functions they safeguard and promote the welfare of children. The NSCB is required to assess whether Board partners are effective in this regard and part of this process is the completion of a self-assessment by agencies known as the Section 11 Audit. The self-assessment tool used for the audit is based on the 'Markers of Good Practice' developed by the former NHS East Midlands Strategic Health Authority, now subsumed within NHS England. Health organisations still use the 'Markers of Good Practice' to assess their own safeguarding effectiveness and the continued alignment of the Section 11 self-assessment tool with the Markers of Good Practice minimises duplicated effort by health organisations whilst using a tried and tested safeguarding assessment tool. The audit requires agencies to assess their compliance with a series of standards, each standard includes details of the assurance required to satisfy that standard and the suggested method of measurement.

In September 2012 the NSCB agreed that the Section 11 Audit should be conducted as part of a two year cycle of self-assessment followed by monitoring of actions to address areas where organisations reported partial or non-compliance.

The audit identified a number of areas where further developmental work was required by some agencies: -

- Training - in particular the strengthening of systems used to monitor the provision of single and multi-agency safeguarding training to staff. Some agencies also reported that training materials required amendment to ensure issues around diversity were adequately incorporated

- Supervision – audit of supervision records and the monitoring of staff attendance at supervision sessions was identified as a gap by some agencies. Arrangements for providing child protection supervision was also a problem for some agencies - particularly those that had low levels of involvement in child protection cases

- Whole Family/Think Family – a number of agencies reported the need to increase understanding of the impact on children's welfare of any problems that mothers, fathers and other key carers are experiencing

- Knowledge of the procedures to follow in cases of forced marriage or honour-based violence was also identified as an area for development.

Organisations reporting partial compliance or non-compliance with any area of the self-assessment were requested to provide progress reports in October 2013 that detailed the work that had been completed and this was subsequently reported to the Board.

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The Multi Agency Audit Sub group agreed that the self-assessment tool for the 2014 Section 11 Audit should remain substantially the same as the tool used for the previous audit to allow comparison between the returns. Some minor revisions were required to take account of issues raised through the Learning and Improvement Framework and the self-assessment has now been distributed to partner agencies with completed returns required by the end of July 2014. Analysis of the returns will be presented to the NSCB Executive in early November 2014.

REVIEW FUNCTIONS

Review functions

Well established case review processes are in place within Nottinghamshire to ensure that agencies reflect on the quality of services provided and learn lessons to reduce the risk of harm to children in the future.

CHILD DEATH REVIEWS

Child Death Overview Panel (CDOP)

Whenever a child dies it is a personal tragedy for members of their family and friends. The CDOP reviews all child deaths in Nottinghamshire to identify what might be done to prevent similar deaths in the future. The panel includes Consultant Paediatricians, Specialist Nurses, Midwifery Services and the East Midlands Ambulance Service. Membership also includes representatives from Children, Families and Cultural Services of Nottinghamshire County Council, Nottinghamshire Police and Public Health. This year one of the NSCB lay members has joined the subgroup and this has brought an additional focus to the consideration of cases.

Arrangements are in place to ensure learning is shared between the Nottinghamshire CDOP and Nottingham City CDOP through regular cross authority events.

The panel has met seven times during the year and considered 44 cases (11 unexpected child deaths and 33 expected deaths). Extracts from the national data set submitted to the DfE can be found at **Appendix F** to this report. The number of child death reviews ongoing at the year-end has increased. This is due to a number of factors including the need to await the outcome of coronial proceedings, ongoing serious case reviews and the cancellation of a meeting during the year. This will be kept under review by the Chair with the NSCB Development Manager and the Child Death Administrator and additional subgroup meetings will be arranged as necessary. Of the 44 deaths reviewed, 10 were found to have modifiable factors and these resulted in action being taken by the subgroup as detailed below. There were 17 neonatal deaths reviewed by the panel, which is in line with previous years. It is noted that 18 of the deaths reviewed were attributable to known life limiting conditions – this figure is significantly higher than in the previous 3 years.

REVIEW FUNCTIONS

Child Death Review - Key Achievements

- A short film (available via the NSCB website) has been produced by young people to promote road safety in their peer group. The project that developed the film was funded by the NSCB following a number of fatal road accidents involving teenagers. Members of the CDOP and Nottinghamshire County Council's Road Safety Partnership helped facilitate young people's groups across the county to develop ideas for the film and students from West Notts College put those ideas into action and created a film which has now been launched. The aim of the project was to improve road safety awareness amongst older teenagers and reduce the number of road traffic fatalities. The sessions with young people's groups raised awareness of the issues amongst participants and the film is going to be distributed to schools with lesson plans and a further evaluation post distribution is planned.

- Messages have been promoted for:
  - the safe storage of medicines;
  - safe sleeping for babies and
  - bath-time safety for babies and young children.

- Rapid Response multi-agency training has been delivered to ensure that professionals know their responsibilities to work together immediately following the unexpected death of a child

- Child Protection Coordinators have been briefed in order to strengthen practice around initial and final case discussion meetings

- In the light of the increase in child deaths resulting from life limiting conditions, CDOP have ensured that the quality of palliative care and subsequent bereavement support provided have been reviewed when such cases are discussed. Feedback from the family is included within the review where this is available. There have been some notable examples of good practice, in particular around support for families where the end of life plan involves caring for the child at home. Amongst other things, this has involved consistency in the staff providing medical care going above and beyond to support families at such a distressing time. This reflects the improvements that partners have introduced over recent years to provide a service that enables families' wishes to be fulfilled.

The subgroup reviewed its terms of reference to ensure compliance with Working Together to Safeguard Children 2013. The subgroup's links to the NSCB Learning and Improvement Framework have been strengthened.

REVIEW FUNCTIONS

Child Death Review Priorities for 2014/15

- *The CDOP will work towards ensuring as wide dissemination as possible of the road safety film and evaluate the impact it has.*
- *Developing the role of the CDOP within the NSCB Learning and Improvement Framework and, in particular, building appropriate links with the NSCB Training Coordinator to strengthen the dissemination of learning as it arises.*
- *Continuing the work to ensure clarity over information sharing processes at the early stages of each case so that all relevant information is shared in a proportionate way.*
- *Maintaining appropriate multi-agency attendance at the panel meetings.*
- *Strengthening communications with the registrar's service.*
- *Ensuring that the communication pathway to feedback to parents where appropriate after the completion of the CDOP process is clearly defined.*

SERIOUS INCIDENT REVIEWS

A range of reviews are commissioned by the NSCB to ensure that learning and areas for improvement are identified and, where appropriate actions to bring about change, are agreed.

The Serious Incident Review Group plays a key part in this function and its responsibilities have been set out earlier in this report. The subgroup includes representatives from Children, Families and Cultural Services of Nottinghamshire County Council, Police, Probation and the Health communities, including NHCT. Four cases were referred to the sub group during the year. A recommendation to conduct a serious case review was made with regard to two of the cases referred. The sub group proposed that a single agency Learning Review be conducted with regard to a further case and the remaining case resulted in a recommendation of no further action. The NSCB chair agreed with the recommendations from the sub group and in addition commissioned a further serious case review in response to additional information about a case emerging during the associated criminal trial and Family Court processes. When a review is commissioned a code is allocated (e.g. EN12) to preserve the anonymity of the families involved.

REVIEW FUNCTIONS

Serious Incident Reviews - Key achievements

- Two serious case reviews (EN12 and FN13) were completed during the year (2013/14) and the reports have been published through the NSCB web site Serious case reviews - Nottinghamshire Safeguarding Children Board - Nottinghamshire County Council. A further report related to the CN10 serious case review, which had been completed in September 2010, was published following the completion of criminal and coronial proceedings.

- A further two serious case reviews (GN13 and HN13) that were commenced during the year were completed in June 2014 and the reports will be published in due course once outstanding matters have been addressed.

- A single agency Learning Review was completed in October 2013 and the findings reported back to the sub group.

- The NSCB has maintained links with the Nottinghamshire Safeguarding Adults Board during the course of a serious case review conducted by them into the death of a young adult to ensure relevant learning was shared.

- The Serious Incident Review Group has overseen the involvement of partner organisations in two reviews which are ongoing in neighbouring Local Safeguarding Children Boards (LSCB).

- Responsibility for evaluating the impact of serious case reviews has transferred to the NSCB full Board – this has emphasised the importance of not only carrying out reviews effectively but ensuring that senior managers are held to account for delivering the changes required from reviews.

- The role of the Serious Incident Review Group as an integral part of the NSCB Learning and Improvement Framework has been strengthened.
    - Active consideration of the appropriate methodology for reviews with a view to ensuring the most effective way of establishing the learning in each case is evident, for example traditional methodologies, Significant Incident Learning Process and learning reviews have all been used.
    - A flowchart has been developed to provide clarity on the process to be followed from consideration of referral of a case to the subgroup through to the conclusion of a review and subsequent impact evaluation.
    - The NSCB Chair's decision making has been facilitated and strengthened by the introduction of a new summary information form which provides an outline of the case, the subgroup's recommendation and the reasons for that recommendation.

REVIEW FUNCTIONS

- Progress with action plans arising from completed reviews has been monitored on a regular basis, to ensure appropriate scrutiny. The final two outstanding actions relating to DN11 were signed off as completed in October 2013. In addition, the individual agency and overview action plans relating to EN12 have been reviewed regularly throughout the year and 64 out of a total of 67 actions have been signed off.

- Tools linked to the learning from recent reviews, including the Bruising in Babies Pathway and Excellence in Safeguarding, have been disseminated to practitioners and the impact of these will be evaluated in due course.

Serious Incident Review Group Priorities for 2014/15

- *The Serious Incident Review Group will continue to develop its role within the NSCB Learning and Improvement Framework and, in particular, building links with the NSCB Training Coordinator to strengthen the dissemination and impact of learning from reviews.*

- *The subgroup will also review the current serious case review toolkit to ensure compliance with Working Together to Safeguard Children 2013 and to enable agencies to engage effectively in review processes.*

LEARNING FROM CASE REVIEWS COMPLETED DURING 2013-14

Summary of the learning identified from serious case reviews:-

Serious Case Review (EN12)

This review looked into the circumstances surrounding serious non accidental injuries being suffered by a premature baby shortly after discharge from hospital and the following learning was identified

- The significance of bruising to non-mobile babies.

- The potential challenges of caring for a premature baby and the importance of appropriate planning prior to discharge from hospital.

- The importance of seeing parents alone and raising the issue of domestic abuse throughout pregnancy.

- The importance of timely and accurate recording of information and accessing and giving proper weight to promptly recovered historical records.

- The importance of good quality supervision and ensuring that agency staff are skilled to deal with the tasks required by the role appointed to.

REVIEW FUNCTIONS

Serious Case Review (FN13)

This review related to historical serious sexual abuse that took place between 1997 and 2006 and the following learning was identified

- The voice of the child was not clearly heard and understood throughout the period by all agencies. In particular, the way in which the children's statements, allegations and retractions were viewed and the consequent impact on decision making – it was found that more weight was attached by professionals to a retraction than to an allegation and this influenced the decisions that were made.

- The failure to access and use a coherent and consistent theoretical model or framework to facilitate understanding and managing risk in sexual abuse.

- The lack of professional curiosity and willingness to intervene and take action. The review found that no-one was advocating for or championing the children and driving the case.

Learning Review

This learning review was commissioned following a baby receiving life threatening injuries – the baby's family had involvement with a range of health services and a reflective learning review was led by Val Simnett, the Designated Nurse for Nottinghamshire CCGs with support from Hannah Hogg, NSCB Development Manager. The following challenges and issues were identified:

- Practitioners acknowledged the difficulty sharing information between health recording systems which were not compatible. Staff had to try hard to find out whom to communicate with.

- Mental health workers have trouble identifying which workers were involved with families.

- Monthly midwifery/health visitor liaison meetings would be unpredictable depending on staffing situations and competing priorities

- Midwifery hand held notes did not identify the lead Obstetrician.

- Staff sickness and vacancies impacted on the level of service offered and professional priorities.

- Health visitors relied on midwifery communication of vulnerable women to enable them to prioritise ante-natal visits. Current electronic midwife health visitor communication systems were cumbersome and do not identify risk factors

- Health visitors providing services in some child health clinics had no access to records to alert them to vulnerable children or children at risk.

- Professionals acknowledged that the traditional format of child health clinics might not be conducive to access by mothers with mental health problems.

- Professionals accepted parental reports on changes in mental health care plans. These should have been confirmed by communication with the workers involved.

DISSEMINATION AND IMPACT EVALUATION

The Serious Case Review Reports for the above cases have been published and are available via the NSCB webpage Serious case reviews - Nottinghamshire Safeguarding Children Board - Nottinghamshire County Council

Learning from the reviews has been disseminated through:

- The 'What's New in Safeguarding' seminars.
- A Learning from Case Reviews seminar held jointly with Nottingham City Safeguarding Children Board (including findings from regional reviews).
- The NSCB Newsletter.
- A serious case review briefing paper circulated to Board members which provided a summary of the issues identified from completed reviews and the emerging themes from those underway.
- A specific briefing paper regarding the Learning Review was developed for health practitioners and circulated by the Designated Nurse for Nottinghamshire CCGs.
- Briefings to specific staff groups.
- New 'Learning and Improvement' Bulletins.

The NSCB Training Coordinator has participated in the reviews at key stages to ensure that learning was incorporated within the NSCB Training Programme. Specific training events had been commissioned to address issues identified through reviews including neglect and sexual abuse.

Learning from recent reviews has been incorporated into the new NSCB Interagency Safeguarding Children Procedures and the new and revised content is detailed earlier within this report. The effectiveness of the new procedures will be evaluated through practitioner workshops and dip sampling.

REVIEW FUNCTIONS

The NSCB full Board now takes responsibility for evaluating the impact that implementing review recommendations has had and this is a reflection of the importance placed on improving practice under the NSCB Learning and Improvement Framework.

In March 2014 the Board conducted an impact evaluation exercise for the EN12 serious case review. Each agency involved in the review was invited to provide feedback on the impact of the actions taken within their own organisation.

It was apparent that impact evaluation is an area still being developed by each agency and the Board as a whole. However, although some actions remain pending, it was noted that key areas had been addressed, including:

- Extensive training around referral pathways in district councils;
- Improved auditing of supervision in children's social care to ensure quality of focus and reflection is maintained;
- A focus within Nottinghamshire Healthcare Trust on pathways for and barriers to learning with a significant positive impact and sustained improvement;
- A random check of GP practices which established that processes to flag cases are embedded and staff were aware of the relevant guidance – this has created greater awareness of children at risk;
- Discharge planning for babies has improved, with improved attendance by medical staff at discharge planning meetings, ensuring that any safeguarding issues are addressed.

It was acknowledged that it can be difficult to identify direct links between actions taken as a result of reviews and outcomes and that positive impact is often attributable to a combination of factors. However, the Board will continue to seek to establish the impact of reviews on the outcomes for children.

The Board has sought and received reassurance regarding the effectiveness of advocacy and short breaks arrangements for looked after children as a follow up to the DN11 serious case review where concerns about the provision of those services during that period had been identified.

MULTI-AGENCY AUDIT

Multi-agency audit

The profile and extent of multi-agency audit activity has greatly increased during the year. A new Multi-Agency Audit Sub group was established reporting directly to the Board with senior leadership and representation from partner agencies.

Key Achievements

- *An audit strategy, framework and process have been developed which sets out the purpose of multi-agency audit, the contribution it makes to the learning and improvement framework and key elements of multi-agency audit processes including the involvement of practitioners and the value of gathering the views of children and families.*
- *Audit findings are presented directly to the Board and used to challenge safeguarding practice.*
- *Two key multi-agency audits have been undertaken and reports presented to the Board outlining the findings.*

A multi-agency audit programme for 2014/15 has been agreed. The audit priorities have been guided by learning from serious case reviews, performance indicators, drilling down into known areas of concern identified through previous audits, feedback from learning and development forums/policy implementation and the need to establish a baseline assessment of performance

VOICE OF THE CHILD AUDIT

This audit was conducted to examine how agencies listened and responded to the views of children and young people. The subject of the audit was prompted by a report published by Ofsted which analysed 67 serious case reviews and highlighted the importance of listening to the voice of the child. The report concluded that in too many cases:

- The child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings.
- Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute.
- Parents and carers prevented professionals from seeing and listening to the child.
- Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.

- Agencies did not interpret their findings well enough to protect the child.

The NSCB Voice of the Child Audit provided an opportunity for agencies to benchmark their practice against the five themes identified above and contribute to a multi-agency assessment of how well the voice of the child is heard and responded to across Nottinghamshire.

The audit findings were reassuring in that the vast majority of cases were rated satisfactory to excellent. In a very small number of cases the audit identified unsatisfactory practice that was specific to that particular case and was not reflective of the overall findings of that agency – these issues were immediately addressed by the agency concerned. The absence of information, particularly regarding religion but also to a lesser extent ethnicity, was identified as an issue by a number of agencies and had been highlighted in a previous audit. In the context of hearing the voice of the child it was recognised that the lack of information prevented an opportunity to consider the identity of the child to ensure that practice is sensitive to racial, cultural, linguistic and religious identity. Those agencies where recording of religion/ethnicity was identified as an issue included within their own recommendations actions to address this shortfall.

Voice of the Child Audit - Action taken

- *Agencies have been asked to evidence within the 2014 Section 11 audit how they hear the voice of the child in their policies and practice.*
- *Agency specific 'practice pointers' were developed and disseminated within those organisations.*
- *The learning from the audit has been incorporated within the NSCB training programme and reference to the generic practice pointers was included within the 'What's New in Safeguarding' series of events.*
- *The NSCB reinforced the need to record information regarding religion and ethnicity as this supports the voice of the child being heard.*

INITIAL CHILD PROTECTION CONFERENCE AUDIT

Child Protection Conferences are a central element of the arrangements for planning measures to keep children at risk of significant harm safe. This area of safeguarding practice was identified as a subject for audit due to the following:

- High numbers of ICPCs compared to statistical neighbours.
- Comparatively high numbers of child protection plans which are ended at the first Review Child Protection Conference (3 months).
- Case Reviews which have highlighted issues related to ICPCs (e.g. Learning Review).
- The NSCB Voice of the Child audit identified the need to have explicit expectations for the engagement of and communication with children and young people to ensure that their voice is heard and acknowledged in all decision making and at all stages of the case.
- Concerns discussed at the NSCB regarding the apparent low participation at ICPCs by some agencies and the subsequent work overseen by the Performance and Quality Sub Group 2012/13 to improve this.
- Nottinghamshire County Council, Children's Social Care case review in March 2013 identified cases where there were low thresholds for child protection planning, child protection plans which lacked focus and records of ICPCs not being completed and distributed in a timely way.

The audit identified a number of aspects of Child Protection Conferences in which practice was not as effective as it should be, some of which also featured in the earlier review findings that prompted the audit. In particular in only 43% of the audited conferences did the outline Child Protection Plan address identified need and risk, have clear actions and timescales and identify what needed to change. There were also deficiencies identified in the way that children and their families were engaged with the conference process. The following issues were specifically highlighted for the Board to respond to:

- How children and young people can be supported to participate in the ICPC process and to have their wishes and feelings represented in the meeting in a meaningful way.
- How relevant professionals can participate in and record the outcomes of Child Protection Strategy Discussions where section 47 inquiries are initiated.
- Improving the process for inviting professionals to attend conferences, and
- Consideration of a longitudinal audit of the same cases to ascertain the long term impact of the child protection process on the outcomes for children.

MULTI-AGENCY AUDIT

ICPC Audit - Action taken

Following on from the presentation of the audit findings to the Board the following action was taken:

- *New Practice Guidance was provided for Children's Social Care staff which included updated information on the process for sending invitations to agencies, particularly health colleagues and the importance of involvement of families and children/young people.*
- *The NSCB Chair had written to all partners regarding engagement with conferences and provision of reports and suggestions made in response for ways to improve practice were provided to Children's Social Care to take forward:*
- *The audit findings were disseminated via the NSCB newsletter and through training provision.*
- *A generic template for child protection conference reports had been developed and circulated to partner organisations.*
- *Children's Social Care Practice Support Team carried out a series of interviews with children who were subject to child protection plans to find out what their views were on the way professionals worked with them and their experience of the child protection process. A questionnaire survey was used to complement the interviews with children and young people and gathered the views of parents and carers. The findings were presented to the NSCB Executive providing a valuable insight into what helped children feel safe and the real life experiences of children and young people on child protection plans. Overall the results were very positive and encouraging. It is planned to repeat the interviews in the future and expand the process to include Looked After Children.*
- *Two new guides for social workers have been prepared to improve the quality of participation by children and young people in Initial Child Protection Conferences and Review Child Protection Conferences – the guides provide useful background information, details of the availability of advocacy arrangements as well as tools to assist direct work with children.*
- *Continuing work around the Child Protection Conference process and the co-ordination of Child Protection Plans is being progressed including the use of secure email for conference invitations and further training to improve the quality of child protection plans.*

A follow up audit is scheduled to take place as part of the 2014/15 NSCB audit programme which will allow progress to be measured.

MULTI-AGENCY AUDIT

MISSING CHILDREN AUDIT

Missing children are identified as a vulnerable group and a priority area of work for the NSCB. A missing children audit was therefore commissioned and completed during the year to identify the quality and effectiveness of multi-agency working and the impact of multi-agency interventions on the outcomes for young people.

The following key findings were identified by the audit:

- The audit confirmed that the missing children protocol was embedded, with evidence of good and adequate work leading to positive outcomes for young people.
- There was evidence of multi-agency work across the majority of the cases. There continued to be engagement with health to share information about missing episodes.
- The voice of the child needed to be consistently and clearly heard through return interviews and planning.
- The quality of the inter-agency work was evident on relevant agency files.
- There was a need to evidence a persistent and supportive approach to the young person and their carers.

Action taken

The Missing Children Steering Group prepared an action plan in response to the audit findings and the following update provides a summary of the current position: -

- *The Missing Children Protocol has been updated and now incorporates the new DfE statutory guidance.*
- *The Targeted Support Service is reviewing their operation and practice - progress will be reported to the NSCB in September 2014.*
- *A review of the arrangements for the completion of return interviews is currently ongoing.*
- *The learning from this audit will be disseminated and incorporated into the planned multi-agency training events for 2014/15.*
- *Health professionals have put in place measures to ensure that relevant information about missing children is available to other health colleagues.*

MULTI-AGENCY AUDIT

Multi Agency Audit Priorities for 2014/15

- *Coordinate and oversee the delivery of the Multi Agency Audit Programme*
- *Develop the use of observational visits to contribute to the audit process*
- *Further strengthen the contribution that audit work makes to the NSCB Learning and Improvement Framework*

ENGAGEMENT WITH AND PARTICIPATION OF CHILDREN / EQUALITY & DIVERSITY

Engagement with and participation of children / equality & diversity

ENGAGEMENT WITH AND PARTICIPATION OF CHILDREN

Over the past year there has been an increased effort to ensure that the children and young people are engaged with and participate in the work of the Board and in decisions that affect them.

Examples of where this has been successfully achieved are provided within this report and include:

- Multi-Agency Audit: the NSCB Multi Agency Audit Framework includes an expectation that the views of children and young people will be gathered to inform multi-agency audit work. Young people contributed to the ICPC and Missing Children audits.

- Interviews with children on child protection plans: following the ICPC audit children and young people subject of child protection plans were interviewed by Children's Social Care Practice Support Workers and the findings reported to the NSCB Executive.

- Road Safety Awareness Film Project. This was a project funded by the Board which supported young people to develop a film to communicate to their peers the risks of not paying attention when using the road. The NSCB Manager and members of the CDOP attended the launch of the film as part of a week-long celebration of the creative skills of young people in Nottinghamshire.

The NSCB Manager continues to liaise with the Nottinghamshire Young People's Board. Further work to develop a statement of the purpose of engaging with the Nottinghamshire Young People's Board, the arrangements for doing so and how the effectiveness of this engagement will be measured is included within the Business Plan 2014-16. The Children's Trust Board have agreed a revised Participation Strategy and are undertaking work to ensure that services are accessible to children and young people – this is included within the Children and Young Persons Plan.

EQUALITY AND DIVERSITY

The Section 11 Audit includes a requirement for all agencies to assess whether services are provided in a way that does not discriminate. Equality Impact Assessments are completed for locally prepared practice guidance e.g. revisions to sexual abuse and domestic violence guidance. A focus on the child's identity is incorporated within all NSCB training courses and the content of the *Responding to*

ENGAGEMENT WITH AND PARTICIPATION OF CHILDREN / EQUALITY & DIVERSITY

Unexpected Deaths course has been amended to reflect diversity issues. The Voice of the Child Audit identified that recording of ethnicity and to a greater extent religious belief was still an issue. Agencies have been requested to take action to address this and communications highlighted the importance of gathering this information in order to appropriately respond to the needs of the child.

Priority groups of children

The following section describes the work that is being carried out within Nottinghamshire to protect the most vulnerable children identified within the NSCB Business Plan

CHILDREN AT RISK OF SEXUAL EXPLOITATION (CSE)

Child sexual exploitation (CSE) remains a high profile area of safeguarding children work and is a subject has attracted widespread concern.

A multi-agency group was established under the auspices of the NSCB and Nottingham City Safeguarding Children Board to take forward developmental work related to CSE. The group meets quarterly and is chaired by a Detective Inspector from Nottinghamshire Police Sexual Exploitation Investigation Unit. The chair reports to the NSCB Executive on progress with the local strategy and action plan. Within Children's Social Care there is a strategic lead whose role is to support developments in this area of work.

CSE Key Achievements

- *Raising professional awareness of CSE through a range of training courses.*
- *Better engagement with children, young people and their families through a specially commissioned play and the recruitment of a project worker.*
- *Organisational issues – plans to further strengthen resources.*
- *Improved data collation and analysis.*

Training and professional awareness

Training has been provided as part of the NSCB training programme (details are contained in **Appendix D),** to raise professional awareness in identifying and responding to child sexual exploitation. A basic E learning module is now available to provide the opportunity for all staff, including those who have contact with children in more peripheral roles e.g. park rangers or licensing officers, to access training on this issue. This is important as it is recognised that some workers who do not work directly with children may be in positions to identify concerning behaviour and share intelligence.

PRIORITY GROUPS OF CHILDREN

A practice forum, led by the NSPCC has been established and provides an opportunity for professionals to come together to discuss cases and share best practice and learning.

Engagement with children, young people and their families

Thirteen schools and academies have benefitted from a specially commissioned play performed by an educational theatre company. The play and an accompanying workshop aim to increase children's awareness of risks of sexual exploitation. Feedback was positive and all of the remaining schools and academies in Nottinghamshire have been offered one free performance with the option to purchase more during 2014/15.

It is important that parents and carers are also aware of the risks of sexual exploitation to support them in trying to keep their children safe. To facilitate this, a free E learning course developed by the voluntary sector, has been shared with a range of professionals who work with parents or carers with the request that they promote it. This included foster carers both within the local authority and the independent sector. All secondary schools and academies have also been asked by the Corporate Director for Children, Families and Cultural Services to promote the E learning with the parents of their pupils.

A child sexual exploitation project worker from the voluntary sector is now available to work with a number of children who may be at risk of, or experiencing, sexual exploitation. This post is available for a year and will be evaluated by their organisation in conjunction with officers from Children, Families and Cultural Services.

Further work is planned to promote the engagement of children by, for example, their participation in child sexual exploitation multiagency meetings.

Organisational issues

Nottinghamshire County Council in partnership with the NSCB has actively considered how to drive forward this work through the creation of a child sexual exploitation coordinator half time post by re-aligning responsibilities. It is expected that this work will commence during 2014/15 allowing a specific focus on key areas such as the engagement of young people and further develop joint working with the police.

In addition to the developmental work being undertaken, there is a well-established operational response to cases. Multi-agency strategy meetings are held for cases where it is identified that children or young people are at risk of, or are experiencing, child sexual exploitation. These meetings are chaired by a Child Protection Coordinator and relevant agencies are involved in order to ensure appropriate sharing of information and planning.

PRIORITY GROUPS OF CHILDREN

Feedback from the 2013/14 Governor Compliance Checklist for schools, which is specifically for secondary schools and academies, has been evaluated. They were asked the question

Does your school include Child Sexual Exploitation (CSE) within PHSE curriculum?

Twenty-two out of 46 secondary schools/academies returned the checklist and of these 16 responded to the question. Seven of the 16 include child sexual exploitation within the curriculum across all year groups and 9 across some. One learning centre also provides input across all year groups and 4 special schools confirmed that they provide work as appropriate to the needs of the children.

Promoted through Nottinghamshire County Council, the NSPCC continues to offer work to all schools with Year 5 and 6 pupils on 'keeping happy and safe' which includes an e-safety and exploitation angle. The Nottinghamshire County Council anti-bullying coordinator also offers e-safety sessions to parents and schools and other settings, predominantly in the primary sector. The aim of this training for schools is to promote the embedding of e-safety within the curriculum, and the ethos of the school, by raising awareness, showing and recommending resources and talking about the safeguarding issues for staff and students. For parents the emphasis is on keeping up to date with new technology and how young people are using it and how to support young people so they can grow up safely in the digital world. There are currently approximately 20 sessions provided each term.

Data Analysis

During 2013/14 104 sexual exploitation strategy meetings have been held in relation to 47 individual children. This is an increase in the number of meetings from the previous year and demonstrates a higher level of identification and referral to services. The risk of child sexual exploitation also features within some reports when children have gone missing. The police continue to investigate a range of cases linked to child sexual exploitation in collaboration with children's social care and other agencies and there have been convictions arising from their work.

PRIORITY GROUPS OF CHILDREN

CSE Priorities for 2014/15

- Deliver training and awareness raising of CSE to professionals.
- Continue efforts to engage with secondary schools and academies in promoting the inclusion of CSE within their curriculum.
- To promote the Pintsize theatre tour of LUVU2 within all secondary schools and academies within Nottinghamshire and to consider how this can continue in the longer term.
- Further develop data analysis work to inform practice and strategic developments.
- Work towards establishing the CSE coordinator role within the local authority.
- Continue to raise parental and carer awareness of CSE and to increase their participation in the process where concerns have been identified about their children.

MISSING CHILDREN

Strategic and development work is overseen by a multi-agency steering group which meets quarterly. In addition to an annual report to the Nottinghamshire Safeguarding Children Board, quarterly reports were provided to the NSCB through the Performance and Quality sub group. This group has now been disestablished and future reporting will be through a quarterly monitoring report to the Executive.

National and Local Strategy and Partnerships

The Department for Education has revised the 'Statutory guidance on children who run away or go missing from home or care' (January 2014). This incorporates the April 2013 Association of Chief Police Officers (ACPO) guidance that adopts new definitions of 'missing' and 'absent' which is the most significant change to the process. The guidance continues to emphasise that children who go missing or run away, including those looked after, are vulnerable, potentially at risk and need to be safeguarded. The links between child sexual exploitation and children who go missing remain.

As a result, the local NSCB inter-agency protocol; *Children Who Go Missing From, Home, Care or Education (2012*) has been revised. Nottinghamshire Police will adopt the ACPO specific guidance for police officers in October 2014. The Nottinghamshire strategy and action plan has also been revised to reflect the changes.

Current Service Provision

Once reported to the police, a missing report is taken; when a young person is found a 'safe and well' check is completed by the police and notification sent to the Children Missing Officer (CMO) within Children's Social Care. The Police are the lead agency in trying to locate the child. The CMO applies the local protocol, forwarding on requests for a *return interview* or *multi-agency meeting* to the relevant

team within Children's Social Care or Targeted Support Services. The CMO monitors compliance, which continues to be one of the strengths of the system. The return interview aims to be completed within 72 hours. It provides an opportunity to understand why the young person has gone missing, to plan support and prevent or reduce future occurrences.

Records are maintained of the number of missing episodes and the number of individuals that these relate to.

Towards the end of 2013/14, aspects of the work completed by the discrete Missing Service, which was a partnership between Targeted Support Services and the voluntary sector, was decommissioned and the work absorbed within the Targeted Support Services.

Nottinghamshire Police have recruited three missing person's coordinators to support the full implementation of the ACPO guidance in October 2014.

It is acknowledged by Nottinghamshire Police that the sharing of information in a timely way in respect of children classified as 'absent' will be potentially a challenge as there is currently no automated process for this. Information regarding children classified as 'missing' will continue to be shared in an automated way.

Data Analysis

- Excluding Other Local Authority (OLA) Looked After Children, the number of missing episodes remained stable (1280 to 1282) but the number of individuals substantially decreased from 720 to 644. This mainly relates to a decrease in the number of young people missing from home.

- Regarding Nottinghamshire Looked After Children, there was an increase of 30 individual young people and 106 missing from care episodes. This is believed to be in part to increased reporting but also to an increase in the number of older looked after children within the care population. This will be monitored through the coming year. The data relating to looked after children suggests that they are more likely to go missing from external providers (i.e. non NCC provision) or when placed out of the county.

- There was a 51:49 male:female ratio of young people who go missing compared to 50:50 the previous year. When comparing episodes, however, it is 44:56 which indicates that females go missing more frequently. The ethnicity of children going missing largely reflects the child population within Nottinghamshire. The peak age range of children going missing is 13-17 years with 70% aged 13-16 years and a slight decrease in children less than 13 years during this year.

PRIORITY GROUPS OF CHILDREN

- During the year, approximately 650 return interviews were completed; this represented an increase from 52% to 57% of requests, which was within the context of an additional number of return interviews completed (179). An additional 14% of young people would not engage, declined the offer or advice was given. The remaining 29% of return interview requests were not returned and there is thus still room for improvement although within a context of continuing improvements. The timeliness of return interviews completed within 72 hours continued to increase (51%) with the majority done within five days (70%) and 88% within 10 working days.

- 112 multi-agency meetings were held (an increase of 21) which was 64% of those requested which again reflects an improvement in practice although there is still potential for further enhancement.

- The reasons young people give for going missing are varied but are mostly about the relationship with their parents or boundary issues; but also some relate to school based issues.

PRIORITY GROUPS OF CHILDREN

Missing Children - Key achievements

- *Developing an audit to quality assure the work we do: The scheduled NSCB audit was completed and details of the findings can be found in an earlier section of this report.*
- *Improving our engagement with young people to aid strategy and practice and ensure their voice is heard: This was a key feature of the NSCB audit and there has been a strong focus on the return interview.*
- *Ensuring a more sophisticated analysis of the data, looking at 'hot spots' and an understanding of any risk or harm the child has experienced: There has been improved scrutiny of and response to the data, for example, where a child's missing episodes have escalated, there has been liaison with the relevant service or where a children's home had an increase in notifications there was specific contact. To formalise this process, a cross-authority / multi-agency approach has been implemented through the introduction of a multiple missing and hotspots meeting at the end of April 2014.*
- *Monitoring the use of disruption tools by the police: The police have issued 17 child abduction warning notices against people who may pose a risk to children. This was in respect of eight children which is an increase from five the previous year. This can be an effective means of disrupting the relationship between the child and the adult harbouring them.*
- *Intelligence sharing between agencies. Intelligence has been shared on a case by case basis but it is recognised that this could be strengthened.*
- *Development work with the Looked After Children's Teams to improve the response to Looked After Children (LAC). A specific briefing was held with LAC social workers and team managers and there is ongoing communication with the Children Missing Officer and these teams. There is also connectivity with the Placements Service and other agencies around LAC both in and out of the County. A LAC team manager also sits on the missing children steering group.*

PRIORITY GROUPS OF CHILDREN

Missing Children Priorities for 2014/15

The work relating to missing children is robust but with areas for development operationally and strategically. The priorities for the coming year are:

- *Implement the revised NSCB missing children protocol and ensure a process for the timely notification of absence notifications is in place.*
- *Review arrangements for the completion of independent return interviews.*
- *Updating electronic reporting processes to reflect the revised protocol.*
- *Plan and deliver appropriate training events including a LAC specific event.*
- *Develop an ongoing audit process.*
- *Embed the missing coordinator role within the police and develop a process to strengthen intelligence sharing between agencies.*
- *Improve our engagement with young people and ensure their voice is heard through return interviews, planning and outcomes.*
- *Further develop the inter-agency multiple missing and hot spots meeting.*
- *Development of recording within health regarding young people who go missing.*

PRIORITY GROUPS OF CHILDREN

CHILDREN AT RISK THROUGH DOMESTIC VIOLENCE OR ABUSE

Children who live in a home where there is domestic violence are known to be at an increased risk of suffering harm. This connection has been understood for some time and recent case reviews carried out within Nottinghamshire have reinforced this. The proportion of children subject of child protection plans who live in households where domestic violence or abuse remains high (approximately 60% of the total number of children (**Appendix E**)).

Since April 2013 the definition of domestic violence has included 16 and 17 year old victims and there is increasing concern both locally and nationally about abuse in teenage relationships and teenagers abusing adult carers

Data analysis

Reports to Nottinghamshire Police about domestic violence have increased in the year 2013-14 by 1.6%. This is considered to be a positive outcome, the result of growing confidence in the Police response and the effectiveness of support services. However a steep rise of over 9% in domestic abuse crime is of concern. This follows a national trend so cannot be fully understood in the local context. The steepest rise has been in South Nottinghamshire which has historically had relatively low levels of domestic abuse. Only 13% of all victims report repeat crimes. This suggests that the increase may be about more people coming forward rather than failure to resolve existing cases. There continues to be a problem getting sufficient evidence to charge domestic abuse perpetrators but the figures on charging and prosecution show that when detection has been possible there are better outcomes in the criminal justice system.

Police Crime Data	Year to March 2013	Year to March 2014	%age change
Domestic Abuse Incidents	9854	10013	1.6% increase
Domestic Abuse Crimes	3897	4270	9.6% increase
Domestic Abuse Repeat Victims	13% of all victims	13% of all victims	No Change
Domestic Abuse Crimes detected	56.5%	49.7%	Negative Change
Sanctioned detections resulting in charge	46.7%	53.5%	Positive change
Successful Domestic Abuse Prosecutions	71.7%	73%	Positive change

PRIORITY GROUPS OF CHILDREN

The Safer Nottinghamshire Board (SNB) provides strategic leadership for the effective delivery of services to tackle domestic violence through its Domestic Violence Executive Group. Members of the NSCB sit on the Domestic Violence Executive and support connectivity between the two Boards.

A new joint SNB/NSCB initiative has been the formation of the Nottinghamshire Children and Young People Domestic Abuse Forum. The Forum brings together statutory and third sector partners working on all aspects of domestic abuse where children and young people are involved. It reports to the SNB, the Health and Wellbeing Board and NSCB. The initial work of the Forum has included the mapping out of services for children and young people and this has linked to the work of the NCC Targeted Support Service which is looking at pathways to support teenagers, training professionals about teenage violence and linking with other partners to improve outcomes for young victims and perpetrators.

Nottinghamshire Police has invested greatly in educating all police officers and frontline staff in relation to domestic abuse. The DASH risk assessment form that officers are required to complete has a section specifically to detail children who may be in need of safeguarding connected with the victim or perpetrators of domestic violence. The police reviewed their processes and from January 2nd 2014 greater officer professional judgement is allowed when completing the DASH. Each domestic abuse incident where children are connected is referred through to Children's Social Care via the Nottinghamshire Multi Agency Safeguarding Hub (MASH).

Nottinghamshire Encompass

Starting with a pilot in September 2014 in Rushcliffe and Newark & Sherwood Districts, the Encompass Project, based in the MASH, will deliver alerts to schools and children's centres about children and young people present in households where high and medium risk domestic abuse takes place. This will bring schools and children's centres into the domestic abuse information sharing network already available to MASH partners. Schools will designate individuals to receive these alerts who will then use their judgement as to how to support the child, or refer them on to more specialist services. In January there will be a review of the pilot and any necessary revisions made to the model. Following this the Encompass Project will be extended across Nottinghamshire

Domestic Homicide Reviews

Since April 2011, community safety partnerships have been required to review cases of homicide where the victim is killed by a partner, former partner, or family member. The SNB oversees the effective completion of Domestic Homicide Reviews (DHR). Links between the NSCB and DHRs that involve children or young people are maintained through the NSCB Chair and Board members. The NSCB Chair has advised on the conduct of DHRs and preparation of DHR reports. In 2013/14 no reviews involving children were published.

PRIORITY GROUPS OF CHILDREN

SAFEGUARDING LOOKED AFTER CHILDREN

Independent Reviewing Officers (IRO) play an important part in safeguarding looked after children (children in the care of the local authority by virtue of a Court order or for a period longer than 24 hours). The IRO service is part of the Independent Chair Service (ICS) provided by Nottinghamshire County Council. The ICS is responsible for quality assuring social work practice in relation to children in public care or children subject to a child protection plan and to promote effective interagency working. The Independent Chairs have continued to contribute to the development and promotion of good practice by addressing concerns regarding care planning for children, identifying areas of development and highlighting good practice.

Independent Reviewing Officers were introduced to represent the interests of looked after children. The core purpose of the role is to ensure the care plan fully reflects the child's needs, that their wishes and feelings are sought and that the actions set out in the plan are consistent with Nottinghamshire County Council's legal responsibilities towards the child. The IRO also has a duty to monitor the Council's overall performance and challenge any poor practice in the care planning process. The IRO is responsible for making sure the child has access to an advocate and understands how they can support them during the review meeting.

If the IRO is unable to agree the plan for the child or young person then they can refer their concerns to CAFCASS, (Children and Family Court Advisory Service) who may consider taking legal action on behalf of the child or young person against the Local Authority.

PRIORITY GROUPS OF CHILDREN

Looked After Children (LAC) - Key achievements

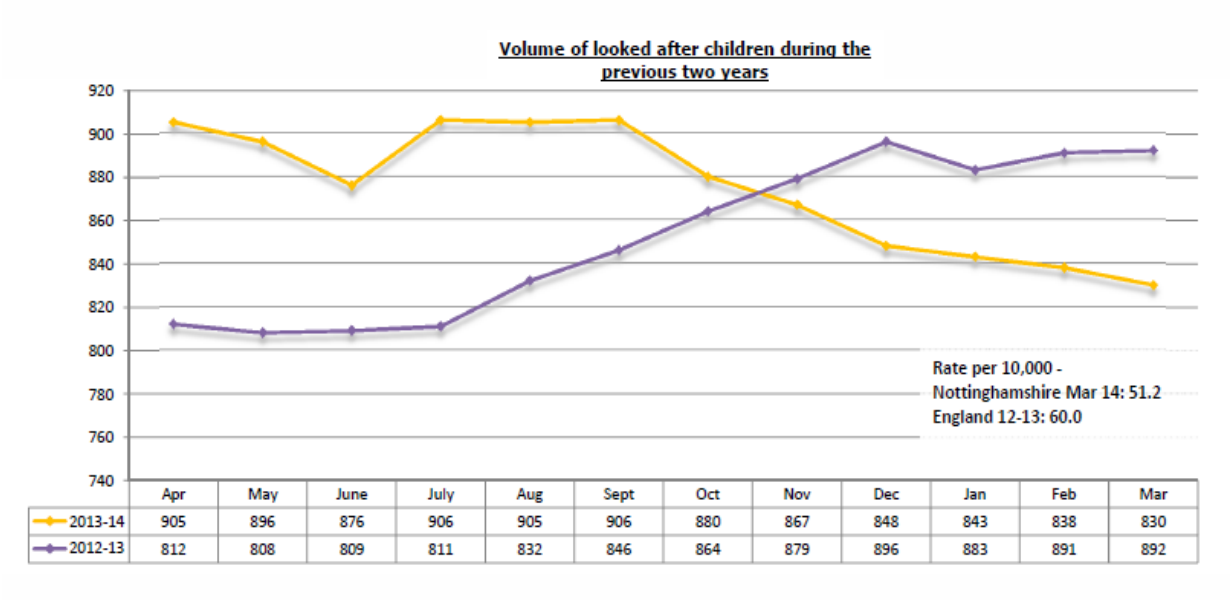
- During the year the IRO service developed arrangements for accessing independent legal advice through a spot purchase arrangement. This enables IROs to consult with an independent solicitor if there are any issues around the care plan.
- IROs have been identified to take on a lead role with specific topics (e.g. working with children who have disabilities) in order to develop specialist knowledge within the team
- Over the past year there have been continued efforts to increase the number of permanent staff within the service. There are currently 13.1 IRO, 10.5 permanent staff and 2.6 agency. Due to increased demands on LAC over recent years it was necessary to increase the number of IROs.
- Service Managers have observed the IROs in reviews and sought the views of agency representatives - generally positive feedback has been received about the chairing skills of the Nottinghamshire IROs.
- IROs are aware of the vulnerability of children on their caseload who live outside the local authority, those who go missing and those at risk of sexual exploitation. As a group they take extra care to ensure they are not further disadvantaged by services being delayed or by a lack of response to the concerns being highlighted. IROs track what is happening with the cases, makeing sure the social worker and agencies are adhering to required expectations of visits and meetings.
- Evidence of a more robust approach by IROs to challenging local authority practice.
- The introduction of a new alert system to raise concerns about partner agencies contributions to care plans.
- A signs and symbols leaflet has been developed for 0 to 18 year olds in consultation with young people, service providers, specialist schools, IROs with specialist knowledge of working with children who have disabilities. The leaflet has been designed to aid the communication of young people's views and wishes.

Data Analysis

Throughout 2013/14 there has been a focus in making sure permanency plans are in place for each looked after child and that adoption is being progressed as quickly as possible. A review for a looked after child forms part of a continuing planning process for that child and is held to make plans to safeguard and promote the child's welfare.

PRIORITY GROUPS OF CHILDREN

On 31 March 2013, there were 892 children and young people looked after and the total number of LAC reviews between April-March 2014 was 2,722 and 95% of those, (2,579) were held within timescale. As can be seen from the chart below, there was a notable increase in LAC numbers from December 2012 to September 2013 however numbers have been relatively stable from Jan-March 2014.



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2013-14	905	896	876	906	905	906	880	867	848	843	838	830
2012-13	812	808	809	811	832	846	864	879	896	883	891	892

- There has been a significant increase in the number of children and young people who have been made subject to special guardianship orders (SGOs) to former foster carers. This is seen as a positive outcome for children. During 2012-2013 8.4% of children left care due to an SGO being made whereas in 2013-2014 this increased to 15.9%.

- In most cases where a child who is the subject of a child protection plan becomes looked after they will no longer need to remain on a child protection plan. If they do it usually involves the case being presented to court and will be necessary to await the outcome before a decision on a single plan can be made. The IROs, in conjunction with the Child Protection Coordinators, have actively been addressing this to ensure children/young people are subject to one review process, at the end of March 2014, only12 children were recorded as dual status, being looked after and subject to a child protection plan.

PRIORITY GROUPS OF CHILDREN

As part of their quality assurance role the IROs will gather information about attendees with respect to their involvement and written contribution and will offer feedback on any particular practice issues to social care and other agencies. Where there are significant concerns relating to practice and drift, the IRO will initiate an alert and send it to the team manager or agency for their attention. During 2013-2014, a total of 192 alerts were raised. This is a significant increase over the previous two years and evidences that the IROs are being more robust in challenging the local authority where appropriate about concerns relating to practice, including any delay in progressing recommendations.
The following themes were noted with regard to the alerts processed:

- Incomplete assessments causing delay in decisions about planning.
- Permanence options for young person not fully explored.
- Concerns around confidentiality of placement.
- Pathway plan not completed fully.
- Delay in requesting initial lac review when a child is placed with a family under regulation 24 .
- Delay in making application for court proceedings to be initiated to secure permanence for children.
- Increase in service being provided to child with disabilities.
- Delay in foster carers being assessed to possible adoption of fostered child.
- Lack of preparation for young person leaving care.
- Absence of appropriate paperwork;Personal Education Plan PEP, health assessment and essential information.
- Young person does not understand their care plan and why they are in LA care.

During 2013 the IRO service also introduced sending alerts to external agencies where there were concerns about their contribution to the needs of the child or young person's plan. Two alerts have been initiated and both related to education; concerns that School is not addressing matters in line with Educational Statement and a LAC placed in Nottingham had not yet been allocated a school. The dispute resolution process has been strengthened with greater service manager oversight with a robust system which is able to track and monitor responses in a timelier way. The majority of alerts issued have been resolved at Team Manager Level with a few being escalated to Service Manager Level.

PRIORITY GROUPS OF CHILDREN

It is also important to note IROs also feedback positive practice to social workers and other agencies in respect of the work undertaken with looked after children.

Data has been collected by the IROs regarding a number of key tasks that are part of the processes to safeguard LAC and this further informs the quality assurance of this area of work. The following have been noted from this data collection:

- The LAC report prepared by the social worker is not consistently received prior to the review.
- IROs try to see the child/young person alone but sometimes they do not wish to meet with the IRO.
- If the child/young person attends the review then the IRO consults with them prior to the meeting starting.
- The “Listen to me” document is not consistently being used and this is being addressed by the IRO in the review.
- Efforts are made to hold the meeting at the venue of the child/young person’s choice but this is not always achievable.
- Children and young people are being consulted by IROs about whom they want to attend their review once they have established a good working relationship with them.

A detailed report will be provided with this information for social care teams and agencies to comment on good practice within the next 6 months.

PRIORITY GROUPS OF CHILDREN

Participation and engagement of Looked After Children

The following examples illustrate the methods used to engage young people in the review process:

Child 1

A 17 year old person co-chaired their own review. This worked well as she has attended her reviews since she came into care when she was 12 and she has ongoing support from Children in Care Council which she is a member of. The IRO was impressed as the young person took control of their own care planning whilst discussing their current achievements and what they intend to do in the future once they left care.

Child 2

Involves a sibling group of three girls ranging from 12 to 7yrs, they choose not to attend the review meeting, but the IRO visits them in their foster home to see them alone and they also complete the Listen To Me document for the reviews

Child 3

12 year old person who is deaf and has complex emotional needs, the IRO visits him both at school and foster home to gain a better view of his current situation and needs. His foster carer and teacher provided sign language support. For future visits the IRO will be seeking an independent sign language worker to accompany them.

In order to share the wishes and feelings of children there are a number of good examples of how residential units, internal and private, provide detailed information about the child or young person being reviewed to their IRO. The information provided has been of great value and provides a story about the child or young person's progress and achievements in school and where they live.

When a longstanding IRO left the service in September 2013 she made great efforts to introduce the new IRO where she could and also wrote to the children and young people she had worked with for a long time to explain why she was leaving and provided a personal message about her involvement with them as their IRO.

Children with complex communication needs are generally provided with an IRO who has developed skills and has specialist knowledge in working with children with disabilities. It has been noted by the

two nominated IROs for these children that due to them strongly advocating on their behalf there is more evidence of participation occurring due to more creative ways being adopted in establishing their wishes and feelings.

Young People's achievements

IROs embrace the achievements of children through LAC reviews and here are some examples.

Child 1

As a consequence of early life experiences, two young people were lacking in confidence and self-esteem. Both have thrived in their foster placement, took up street dancing classes and have performed at numerous venues. One of them has a passion for computers and is studying with the view to a career in forensic technology.

Child 2

A young person attended a celebration event at County Hall in November 2013; they invited numerous adults who were involved in their life including their IRO. The young person was interviewed along with others by the local press and undertook a presentation. It was a proud occasion to see all the people involved with the young person offering her support at this event.

Child 3

A 13 year old recently took part in the National Roller Hockey competition and reached the semi-final where she received a bronze medal. The young person also played for the women's team where she reached the final and won the cup. Given these achievements the young person is due to go to the Youth Olympics in Las Vegas in July this year to compete in roller hockey.

PRIORITY GROUPS OF CHILDREN

Safeguarding Looked After Children Priorities for 2014/2015

- Complete a questionnaire with children and young people to ascertain their views about the service they receive from the IROs. This will take place during June and the feedback will be collated by the Social Work Support Service.
- Liaise with the No Labels group to review the questionnaire used for 9 years upwards and with their assistance devise a questionnaire that can be used for children 5-9 years. Also to consider the possibility of producing child friendly minutes.
- Invite more young people to chair their meetings and explore with the NO Labels group of other creative ways of involving children and young people in their reviews.
- Strengthen and develop other ways of developing contact between the IRO and young person in between reviews.
- Implementation of the Signs and Symbols leaflet.
- Continue to meet CAFCASS to explore how we can work better together for the benefit of children and young people.
- Strengthen the involvement of IROs in particular groups focusing on looked after children, for example the Corporate Parenting committee.
- Undertake an evaluation of the effectiveness of the dispute resolution process and consider how IROs improve outcomes for looked after children.
- Service managers of the service to continue to observe IROs chairing reviews and invite feedback from carers, children, social workers and other agencies.

CHILDREN WITH PARENTS OR CARERS THAT HAVE MENTAL ILL HEALTH AND/OR DRUG AND ALCOHOL PROBLEMS

Nottinghamshire was one of nine areas which participated in an Ofsted thematic review of joint working between adult and children's services when parents or carers have mental health and/or drug and alcohol problems. This review was reported in March 2013 as "What about the children?" and made a number of recommendations to improve services. These centred on improving:

- Identification of children exposed to parental mental health and substance misuse and those who undertake carer roles.

- Awareness by professionals working with parents of the impact that these issues have on children.
- Co-ordination and joint working between adult and children's services in relation to these families, throughout the process of assessment, planning and delivery of services.
- Quality assurance of this work.

A task and finish group of professionals was established to identify areas of work required locally to address these recommendations. The action plan drawn up by the group was presented to the NSCB and it was highlighted that a greater multi-agency focus was required and this led to a revised plan of work which is currently ongoing.

PRIORITY GROUPS OF CHILDREN

PRIVATELY FOSTERED CHILDREN

A private fostering arrangement is one that is made privately for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more. Close relative in this context means grandparent, brother, sister, uncle, aunt or step-parent (by marriage).

Parents and private foster carers are legally obliged to inform children's social care at least 6 weeks before the child goes to live with a private foster carer or within 48 hours, if the arrangement is made in an emergency.

It is the duty of Nottinghamshire County Council to satisfy itself that the welfare of children who are, or will be, privately fostered within Nottinghamshire is being, or will be, satisfactorily safeguarded and promoted. The local authority must continue to satisfy itself that a private fostering arrangement is satisfactory by supervising, regulating and advising.

Children's Social Care responds to notifications of individual private fostering arrangements, where possible, before children and young people move in to live with their private fostering carer, by undertaking an assessment of the suitability of the arrangement and thereafter conducting regular visits

Ofsted have recently re-published an updated version of their report 'Private Fostering; better information, better understanding'. The report sets out key findings from further inspections of local authority private fostering arrangements and makes a number of recommendations particularly in relation to:

- Data collection.
- Improving arrangements for the self-evaluation of private fostering services.
- Better targeting of awareness raising work.

The report suggests that local authorities, local safeguarding children boards and the Department for Education should work together towards implementing the recommendations in the report.

PRIORITY GROUPS OF CHILDREN

Private Fostering - Key achievements

- *A Service Manager in children's social care has been appointed as the operational lead for private fostering.*
- *A Practice Consultant from the Social Work Practice Support Service is currently undertaking briefings for staff in the Multi Agency Safeguarding Hub so that they are able to identify cases where a notification for private fostering should be made and staff are aware how to process cases as a notification of private fostering.*
- *Nottinghamshire County Council Customer Services have been provided with guidance on how to deal with general enquiries from members of the public regarding private fostering, any case specific enquiries are referred through to the MASH.*
- *A briefing was provided to the Children's Social Work Services Management Meeting emphasising the importance of identifying private fostering arrangements and complying with regulations concerning suitability assessments and visits.*
- *Two seminars were facilitated by the Designated Principal Child & Family Social Worker for health and education colleagues to improve their awareness of private fostering arrangements. Positive feedback was received from those that attended indicating that they had found them very informative and intended to cascade the information learnt to colleagues in their agencies.*
- *New 'episodes' have been developed for use in Framework-i (children's social care database) which support the assessment of suitability of placements and recording of visits.*
- *1:1 support from e-support workers has been introduced to support social workers using the new episodes and improve data quality.*
- *Public awareness of the notification requirements for private fostering arrangements through websites, leaflets and informing agencies.*

Data Analysis

Each local authority is required to submit data regarding private fostering arrangements in their area. This year's provisional return is attached at Appendix I and is currently being validated and may be subject to slight adjustment.

The data return includes information on the number of notifications of private fostering arrangements, the timeliness of the initial response to those notifications and subsequent compliance with visiting frequency requirements. The previous year's return has been included for comparison.

PRIORITY GROUPS OF CHILDREN

Although the legislation requires parents and carers to notify the local authority of their intention to enter into a private fostering arrangement it is more common for arrangements to be identified by children's social care or partner agencies – the term 'notification' is therefore a little misleading and in this context is used to describe when children's social care first become aware of a private fostering arrangement.

The number of new notifications received during 2013/14 increased to 25 which is a positive indication that more arrangements are being identified. Compliance with requirements to conduct an initial visit within 7 days was good (84%). Performance regarding frequency of visits was high with 92% of visits for new notifications being carried out within the 6 weekly requirements and 91% of visits for longer standing arrangements carried out within the required frequency of 6 weekly for the first year and then every 12 weeks thereafter.

Demographic data was not available at the time of preparing this report but will be included within the annual return.

The provisional data indicates an increase in performance across all the measures compared with the previous year. This is thought to be due to greater awareness of the local authority's responsibilities under the regulations and improved data quality, following on from the work listed under the key achievements section earlier. It is anticipated that annual data for other local authority areas will be published later in the year and this will allow a comparison of performance although it is acknowledged that normal statistical neighbour comparisons are invalid for this type of work because of the specific factors that can lead to a distortion of the figures (e.g. the existence of language colleges in some areas).

PRIORITY GROUPS OF CHILDREN

Private Fostering Arrangements Priorities for 2014/15

- Subject to further guidance and dialogue between the DfE, local authorities and LSCBs improve data collection by gathering information on:
    - How notifications/referrals were first made.
    - Categorising the types of young person by reason for placement.
    - How long individuals were living in their family placements before referral.
    - The proportion of self-referring cases (this is seen as an indicator of effectiveness).
    - Schools clarifying the numbers of children not living with their parents as part of the admissions process and annual returns.

- As a result of improved data collection improve the self-evaluation of private fostering services through the local authority annual report.

- Continue to target awareness raising work with education and health agencies.

- Continue to improve the quality and timeliness of social care assessments. The Social Work Practice Support Service will continue to work with Children's Social Care staff in relation to the quality of assessments and use of the electronic system in relation to accurate recording.

- The Social Work Practice Support Service currently has a leaflet project and is reviewing and updating leaflets, which will include private fostering leaflets.

There is evidence of improved performance in relation to the services provided regarding private fostering arrangements. Work around awareness raising and improving recording does seem to have had a positive effect. The number of notifications remains low which is acknowledged as an issue nationally. The Ofsted report referred to earlier suggests ways to further improve services and the developmental areas outlined include recommendations drawn from that report and planned local initiatives.

NSCB EFFECTIVENESS, CONTRIBUTION AND CHALLENGE

NSCB effectiveness, contribution and challenge

Throughout the course of the year the NSCB has sought to examine how it carries out its responsibilities and explore new, more effective ways, of working. Development sessions, self-assessments and the commissioning of an independent review into the effectiveness of the NSCB have been used to ensure that the Board is in a better position than ever to understand its strengths and weaknesses and to respond to the increasing demands.

Renewed focus to the way the NSCB operates

During the year changes have been made to the way the NSCB functions. The establishment of a new Multi-Agency Audit Sub Group led by the Corporate Director for Children, Families and Cultural Services, has significantly raised the profile of this work and emphasised the importance of multi-agency audit to understanding how safeguarding practice can be improved. Similarly transferring the responsibility for evaluating the impact of serious case reviews to the NSCB full Board demonstrates that learning and improvement is a fundamental element of its work. The NSCB Executive has taken on responsibility for ensuring that the NSCB subgroups are effectively carrying out their functions and NSCB members who lead these groups have an increased role in identifying any issues that require action. The NSCB Executive also examines performance data relating to key safeguarding activities.

The findings of the independent review into the effectiveness of the Board were presented at a specially convened meeting. The review found positive aspects of a well-functioning Board with significant progress having been made since the development day in April 2013. In particular it noted the work of the new audit group and the improvement in the effectiveness of Board meetings. Specific new work-streams arising from the review have been included within the business plan for 2014-16 **(Appendix C)**

NSCB members have brought to the attention of the Board findings from their own inspectorate and self-evaluation processes, this has included quality assurance audits related to CAFCASS and NHS Bassetlaw and the Nottinghamshire Police mock safeguarding inspection.

Emphasis on learning and improvement

The NSCB has demonstrated a continuing commitment to commission and conduct reviews, including serious case reviews, in order to identify how individuals and organisations can better work together to safeguard children. All of the serious case review reports have been published on completion of the reviews and once any associated criminal proceedings and/or inquests have taken place. This

demonstrates willingness by the NSCB and its partner agencies to be transparent and to share any learning from the reviews in order to improve safeguarding.

Resources to support the work of the Board have been strengthened during the year after a significant period where two NSCB Officer posts were unfilled. In July 2013 Hannah Hogg was appointed to the NSCB Development Manager role and in January 2014 Trish Jordan took on the role of NSCB Training Coordinator. The new appointments have made it possible to move forward NSCB work particularly around the implementation of the NSCB Learning and Improvement Framework with increased attention to be given to disseminating the learning from reviews, drawing in learning from audit and incorporating key messages within the NSCB training programme and commissioning outside providers to deliver specific training events.

Frontline visits

The programme of visits by NSCB members to frontline practice has continued and contributes to efforts to achieve greater connectivity between the Board and operational staff; the visits have facilitated two way communications and provide opportunities to identify any issues impacting on child protection work. Visits have been carried out by NSCB members this year to District Child Protection Teams, Clayfields Secure Children's Home, the Multi Agency Safeguarding Hub (MASH) and the Early Help Unit. Reports outlining the findings from those visits, including any recommendations, have been presented to the Board. The following is a sample of those reports: -

Clayfields Secure Children's Home

'The atmosphere within the unit felt positive – the young people appeared relaxed and comfortable in their surroundings and in their relationships with staff despite the high security arrangements'.

'Educational provision as described above appears to be having a significant impact on the self-esteem and life skills of the young residents'

A review of the consultation processes for young people was suggested by the NSCB members who visited following on from their discussions with residents who made it clear that they did not have confidence in the Young People's Council as a means of resolving issues.

MASH

'Specifically of interest was how schools and education were working within the Hub and the way that head teachers were sharing the role of link person which showed excellent partnership working, the

valuable work of the health service contacts who provided a link through all the different aspects of health and the recent integration with probation'.

Options for housing to be represented within the MASH are being explored by the District Safeguarding Group following the visit.

Early Help Unit
'Experienced staff team who work closely together to ensure that the right help and support is found for each child and their family'

NSCB members were reminded of the need for consent from families to share information so that support can be offered.

Children's Social Care – District Child Protection Team

I came away from the day without concerns about practice, case-loads or staff morale. But this is highly demanding work and all three issues are critical areas of risk. The connections between the Board and the front line and senior managers and the front line need to be nurtured so that individuals and the organisation can be resilient when under pressure.

Overall the visits identified many positive aspects of front-line service delivery in the county and a commitment by staff to providing the best service possible. Where potential improvements were identified, in many cases by the staff spoken with, action to take these forward was agreed by the Board.

New interagency safeguarding procedures

The development and implementation of new interagency safeguarding children procedures provided an opportunity to further link in with frontline practitioners with workshops taking place to explore in depth current safeguarding practice and the procedures and guidance required to support it.

NSCB EFFECTIVENESS, CONTRIBUTION AND CHALLENGE

NSCB Challenging Organisations' Service Provision and Safeguarding Practice

This report provides details of where the NSCB has challenged organisations regarding services provided and safeguarding practice in order to test the adequacy of arrangements. This has been in connection with the findings of reviews and audit work, specific monitoring of key activities through the performance information report and scrutiny of plans prepared by other strategic partnerships; as well as issues brought to the attention of the Board by external organisations and individuals. The NSCB uses the regular meetings of the Board and Executive, as well as direct contact with agencies and partnerships by the independent chair, to challenge and seek assurance regarding performance. Whilst it is not possible to provide the details of all cases where challenge has taken place the following summary provides some of the most notable examples:

- The effectiveness of child protection planning arrangements
- Accommodation of looked after teenagers and care leavers.
- The provision of health services for children in care.
- The prominence accorded to children and young people in preparation of the Health and Wellbeing Strategy
- The operation of the Multi Agency Safeguarding Hub (MASH) - including need to address backlogs in dealing with domestic violence notifications and the application of thresholds.
- The response to children who have been sexually abused and specifically the provision for medical examination.
- Adult mental health, drug and alcohol issues and the response by relevant agencies to the Ofsted thematic inspection 'What About the Children?'
- The effectiveness of early help provision and interface of these services with statutory child protection arrangements
- The incidence of re-referral of children to the MASH.

EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS – ISSUES, CHALLENGES AND PRIORITIES

Effectiveness of safeguarding arrangements – issues, challenges and priorities

Whilst it is clear that the risk of harm to children and young people cannot be eliminated entirely and there is no complacency regarding the need to continually improve services and their coordination, the NSCB is satisfied, through its quality assurance, review and audit functions, that the arrangements to safeguard children put in place by its partner agencies are overall appropriate and effective. The Board is further satisfied that robust arrangements are in place to identify areas which should be improved and that key issues have been prioritised in the plans of the Board, its partner agencies, and other strategic partnerships.

We have identified three strategic priorities to drive the work of the NSCB over the next two years to correspond with the scope of the Children & Young People Plan and the Health and Wellbeing Strategy. The priorities and actions will be reviewed annually in addition to the review of progress carried out each quarter by the Executive.

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

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

- Strengthening the role and engagement of partner agencies in the work of the NSCB and developing a culture of open and transparent self-analysis. Improving communications with key stakeholders, in particular children and young people. Ensuring frameworks to support safeguarding are in place and that the NSCB is effective at the delivery of its core purpose (in line with Working Together 2013).

EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS – ISSUES, CHALLENGES AND PRIORITIES

The business plan attached as **Appendix C** sets out further details including the desired objectives under each priority and how it is planned to achieve them. The following are some key highlights:

- Embedding the NSCB learning and improvement framework to ensure that priority areas of safeguarding are clearly understood, appropriate actions are developed to improve practice and evidence of the impact on improving outcomes for children and young people is gathered.

- Continue implementation of plans to improve responses to particular groups of vulnerable children, including those who go missing and those at risk of sexual exploitation.

- Training – specific work to improve the NSCB training strategy and bring it up to date, review/refine and fully implement the quality assurance process, introduce an evaluation of the impact of procedures and practice guidance.

- Communications and engagement – specific work to include the updating of the communication and engagement strategy and a specific focus on how the NSCB communicates with and responds to the views of children and young people.

- Review the role of the Safeguarding Children Information Management Team in light of the introduction of the MASH.

Children and young people are key stakeholders in services which they and their families receive, and also in the partnership frameworks within which these services operate. Ensuring that their voices are heard in both respects remains a priority for the NSCB.

The delivery of action plans to reduce the risk of child sexual exploitation and/or children going missing is a key objective for the NSCB, as is ensuring that the response to children who disclose sexual abuse is effective. Supporting the development of the right services and providing revised interagency guidance and training are important priorities for the Board.

EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS – ISSUES, CHALLENGES AND PRIORITIES

Key Challenges for agencies and partnerships during 2014/5 and beyond

- Ensure that the responses by all agencies and organisations to resource constraints take a long term view on the need to reduce child abuse and neglect and contribute to breaking the inter-generational cycle of adverse outcomes for children.
- Ensure that in the delivery and review of all strategic partnership plans and agency service developments, the needs of and impact on children and young people are fully considered.
- Reassure and maintain the confidence of the people of Nottinghamshire, including the staff of partner agencies, in the effectiveness of safeguarding arrangements; particularly in the context of local and national attention on responses to child sexual exploitation and historic sexual abuse.
- Ensure that arrangements for the introduction of the absent classification for missing children do not increase vulnerability and risk.
- Embed current initiatives to improve the robustness of child protection planning.
- Ensure piloting of the Safeguarding Assessment and Analysis Framework does not adversely impact on services outside of the pilot area.
- Ensure that the current review of CAMHS leads to provision of effective and coherent services for all children with mental health difficulties – including capacity in services for those who need in-patient treatment.
- Completion of the work in response to the 'What About the Children' thematic report to ensure that all children exposed to parental mental health and substance misuse issues are identified and responded to appropriately.
- Ensure that the comprehensive multi-agency approach to preventing and responding to Child Sexual Exploitation in Nottinghamshire is embedded into ongoing service provision.

APPENDICES

Appendices

NSCB Annual Report 2013/14

Appendices

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Appendix A

Nottinghamshire Safeguarding Children Board Membership

(As at 31/07/2014)

Chris Few	**NSCB Independent Chair**
Julie Gardner	**NSCB Vice Chair & Chair of NSCB Executive** Associate Director of Social Care, Nottinghamshire Healthcare NHS Trust
Nottinghamshire County Council Representatives	
Anthony May	Corporate Director, Children, Families & Cultural Services
Steve Edwards	Service Director, Children's Social Care, Children, Families & Cultural Services
John Slater	**Chair of NSCB Serious Incident Review Group** Service Director - Education Standards and Inclusion, Children, Families & Cultural Services,
Laurence Jones	Group Manager, Targeted Support & Youth Justice Service
Pam Rosseter	Group Manager, Safeguarding and Independent Review & Quality Assurance, Children, Families & Cultural Services
Paul McKay	Service Director Joint Commissioning, Quality and Business Change, Adult Social Care and Health
Justine Gibling	Group Manager, Early Years and Early Intervention, Children, Families & Cultural Services
Gary Eves	Senior Public Health and Commissioning Manager
Health Community Representatives	
Cathy Burke	**Chair of NSCB Child Death Overview Panel (CDOP)** Consultant Nurse, Safeguarding, NHS Bassetlaw Clinical Commissioning Group
Val Simnett	Designated Nurse Safeguarding Children, NHS Newark & Sherwood, Mansfield & Ashfield, Nottingham West, Nottingham North and East and Rushcliffe Clinical Commissioning Groups
Dr Fiona Straw	Designated Dr for Safeguarding (South), Nottingham University Hospitals NHS Trust
Deborah Oughtibridge	Deputy Director of Nursing and Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Elaine Moss	Director of Quality and Governance, Newark and Sherwood Clinical Commissioning Group
Rebecca Stone	Assistant Director of Quality and Patient Safety, Nottingham North and East Clinical Commissioning Group

Alfonzo Tramontano	Assistant Director of Nursing, Derbyshire and Nottinghamshire Area Team, NHS Commissioning Board,
Denise Nightingale	Head of Service Improvement, NHS Bassetlaw Clinical Commissioning Group
Dr Stephen Fowlie	Medical Director, Nottingham University Hospital NHS Trust
Wendy Hazard	Clincal Quality Manager, Nottinghamshire Div. HQ, East Midlands Ambulance Service
Bushra Ismaiel	Consultant Community Paediatrician, Designated Doctor for Safeguarding, Lead Clinician for Community Services, Doncaster & Bassetlaw Hospitals Trust
Andrew Haynes	Interim Medical Director of Nursing & Quality, Sherwood Forest Hospitals NHS Foundation Trust
Other Agency Representatives	
Mark Taylor	Assistant Chief Executive, Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company Ltd.
Nigel Hill	Head of Nottinghamshire, National Probation Service
Helen Chamberlain	Superintendent, Head of Public Protection, Nottinghamshire Police
Clare Taylor	Service Manager, CAFCASS
Joh Bryant	**Chair of NSCB Learning & Development Sub Group and District/Borough Council Safeguarding Group** Head of Housing, Broxtowe Borough Council
Sue Fenton	**Voluntary Sector Representative** Nottinghamshire Association of Voluntary Organisations Manager, Home Start Nottingham
Lay Members	
Victoria Morley	
Peter Wright	
Advisors to the Board	
Steve Baumber	NSCB Business Manager
Hannah Hogg	NSCB Development Manager
Trish Jordan	NSCB Training Coordinator
Participant Observer	
Councillor Kate Foale	Lead Member for Children's Social Care

Appendix B

NSCB Financial Arrangements

Agency contributions 2013-14

Agency	Basic contribution
Nottinghamshire County Council Children, Families and Cultural Services Department (includes £7,000 from Schools Forum)	£141,310
Nottinghamshire Probation Service	1,958
Nottinghamshire Police	17,612
Children & Families Courts Advisory Services	550
NHS Bassetlaw Clinical Commissioning Group	23,000
NHS Newark & Sherwood, Mansfield & Ashfield, Nottingham West, Nottingham North and East and Rushcliffe Clinical Commissioning Groups	64,404
Total	**£248,834**

In addition to the above, there was a cumulative figure in reserves from 2012-13 of £104,176.

Expenditure 2013-14

	Actual spend at end of year March 2014
NSCB Administration/Independent Chair/Developmental work	£69,119
Safeguarding Children Information Management Team	£94,780
NSCB Training – delivery and staff costs	£77,621
Serious Case Reviews	£38,723
Total	**£280,243**

Outside the above arrangements, NCC and NHS Nottinghamshire County together meet the costs of the NSCB Manager post.

£30,249 was drawn down from reserves to contribute to the cost of serious case reviews as part of a planned reduction of the reserve

Appendix C

NSCB BUSINESS PLAN 2014 – 2016

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD **BUSINESS PLAN 2014 – 2016**	Nottinghamshire SAFEGUARDING CHILDREN Board

Independent Chair: Chris Few

Effective from: 1st April 2014

Review date: Progress will be reviewed quarterly through the NSCB Executive Group

Strategic Priorities:
We have identified three strategic priorities to drive the work of the NSCB over the next two years to correspond with the Children & Young People Plan and the Health and Wellbeing Strategy. The priorities and actions will be reviewed annually in addition to the review of progress carried out each quarter by the Executive.

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

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

- Strengthening the role and engagement of partner agencies in the work of the NSCB and developing a culture of open and transparent self-analysis. Improving communications with key stakeholders, in particular children and young people. Ensuring frameworks to support safeguarding are in place and that the NSCB is effective at the delivery of its core purpose (in line with Working Together 2013)

Strategic Priority One		Through a comprehensive understanding of the needs of children and young people in Nottinghamshire, to ensure that the work of the NSCB and its partner agencies is focussed on the most vulnerable, their safety and empowerment			
Ref. No.	**What do we want to achieve**	**How will we achieve this**	**Lead NSCB Member**	**Supporting NSCB Officer**	**When are we going to do this**
1.1	Develop a full understanding of the population of children and young people in Nottinghamshire	Analysis of the current and projected needs of children and young people across Nottinghamshire will be provided to the Board and steer its planning priorities	NSCB Chair	NSCB Manager	June 2014
		Accessing partner agencies' reports on their engagement with children and young people, in particular how they ensure the views of children and young people are heard and responded to	NSCB Chair	NSCB Manager	Ongoing
		Details of the current situation regarding safeguarding children in education will be presented to the Board outlining emerging issues, managing allegations and the impact of the Safeguarding in Education Forum	Group Manager Safeguarding & Independent Review	NSCB Manager	June 2014
		Undertake an assessment of the level of Fabricated and Induced Illness and identify any practice issues Delivery of subject specific training on FII	Designated Doctors Bassetlaw and Nottinghamshire County	NSCB Training Coordinator	September 2014
		Establish an understanding of the extent of Female Genital Mutilation within Nottinghamshire through the provision of reports from the acute hospital trusts	Acute hospital trust NSCB representatives	NSCB Manager	September 2014

Ref. No.	What do we want to achieve	How will we achieve this	Lead NSCB Member	Supporting NSCB Officer	When are we going to do this
1.2	Ensure safeguarding practice in relation to particularly vulnerable children is effective	**Child Sexual Exploitation** Implementation of the local CSE action plan to ensure that children at risk of CSE are protected from harm, joint working in response to reports of CSE is effective and appropriate support is provided to the children affected	Head of Public Protection and Group Manager Safeguarding & Independent Review	NSCB Manager	Quarterly reports to the Executive
		Missing Children Implementation of missing children action plans including:- • Identification of key performance indicators for inclusion in the Performance Information Report • Review and revise the Missing Children Protocol • Disseminate the learning from the multi-agency missing children audit	Head of Public Protection and Group Manager Safeguarding & Independent Review	NSCB Manager	September 2014
				NSCB Manager	September 2014
				NSCB Manager	May 2014
		Children subject to sexual abuse • Launch of sexual abuse revised interagency practice guidance and related training • Evaluation of the impact of work related to learning identified through serious case reviews	L & D Sub group Chair	NSCB Training Coordinator	July 2014
			NSCB Chair	NSCB Development Manager	September 2014
		Children exposed to domestic abuse • The work of the domestic abuse forum to be reported to the NSCB • Revise the domestic abuse practice guidance • Evaluation of the impact of work related to learning identified through serious case reviews and Domestic Homicide Reviews	CSC Service Director	NSCB Manager	October 2014
			CSC Service Director	NSCB Manager	October 2014
			NSCB Chair	NSCB Development Manager	December 2014

Ref. No.	What do we want to achieve	How will we achieve this	Lead NSCB Member	Supporting NSCB Officer	When are we going to do this
1.2 (cont.)	Ensure safeguarding practice in relation to particularly vulnerable children is effective (cont.)	**Children living with parents/carers who misuse drugs/alcohol or have mental health issues** • Receive reports from the task and finish group including details of the review of current working practices	CSC Service Director	NSCB Manager	June 2014
		Looked After Children Outcomes for LAC should be monitored by the NSCB including the stability of educational provision and quality of health provision Arrangements for external placements should be scrutinized	CSC Service Director	NSCB Manager	December 2014
		Vulnerable Young Families Support the ongoing development of the Family Nurse Partnerships	NSCB Chair	NSCB Manager	March 2015
		Children who self - harm • Strengthen multi-agency arrangements to respond to children who self - harm • Evaluate the impact of work related to the learning from the NSAB review (F13)	Group Manager Safeguarding & Independent Review/Targeted Support & Youth Justice Services/ Senior Public Health & Commissioning Manager	NSCB Manager	September 2014
			NSCB Chair	NSCB Development Manager	December 2014

Strategic Priority Two		To provide effective scrutiny of safeguarding outcomes for children and young people; embed the NSCB learning and improvement framework and ensure that training, procedures and guidance support improvements in safeguarding children			
Ref. No.	**What do we want to achieve**	**How will we achieve this**	**Lead NSCB Member**	**Supporting NSCB Officer**	**When are we going to do this**
2.1	Local organisations are able to improve services by learning from experience and particularly through understanding the way organisations work together to safeguard and protect the welfare of children.	Embed the effective implementation of the Learning and Improvement Framework	NSCB Chair	NSCB Manager	June 2014
		Develop the NSCB Learning and Improvement Framework to fully describe the arrangements in place and to ensure that priority areas of safeguarding are clearly understood	NSCB Chair	NSCB Manager	June 2014
		A risk register for the Board should be developed that identifies key emerging issues that impact on safeguarding children within Nottinghamshire	NSCB Chair	NSCB Manager	June 2014
		Review each aspect of the framework to evaluate its effectiveness, ensuring that appropriate actions are developed to improve practice and evidence of the impact on improving outcomes for children and young people is gathered	NSCB Chair	NSCB Manager/ NSCB Development Manager/NSCB Training Coordinator	November 2014
		Strengthen the process for evaluating the impact of responding to the learning from case reviews and multi-agency case audits	NSCB Chair	NSCB Development Manager	September 2014

Ref. No.	What do we want to achieve	How will we achieve this	Lead NSCB Member	Supporting NSCB Officer	When are we going to do this
2.2	The connectivity between training priorities/activities and learning through the NSCB Learning and Improvement Framework is clear and effective quality assurance processes are in place for training provision	• Review and revise the NSCB Training Strategy to ensure it reflects the requirements of Working Together 2013, Ofsted and local commissioning needs incorporating the broader learning and improvement activities that will impact on the wider workforce	L & D Sub group Chair	NSCB Training Coordinator	May 2014
		• Review and develop the Quality Assurance Scheme in relation to single and multi-agency training	L & D Sub group Chair	NSCB Training Coordinator	June 2014
2.3	A comprehensive understanding of safeguarding outcomes for children and young people	Performance information which includes evidence of outcomes will be regularly presented to the Executive and areas for action identified • The Executive will ensure that the performance information reporting arrangements take into account the feedback from the NSCB review meeting (10/02/14) and in particular includes information from across the partnership	Chair of NSCB Executive	NSCB Manager	At each Executive meeting

Strategic Priority Three		Strengthening the role and engagement of partner agencies in the work of the NSCB and developing a culture of open and transparent self-analysis. Improving communications with key stakeholders, in particular children and young people. Ensuring frameworks to support safeguarding are in place and that the NSCB is effective at the delivery of its core purpose (in line with Working Together 2013)			
Ref. No.	**What do we want to achieve**	**How will we achieve this**	**Lead NSCB Member**	**Supporting NSCB Officer**	**When are we going to do this**
3.1	Frameworks for effective interagency safeguarding practice are in place	Review the role and function of the Safeguarding Children Information Management Team and how these functions map to the MASH arrangements and child protection processes	CSC Service Director	NSCB Manager	December 2014
		Provide scrutiny around the effectiveness of information sharing protocols	CSC Service Director	NSCB Development Manager	December 2014
		Provide scrutiny around the effectiveness of assessment processes	CSC Service Director	NSCB Manager	December 2014
		Monitor the impact of the Pathway to Provision (thresholds document) and oversee revisions	Group Manager NCC Early Help	NSCB Training Coordinator	March 2015
3.2	The role of members and engagement of partner agencies in the work of the NSCB will be strengthened	Induction arrangements for new NSCB members are reviewed and revised. Ongoing support is provided to the lay members to facilitate their full engagement with NSCB functions	NCC Lead Member & CSC Service Director	NSCB Manager	June 2014 & ongoing
		Representation on the NSCB from health organisations will be reviewed	NSCB Chair	NSCB Manager	September 2014
		Links between the NSCB and the education sector will be strengthened	Service Director, Education Standards & Inclusion	NSCB Manager	March 2015
		A Job Description and appraisal system for individual members will be introduced	NCC Lead Member & CSC Service Director	NSCB Manager	December 2014
		Increase the number of issues from their own organisations brought by NSCB members to the Board for scrutiny and collective challenge	NCC Lead Member & CSC Service Director	NSCB Manager	September 2014 & ongoing

Ref. No.	What do we want to achieve	How will we achieve this	Lead NSCB Member	Supporting NSCB Officer	When are we going to do this
3.3	Communicate the need to safeguard children and provide information on how this can best be done. Strengthen the NSCB connectivity with frontline practitioners	A new NSCB website should be developed that provides easy access to clear information that will: - • equip professionals to work effectively to safeguard children • inform the public on safeguarding issues and the role of the NSCB This work should build on the revisions to the NCC hosted webpage	NSCB Chair/Lay Members	NSCB Manager	June 2014
		Following the implementation of the new interagency procedures in May 2014 the following is carried out: • analysis of the access and use of the procedures and practice guidance • Review and revision of the procedures and practice guidance taking into account the results of the above analysis and feedback received from other sources	Service Director Education Standards & Inclusion	NSCB Development Manager/NSCB Training Coordinator	September 2014
		NSCB Newsletter to be published on a 6 monthly basis with additional bulletins every two months on specific issues	Group Manager Safeguarding & Independent Review	NSCB Training Coordinator	November 2014
		A programme of frontline visits by NSCB members should be carried out in order to connect with key safeguarding practitioners and processes and strengthen two way communications	NCC Lead Member & CSC Service Director	NSCB Manager	June 2014 and ongoing
		Update the NSCB Engagement and communication strategy to include development and implementation of initiatives which secure greater awareness by front-line practitioners of what the NSCB does and what difference it makes	Designated Doctor (FS) & Lay Member (VM)	NSCB Development Manager	December 2014

Ref. No.	What do we want to achieve	How will we achieve this	Lead NSCB Member	Supporting NSCB Officer	When are we going to do this
3.4	Effective communication and engagement with children and young people	Development of a statement of the purpose of engaging with the Nottinghamshire Young People's Board, the arrangements for doing so and how the effectiveness of this engagement will be measured	NSCB Chair	NSCB Development Manager	July 2014
		Invitation to representatives of the Young People's Board to attend an NSCB meeting to inform this work	NSCB Chair	NSCB Development Manager	June 2014
3.5	Agencies and strategic partnerships have safeguarding children as a central element of their planning, business and commissioning activity	The NSCB Annual Report challenges agencies about their responsibilities and performance with regard to safeguarding children	NSCB Chair	NSCB Manager	September 2014
		NSCB members challenge the activities of their own organisations, relevant to safeguarding children, through internal governance arrangements	NCC Lead Member & CSC Service Director	NSCB Manager	March 2015

Appendix D

NSCB Training Information

2013-14 Training Programme - course and attendance information

Course	Frequency	Content	No. of participants.
Introduction to Safeguarding Children	2	Basic safeguarding awareness, personal and organisational responsibilities- commissioned for those agencies that are unable to provide their own singe agency introductory training	43
Working Together to Safeguard Children	17	Safeguarding legislation, policies and procedures. Effective assessments and analysis of risks. Communication and information sharing	401
What's New in Safeguarding	3	Briefing on current local and national safeguarding issues and 'refresher' for practitioners who may have attended core training events	293
Child Sexual Exploitation: Full day	4	How to identify and respond to children and young people who experience sexual exploitation; for all staff who work directly with children and young people.	121
Child Sexual Exploitation: Half day	3	Basic awareness of issues which affect children and young people who may experience sexual exploitation for all staff.	162
Working with Complex Cases	2	Explore and understand the complexities of multi-agency practice and consider the challenge of engaging parents and facing resilience.	56
Improving practice when working with Neglect Seminar	1	Raise awareness of recent learning about neglect and understand challenge of early identification and intervention.	70
Safeguarding Vulnerable Young People	1	How to recognise vulnerability in young people and increase practitioners confidence in working with young people and families, including contributing to assessments of need and risk	47
Child Protection Medicals	2	Provide clarity and resolve issues around Child protection medical examinations, incorporating the legal perspective	93
Learning lessons from serious Case Reviews	1	Disseminate lessons from the most recent SCR's in Nottingham City and Nottinghamshire	95
Responding to unexpected child deaths	1	Details of the different components of the rapid response to an unexpected child death and the role of professionals involved in the process.	42
E Learning Courses	Unlimited	Basic awareness of Child Abuse and Neglect.	1747 Licences allocated. 1331 Passes.

Attendance at NSCB Multi-Agency training by agency/organisation

	2012/13	2013/14
Army	1	2
CAFCASS	7	13
Children Centres	121	159
District & Borough Councils	51	25
Health Sector	**210**	**279**
Nottingham University Hospitals Trust	8	17
County GP Consortium	37	18
Doncaster & Bassetlaw Hospitals Trust	4	4
East Midlands Ambulance Service	3	4
Nottinghamshire Healthcare NHS Trust(mental health services)	30	35
Bassetlaw Health Partnership	7	19
County Health Partnership	83	138
Sherwood Forest Hospitals Trust	22	43
Others	16	1
Nottinghamshire County Council	**450**	**410**
Children Families & Cultural Services(service area not specified)	227	2
Children's Social care	117	239
Youth Families & Culture	43	8
Targeted Support & Youth Justice	52	94
Young Peoples Service	3	9
Early Years & Early Intervention	25	38
Education, Standards & Inclusion	22	15
Adult Social Care & Health	18	1
Environment & Recourses	32	3
Policy Planning & Corporate Services	5	0
Legal	0	1
Nottinghamshire Fire & rescue Service	6	3
Police	46	38
Nottinghamshire Probation Service	32	31
Private	54	42
Schools & Colleges	216	214
Voluntary Sector & Charities	155	121
Other	0	5
Grand Total	**1441**	**1342**

Appendix E

NOTTINGHAMSHIRE

SAFEGUARDING CHILDREN BOARD

2013/14

Performance Information Report

NSCB Performance Information Report

This report to the Nottinghamshire Safeguarding Children Board (NSCB) sets out key performance information for this quarter. The indicators reported have been selected by the Board and include specific areas of practice previously reported through the Safeguarding Improvement Programme reporting arrangements which the Board agreed should continue to be monitored within this framework.

Where targets have been set the Nottinghamshire County Council corporate RAG rating definitions have been used: -

	**Off target by 10% or more**
	**Off target by less than 10%**
	**On or above target**

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD (2013/14)

Performance Information Report

Key Headlines

	Good performance	2012/13	Q1	Q2	Q3	Q4	Trend (Q1-Q4)
Enquiries & Referrals							
No. of Enquiries/Contacts to the MASH	N/A	15,642	4445	4735	4408	4248	↓
No. of Referrals completed by Children's Social Care	N/A	7806	2469	2708	1921	1963	↓
Re-referral Rate (%)	Lower	18.6	24.3	24.9	29.1	28.9	↑
Assessments							
Initial Assessment within timescale – 10 working days (%)	Higher	79.3	64.1	72.7	85.0	88.4	↑
No. of Initial Assessments	N/A	6105	2579	2941	2100	1883	↓
Core Assessment within timescale 35 working days (%)	Higher	3392	80.7	86.3	85.6	87.3	↑
No. of Core Assessments	N/A	82.2	689	684	634	505	↓
Looked After Children							
No. of Looked After Children	N/A	875	894	905	868	830	↓
No. of Admissions into care	N/A	365	112	91	74	69	↓
No. of Discharges from care	N/A	290	98	71	92	82	↓
Child Protection							
No. becoming subject of a Child Protection Plan	N/A	1002	323	238	274	170	↓
No. discontinued of a CP Plan	N/A	881	287	346	344	243	↑
No. of Children on a CP Plan	N/A	786	830	723	657	587	↓
% Children becoming subject of a CP Plan for a second or subsequent time	Lower	17.4	12.1	15.1	19.0	23.5	↑
% Children with CP Plans lasting 2 years or more	Lower	4.7	1.4	5.7	4.7	0.4	↓
% Child Protection Review timescale	Higher	97.5	99.8	99.6	97.2	97.4	↓

1. Nottinghamshire Early Help

Table 1.1 – Total number of CAF compliant assessments completed

	Qtr. 2	*Qtr. 3 - 2013*			*Qtr. 4 - 2014*		
	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of Assessments Completed	76	220	231	143	145	87	119

N.B. Work is ongoing to strengthen the validation of this data

Table 1.2 – Number of CAF compliant assessments by district

	Qtr. 2	*Qtr. 3 - 2013*			*Qtr. 4 - 2014*		
District	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Ashfield	14	38	42	22	29	12	19
Bassetlaw	10	40	37	19	19	11	14
Broxtowe	7	18	32	15	16	9	23
Gedling	16	34	24	23	19	12	13
Mansfield	9	27	34	13	24	13	19
Newark	6	28	35	28	16	16	24
Rushcliffe	14	31	23	11	16	10	6
Nottingham City	0	3	3	8	3	3	0
Other	0	1	1	4	3	1	1
TOTAL	**76**	**220**	**231**	**143**	**145**	**87**	**119**

Table 1.3 – CAF compliant assessments by number and percentage of age band - Quarter 4 - 2013-2014

	Qtr. 2		*Qtr. 3 - 2013*						*Qtr. 4 - 2014*					
Age	Sept	%	Oct	%	Nov	%	Dec	%	Jan	%	Feb	%	Mar	%
Unborn	2	3	1	0	0	0	3	2	0	0	0	0	0	0
Aged 0-4	18	24	30	14	24	10	14	10	18	12	11	13	18	15
Aged 5-11	37	49	43	20	61	26	29	20	34	23	20	23	31	26
Aged 12-16	17	22	136	62	134	58	82	57	80	55	50	57	56	47
Aged 17+	2	3	10	5	12	5	15	10	13	9	6	7	14	12
Total	**76**	**100**	**220**	**100**	**231**	**100**	**143**	**100**	**145**	**100**	**87**	**100**	**119**	**100**

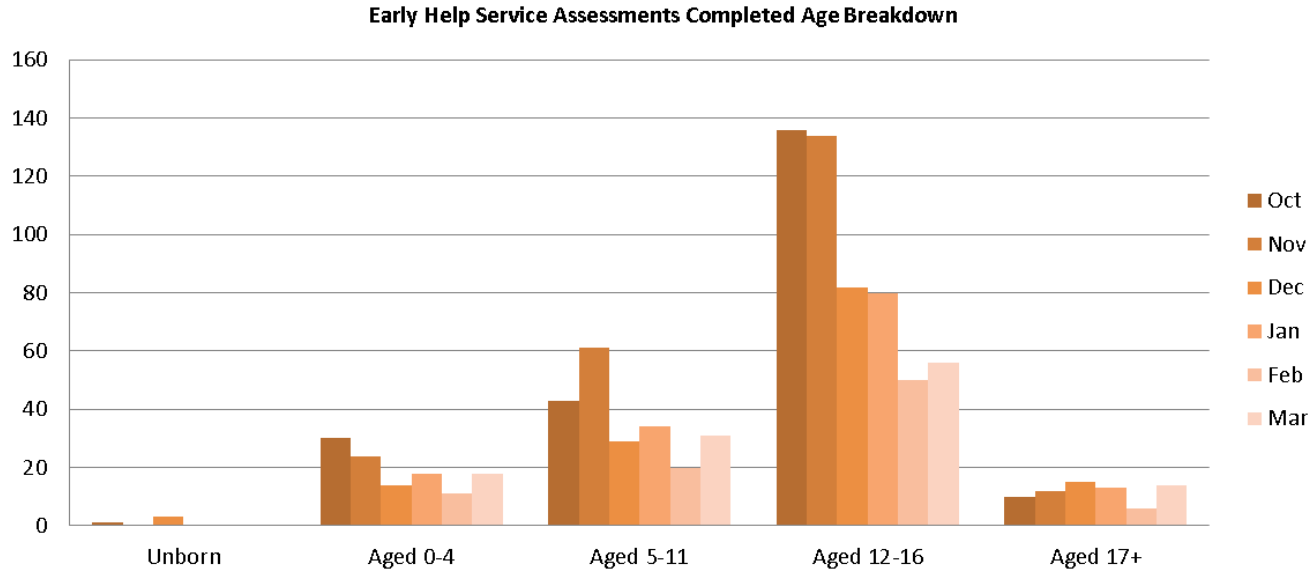
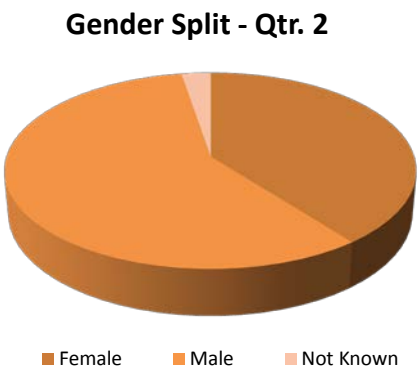
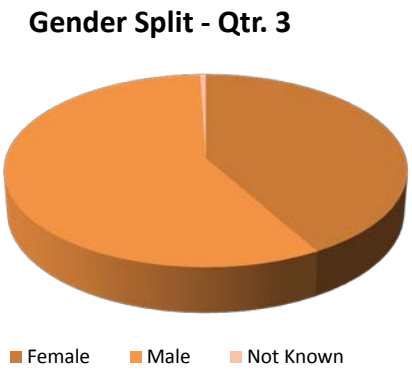
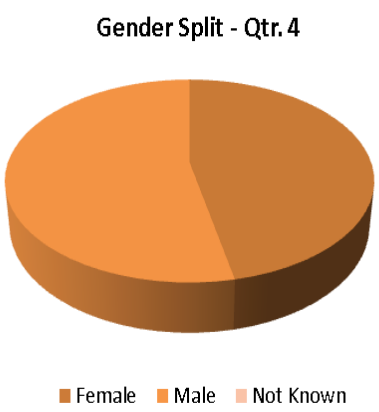


Table 1.4 – CAF compliant assessments by number and percentage of gender - Quarter 4 - 2013-2014

	Qtr. 2		*Qtr. 3 - 2013*						*Qtr. 4 - 2014*					
Gender	Sep	%	Oct	%	Nov	%	Dec	%	Jan	%	Feb	%	Mar	%
Female	30	39	91	41	95	41	62	43	58	40	43	49	63	53
Male	44	58	128	58	136	59	79	55	87	60	44	51	56	47
Not Known	2	3	1	0	0	0	2	1	0	0	0	0	0	0
Total	**76**	**100**	**220**	**100**	**231**	**100**	**143**	**100**	**145**	**100**	**87**	**100**	**119**	**100**







Commentary – Nottinghamshire Early Help

Between October 2013 and February 2014, 2708 early help initiations were recorded as part of the early help dataset. During the same period 826 early help (CAF) assessments were completed and 1797 cases closed by services.

Over eighty-eight percent of early help initiations were requests for services from early help services (fifty per cent for Children's Centres and forty-two per cent for Targeted Support). The remaining eleven per cent of early help initiations were for the logging of early help assessments with the Early Help Unit (forty-seven cent were logged by schools)

Between October 2013 and February 2014, the geographical distribution of completed assessments ranged from seventeen per cent in Ashfield and Mansfield to eleven per cent in Broxtowe and Rushcliffe.

The age distribution reflects the relatively high percentage of completed assessments by Targeted Support with over fifty-eight per cent of assessments completed with young people aged between 12 and 16 years of age between October 2013 and February 2014.

The breakdown by gender of completed assessments is fifty-seven per cent male and forty-two per cent female (the remainder being not known e.g. unborn) for the period October 2013 and February 2014

2. Multi-Agency Safeguarding Hub

Table 2.1: Number of Enquiries into the MASH completed

	2013/14			
	Q1	**Q2**	**Q3**	**Q4**
Ashfield	877	880	809	773
Mansfield	754	785	730	724
Bassetlaw	633	707	707	624
Newark	586	645	564	527
Broxtowe	511	476	509	529
Gedling	560	684	564	569
Rushcliffe	293	307	290	257
Out of County	57	96	83	77
Blank[1]	174	155	152	168
Nottinghamshire	**4445**	**4735**	**4408**	**4248**
Children with a Disability	26	56	50	60

1 These enquiries are data quality issues and sent to the Framework team on a regular basis to be resolved.

Table 2.2 Outcome of Enquiries Completed

	2013/14			
	Q1	**Q2**	**Q3**	**Q4**
Advice & Guidance only – No further action	291	379	586	336
MASH Enquiry Closed – No further action	1050	1197	1189	1338
Case closed after information sharing	317	225	419	252
Pass to other agency – No further action	126	36	23	7
Pass to Early Help – No further action	192	136	199	240
Pass to Assessment Teams	2469	2752	1924	1980
Total	**4445**	**4725**	**4340**	**4153**

Table 2.3: Repeat MASH Enquiries

	2013/14			
	Q1	**Q2**	**Q3**	**Q4**
No. of Children with more than 1 MASH Enquiry in the 3 month period	368	457	431	376
Percentage of children with more than 1 MASH enquiry in 3 month period	9.1	10.4	11.2	9.4

Table 2.4: Timeliness of the MASH Enquiry Process (Original Call Only)

	2013/14							
	Q1		**Q2**		**Q3**		**Q4**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**
On time	820	52	977	60	594	45	523	40
Late	770	48	654	40	719	55	797	60
Total	**1590**	**100**	**1631**	**100**	**1313**	**100**	**1320**	**100**

Timescale = Red rated enquiries 4 hrs pre 14/7/13 and post this date 6 hrs, Amber rated enquiries 8.5 hrs , Green rated enquiries 25.5 hrs

3. Referrals & Assessments

Table 3.1: Referrals to Children's Social Care from the MASH		2012/13	Good	2012/13 Target	2013/14			
					Q1	Q2	Q3	Q4
	No of child referrals completed*	7806	N/a	N/a	2469	5177	7098	9061
AP 04	Re-referrals within 12 months of previous referral as a % of child referrals started	18.6	Lower	26	24.3 	24.9 	29.1 	28.9 
NI 68	Referrals to children's social care going on to initial assessment or strategy discussion (%)	91.9	Median	N/a	100**	100**	100**	100**

* The quarterly figures provided are accumulative across the year.

** The new definition of a child referral has changed to a completed MASH Decision with an outcome of "Undertake Initial Assessment" or "Strategy Discussion" therefore this indicator is always 100%.

Indicator Commentaries

AP04: Re-referrals into Children's Social Care:

The variable performance against this indicator has made it subject to management scrutiny for some time.

An independent audit of re-referrals was therefore commissioned in February 2014 and has identified issues with the categorisation of some repeat enquiries, suggesting that some in the sample audit (20 cases) were the first enquiry and not repeat enquiries, some matters were not repeat enquiries but had additional information received by MASH after the case has progressed, and some repeat enquiries showed that the previous contact/referral was well over one year ago. Of the 10 cases that did contain the same or similar re-referral information, only 4 may well not have been re-referrals if previous intervention had been more positive and proactive.

Overall the view of the audit was that the data concerning repeat MASH enquiries (re-referrals) is not wholly accurate, and that the true picture is of less concern. Further work is now being carried out to clarify the time and definition parameters for collection of data in relation to repeat MASH enquiries.

NI68: Referrals to Children's Social Care going on to initial assessment or strategy discussion:

Children's Social Care continues to focus efforts to apply the thresholds as set out in the Pathway to Provision guidance. Independent audit work has indicated that too much work is being progressed to Children's Social Care, resulting in no further action following initial assessment. With the changes made in the MASH in September 2013, qualified social worker triage should mean that a higher proportion of referrals appropriately go on to initial assessment. The introduction of an Early Help unit in September 2013 also supports effective sign-posting to early help services, rather than referral to children's social care services. From April 2014 management arrangements between the MASH and the Early Help Unit have been aligned to further support consistency of practice.

Table 3.2: Initial Assessments by Children's Social Care				2012/13	2013/14				
					Q1	Q2	Q3	Q4	Total
	Initial Assessments completed within timescale			4844	1653	2137	1784	1665	7239
	Other initial assessments completed			1261	926	804	316	218	2264
	Total number of initial assessments			6105	2579	2941	2100	1883	9503
NI 59 AP01	Initial assessments completed within timescale (10 working days) (%)	**Good**	**Target**	**2012/13**	**2013/14**				
					Q1	**Q2**	**Q3**	**Q4**	**For the year**
		Higher	75.0	79.3	64.1	72.7	85.0	88.4	76.2

Indicator Commentary

NI 59/AP01: Initial Assessments completed within timescale:

The completion of initial and core assessments has been retained within safeguarding practice whilst Nottinghamshire takes part in the DfE pilot of the Safeguarding Assessment and Analysis Framework (SAAF)

Performance in the timely completion of initial assessments has recovered well following the changes implemented to the MASH in September 2013 to address the volume of MASH enquiries being passed for initial assessment.

These changes were designed to bring children's social workers closer to initial call handling, so an appropriate and confident assessment of the information being presented can be made by a qualified social worker. Only those enquiries which meet the threshold for Children's Social Care should be progressed to Initial Assessment, following the social workers recommendation and with Team Manager oversight. In this way, the amount of work entering the system has been stemmed and allowed Children's Social Care to regain its focus on the most vulnerable children and families.

Table 3.3: Core Assessments by Children's Social Care

				2012/13	2013/14				
					Q1	Q2	Q3	Q4	Total
	Completed within 35 working days of initial assessment			2787	556	590	543	441	2130
	Other core assessments completed (out of time)			605	133	94	91	64	382
	Total number of core assessments during year			3392	689	684	634	505	2512
					2013/14				
NI 60 AP02	Core assessments for children's social care that were carried out within 35 working days of their commencement (%)	**Good**	**Target**	**2012/13**	**Q1**	**Q2**	**Q3**	**Q4**	**For the year**
		Higher	72.0	82.2	80.7	86.3	85.6	87.3	84.8

Indicator Commentary

NI 60/AP02: **Core assessments for children's social care that were carried out within 35 working days of their commencement**:

Performance in the timely completion of Core Assessments has remained strong throughout the year, with the number of core assessments being completed remaining at consistently manageable levels.

4. Section 47 Enquiries and Child Protection Conferences

Table 4.1: Section 47 (Children Act 1989) enquiries and child protection conferences		2012/13	2013/14				
			Q1	Q2	Q3	Q4	Total
	Number of children who were the subject of S.47 enquiries	2187	673	611	809	613	2729
	Number of children who were the subject of Initial Child Protection Conferences (ICPCs)	1008	395	273	320	215	1202
	Number of ICPCs	585	201	127	161	123	604
	Number of children whose ICPCs were held within 15 working days of the initiation of the S47 enquiries which led to the conference	873	371	245	300	203	1119
	Percentage ICPCs held within 15 working days of the initiation of the S47 enquiries which led to the conference	86.6	93.9	89.7	93.8	94.4	93.1
	Number of children who were the subject of Review Child Protection Conferences (RCPCs)	2463	623	652	599	567	2441
	Number of Review Child Protection Conferences (RCPCs)	1345	343	371	296	289	1285
	Number of dual status children (children on a child protection plan and looked after)	41	23	13	11	15	15
	Number of dual status children who have been looked after for more than 3 months	8	1	2	2	1	1

		Good	Target	2012/13	2013/14				
					Q1	Q2	Q3	Q4	
NI 65 AP06	Children becoming the subject of a Child Protection Plan for a second or subsequent time (%)	Lower*	14	17.4	12.1	15.1	19.0	23.5	16.6
NI 64 AP05	Child protection plans lasting 2 years or more (%)	Lower*	5.7	4.7	1.4	5.7	4.7	0.4	3.4
NI 67 AP03	Child protection cases which were reviewed within required timescales (%)	Higher	98	97.5	99.8	99.6	97.2	97.4	97.4

NB. End of year totals will sometimes be different to the cumulative total of the information shown for each quarter because annual data relates to individual children

NI67 timescale = 3 months for the first review and every 6 months thereafter

Indicator Commentaries

Commentary: NI 64: Child protection plans lasting 2 years or more (%):

During the January to March 2014 quarter, child protection plans were ceased for 243 children. Of these, only 1 child had had a plan lasting for 2 years or more. This performance reflects the commitment to child protection plans being progressed in a timely manner and has resulted in performance well within the target figure - the year end figure being 3.3%.

Commentary: NI 65: Children becoming the subject of a Child Protection Plan for a second or subsequent time:

During the 4th quarter, 170 children became subject to a child protection plan, of these 40 children had been subject to a plan on at least one previous occasion. This reflects a high proportion for the quarter and was a particular issue in March with 32.8% of plans being repeat plans - this was significantly higher than any other month during the year and resulted in the year end figure being 18.2% which is over the target figure set of 14%. An external audit had considered repeat plans earlier in the year and had found that the thresholds used were generally in line with expectations. The number of repeat plans in March was 19 - which in itself was not significantly higher than some previous months but the total number of new plans was only 58, hence the high proportion. Performance in this area needs to be considered together with the low number of 2 year plus plans. However, it is important to note that this indicator is reported without any time period applied between the ending of the previous plan and the beginning of the new plan. When considering the percentage of children becoming subject to a repeat plan within 2 years of the previous plan ceasing, the figure drops to 8.5% (87 children from the total number of children becoming subject of a plan of 1,018).

Commentary: NI 67: Child Protection cases which were reviewed within required timescales (%):

There were a total number of review conferences during the year of 1285 which reviewed the plans of 2441 children. The drop in performance was significantly impacted by one review conference in October being out of timescale - this conference considered the plans for 6 children, hence the impact on overall figures. The figures for statistical neighbours and England average for 2012-13 (latest figures available) were 95.9 and 96.2 respectively.

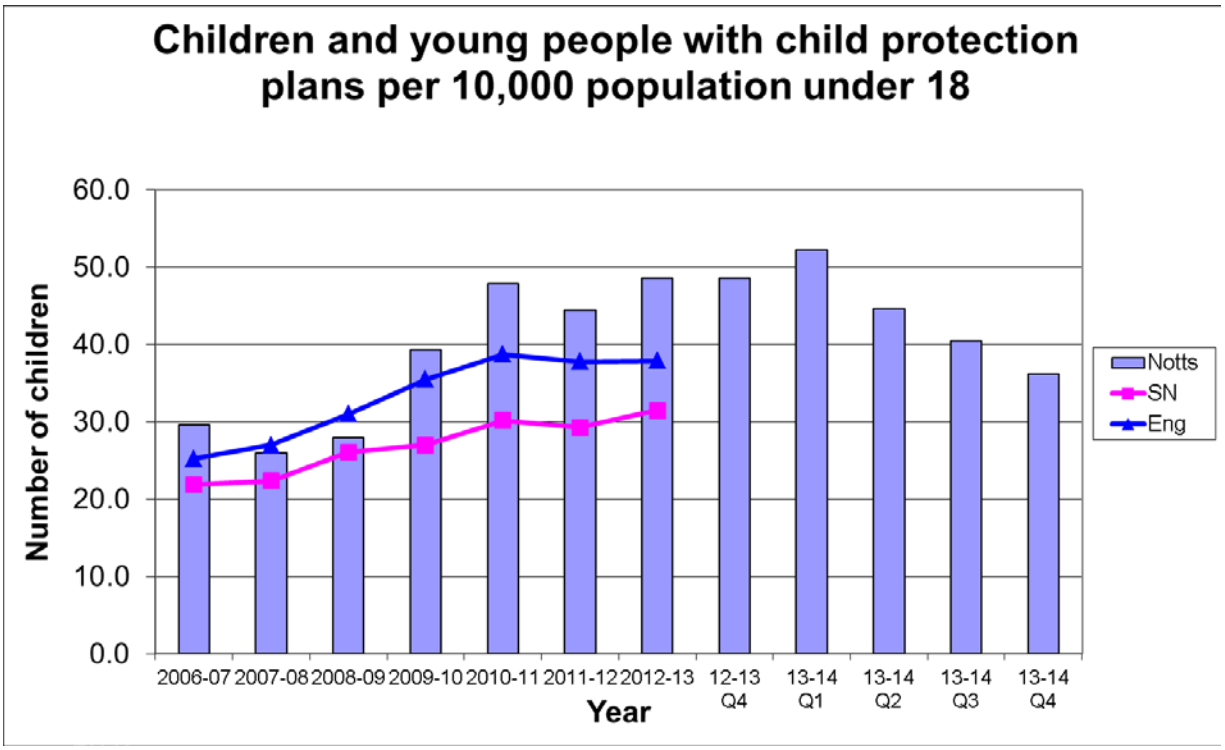
5. Children and Young People subject of a Child Protection Plan

Table 5.1: District and Locality Analysis

District	2012/13	2013/14			
	31/03/13	30/06/13	30/09/13	31/12/13	31/03/14
Ashfield	123	137	115	132	115
Mansfield	132	159	127	120	84
MAN/ASHFIELD	**255**	**296**	**242**	**252**	**199**
Bassetlaw	172	171	150	92	75
Newark	176	163	137	127	141
NEW/BASS	**348**	**334**	**287**	**219**	**216**
Broxtowe	39	60	48	57	71
Gedling	67	83	75	77	61
Rushcliffe	48	37	33	22	20
BGR	**154**	**180**	**156**	**156**	**152**
Others	31	37	18	30	20
TOTAL:	**788**	**847**	**723**	**657**	**587**

All figures are snapshot figures taken at the end of the month

Table 5.2: National Comparison Graph



Commentary: Children subject to a Child Protection Plan – rate per 10,000

At the end of March 2014, there were 587 children subject to a child protection plan in Nottinghamshire. This signified a continual decrease over the year - at the end of March 2013 there had been 788 children subject to a plan. This decrease in numbers reflects a continued focus on ensuring that children's plans are progressed in a timely way, a commitment that children will only be subject to a plan for the least amount of time commensurate with their need for protection and a renewed focus on thresholds. Nottinghamshire has had a high number of children subject to a plan over recent years, compared with statistical neighbours and England average rate per 10,000. As at the end of March 2013, the Nottinghamshire rate was 48.6 compared with 31.5 and 37.9 respectively. By the end of March 2014, Nottinghamshire's rate has dropped to 36.2 – therefore now more in line with both statistical neighbours and England averages compared to the latest figures available.

Table 5.3: Age, Gender and Ethnicity of Children Subject of a Child Protection Plan

Gender	31/03/13		30/06/13		30/09/13		31/12/13		31/03/14	
	No.	%	No.	%	No.	%	No.	%	No.	%
Male	389	49.4	416	49.1	359	49.7	322	49.5	295	50.3
Female	388	49.2	423	49.9	358	49.5	325	49.0	282	48.0
Unborn/Gender n/k	11	1.4	8	0.9	6	0.8	10	1.5	10	1.7
TOTAL:	**788**	**100**	**847**	**100**	**723**	**100**	**657**	**100**	**587**	**100**

All figures are snapshot figures taken at the end of the month

Age	31/03/13		30/06/13		30/09/13		31/12/13		31/03/14	
	No.	%	No.	%	No.	%	No.	%	No.	%
Unborn children	12	1.5	10	1.2	6	0.8	14	2.1	9	1.5
Aged under 1 year	70	8.9	88	10.4	63	8.7	62	9.4	75	12.8
Aged 1-4 years	241	30.6	231	27.3	207	28.6	209	31.8	174	29.6
Aged 5-9 years	238	30.2	276	32.6	239	33.1	198	30.1	176	30.0
Aged 10-15 years	204	25.9	217	25.6	188	26.0	149	22.7	133	22.7
16 and over	23	2.9	25	3.0	20	2.8	25	3.8	20	3.4
TOTAL:	**788**	**100.0**	**847**	**100**	**723**	**100.0**	**657**	**100**	**587**	**100**

All figures are snapshot figures taken at the end of the month

Ethnicity	31/03/13		30/06/13		30/09/13		31/12/13		31/03/14	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
White British	713	84.2	667	84.6	615	85.1	539	82.0	493	84.0
Polish or other Eastern Europe	11	1.3	10	1.3	12	1.7	13	2.0	8	1.4
Any other white background	7	0.8	3	0.4	13	1.8	16	2.4	12	2.0
Mixed background	57	6.7	54	6.9	53	7.3	53	8.1	45	7.7
Asian background	32	3.8	16	2.0	13	1.8	21	3.2	16	2.7
Black background	3	0.4	3	0.4	3	0.4	2	0.3	2	0.3
Any other ethnic group	5	0.6	7	0.9	3	0.4	8	1.2	5	0.9
Not known/unborn	19	2.2	28	3.6	11	1.5	5	0.8	6	1.0
Total:	**847**	**100**	**788**	**100**	**723**	**100**	**657**	**100**	**587**	**100**

All figures are snapshot figures taken at the end of the month

Table 5.4: Child Protection Category for Children Subject of a Child Protection Plan

	31/03/13		30/06/13		30/09/13		31/12/13		31/03/14	
Child Protection Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Emotional	95	11.2	100	12.7	105	14.5	136	20.7	136	23.2
Neglect	219	25.9	221	28.0	217	30.0	251	38.2	256	43.6
Physical	89	10.5	61	7.7	66	9.1	56	8.5	34	5.8
Sexual	44	5.2	42	5.3	43	5.9	31	4.7	28	4.8
Multiple:										
Emotional, Neglect	56	6.6	60	7.6	41	5.7	41	6.2	28	4.8
Emotional, Neglect, Physical	23	2.7	12	1.5	22	3.0	6	0.9	2	0.3
Emotional, Neglect, Physical, Sexual	0	0.0	1	0.1	0	0.0	0	0.0	0	0.0

Emotional, Neglect, Sexual	1	0.1	6	0.8	0	0.0	0	0.0	0	0.0
Emotional, Physical	261	30.8	214	27.2	185	25.6	118	18.0	73	12.4
Emotional, Physical, Sexual	0	0.0	12	1.5	1	0.1	2	0.3	0	0.0
Emotional, Sexual	11	1.3	6	0.8	10	1.4	6	0.9	7	1.2
Neglect, Physical	22	2.6	23	2.9	16	2.2	7	1.1	14	2.4
Neglect, Physical, Sexual	0	0.0	4	0.5	1	0.1	0	0.0	0	0.0
Neglect, Sexual	17	2.0	24	3.0	10	1.4	3	0.5	9	1.5
Physical, Sexual	9	1.1	2	0.3	6	0.8	0	0.0	0	0.0

Table 5.5: Child Protection Category for Children Subject of a Child Protection Plan by District

	Ash	Mans	Bass	New	Brox	Ged	Rush	Other
Child Protection Category								
Emotional	14	28	25	17	17	19	8	8
Neglect	63	31	24	79	23	22	4	10
Physical	14	6	3	4	4	1	1	1
Sexual	4	0	4	5	5	8	2	0
Multiple categories	20	19	19	36	22	11	5	1

Table 5.6 Children Subject of a Child Protection Plan with Domestic Violence

	2012/13	2013/14			
Children subject of a Child Protection Plan with Domestic Violence*	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Number of children subject of a CPP	793	847	723	657	587
Number of children subject of a CPP with Domestic Violence	470	485	415	384	338
% with Domestic Violence	**59.3%**	**57.3%**	**57.4%**	**58.4%**	**57.6%**

6. Participation by Children and Young Persons in Child Protection Conferences

Table 6.1: How the views of the child/young person were obtained ICPCs	2013/14									
	Q1		Q2		Q3		Q4		Total	
	No	%	No	%	No	%	No	%	No	%
Child under 4 at the time of the conference and views not obtained	122	30.9	91	33.5	119	36.8	76	35.2	**408**	**33.9**
Child attends and speaks for themselves	5	1.3	3	1.1	9	2.8	5	2.3	**22**	**1.8**
Child attends and an advocate speaks for them	0	0.0	0	0.0	0	0.0	0	0.0	**0**	**0.0**
Child attends and conveys their views non-verbally	3	0.8	0	0.0	1	0.3	0	0.0	**4**	**0.3**
Child attends; does not speak for themselves/convey their views	1	0.3	0	0.0	0	0.0	0	0.0	**1**	**0.1**
Child does not attend but asks an advocate to speak for them	39	9.9	12	4.4	11	3.4	13	6.0	**75**	**6.2**
Child does not attend but conveys their feelings to the conference	117	29.6	96	35.3	109	33.7	70	32.4	**392**	**32.5**
Child does not attend nor convey their views to the conference	88	22.3	67	24.6	73	22.6	48	22.2	**276**	**22.9**
Not obtained	20	5.1	3	1.1	1	0.3	4	1.9	**28**	**2.3**
Total	**395**	**100**	**272**	**100**	**323**	**100**	**215**	**100**	**1205**	**100**

Table 6.2: How the views of the child/young person were obtained RCPCs	2013/14									
	Q1		Q2		Q3		Q4		Total	
	No	%	No	%	No	%	No	%	No	%
Child under 4 at the time of the conference and views not obtained	156	25.0	195	29.9	150	25.0	183	32.0	**684**	**28.0**
Child attends and speaks for themselves	11	1.8	9	1.4	12	2.0	5	0.9	**37**	**1.5**
Child attends and an advocate speaks for them	1	0.2	0	0.0	0	0.0	0	0.0	**1**	**0.0**
Child attends and conveys their views non-verbally	1	0.2	1	0.2	1	0.2	0	0.0	**3**	**0.1**
Child attends; does not speak for themselves/convey their views	1	0.2	2	0.3	0	0.0	1	0.2	**4**	**0.2**
Child does not attend but asks an advocate to speak for them	32	5.1	47	7.2	21	3.5	17	3.0	**117**	**4.8**
Child does not attend but conveys their feelings to the conference	237	38.0	285	43.7	307	51.3	269	47.1	**1098**	**45.0**
Child does not attend nor convey their views to the conference	91	14.6	48	7.4	87	14.5	90	15.8	**316**	**12.9**
Not obtained	93	14.9	65	10.0	21	3.5	6	1.1	**185**	**7.6**
Total	**623**	**100**	**652**	**100**	**599**	**100**	**567**	**100**	**2441**	**100**

Commentary – Child Participation Rates in ICPCs & RCPCs

In the last quarter of the year, there was a reduction in the number of occasions where children were recorded as neither attending the ICPC nor their views being conveyed - from 73 the previous quarter to 48. From the total number of 798 occasions where children over the age of 4 were subject to an ICPC, direct attendance was recorded 27 times with a further 467 records of children having their views shared either by an advocate or another means. However, there is a significant number where the child's views are recorded as not being shared. The picture is more positive for review child protection conferences. Again there is only a fairly small number of direct attendance recorded (45 from an overall total of 1,761 over 4 years of age) but a further 1,215 are recorded as having their views shared. The percentage of children where views are recorded as not being shared is half that in respect of initial conferences (17.9%:34.6%). During the year there has been improvement in recording to support more accurate data collation and specific work undertaken to improve the ways in which children views can be shared. There have been some examples of good practice in this respect and this will be built on over the next year.

7. Participation by Family & Friends in ICPCs & RCPCs

Table 7.1 Participation by family/carers and friends in ICPCs

Annual 13-14	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
Parent/ stepparent/ partner of parent	564	1082	863	2	142	863	79.8	79.8
Friends/supporter	85	107	105	0	0	105	98.1	98.1
Foster carer	3	3	3	0	0	3	100	100
Other Family Member	203	274	250	0	20	250	91.2	91.2
Other household member	13	14	14	0	0	14	100	100
Other involved professional	283	538	332	165	169	382	61.7	71
Overall total	**574**	**2018**	**1567**	**167**	**331**	**1617**	**77.7**	**80.1**

NB An invitee is classed as 'Participated' if they 'Attended' or 'Sent a report' or both

Table 7.2 Participation by family/carers and friends in RCPCs

Annual 13-14	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
Parent/ stepparent/ partner of parent	1042	1970	1458	3	346	1458	74	74
Friends/supporter	104	117	112	0	3	112	95.7	95.7
Foster carer	10	12	10	0	2	10	83.3	83.3
Other Family Member	363	495	419	0	65	419	84.6	84.6
Other household member	22	26	23	0	2	23	88.5	88.5
Other involved professional	505	910	532	270	297	609	58.5	66.9
Overall total	**1069**	**3530**	**2554**	**273**	**715**	**2631**	**72.4**	**74.5**

NB An invitee is classed as 'Participated' if they 'Attended' or 'Sent a report' or both

8. Participation by Organisations in ICPCs & RCPCs

Table 8.1 Participations by Organisations in ICPCs

Annual 13-14	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
CFCS - Children's Social Care	588	1208	1011	591	186	1052	83.7	87.1
CFCS - Other staff	149	216	164	92	46	179	75.9	82.9
Health - Bassetlaw	137	365	171	190	168	260	46.8	71.2
Health - County	487	1413	750	713	542	978	53.1	69.2
Police staff	241	290	136	53	121	163	46.9	56.2
Probation	79	92	54	51	30	71	58.7	77.2
Legal Services	31	38	37	0	1	37	97	97
Voluntary organisation	21	23	11	11	9	16	48	70
School	389	624	468	377	126	522	75.0	83.7
Staff from other LAs	105	183	121	66	54	134	66.1	73.2
Total	**589**	**4452**	**2923**	**2144**	**1283**	**3412**	**65.7**	**76.6**

Please see appendix E1 for a more detailed breakdown of the attendees. NB An invitee is classed as 'Participated' if they 'Attended' or 'Sent a report' or both

Table 8.2 Participation by Organisations in RCPCs

Annual 13-14	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
CFCS - Children's Social Care	1089	1603	1264	1009	309	1340	78.9	83.6
CFCS - Other staff	310	424	311	167	85	334	73.3	78.8
Health - Bassetlaw	260	652	316	319	284	429	48.5	65.8
Health - County	886	2395	1271	1266	891	1591	53.1	66.4
Police staff	171	196	89	16	79	98	45.4	50.0
Probation	176	200	111	110	75	146	55.5	73.0
Legal Services	45	53	53	0	0	53	100	100
Voluntary organisation	40	53	37	16	15	38	70	72
School	793	1274	1001	747	230	1090	78.6	85.6
Staff from other LAs	163	297	175	99	108	199	58.9	67.0
Total	**1104**	**7147**	**4628**	**3749**	**2076**	**5318**	**64.8**	**74.4**

Please see appendix E1 for a more detailed breakdown of the attendees. NB An invitee is classed as 'Participated' if they 'Attended' or 'Sent a report' or both

9. Looked After Children

Table 9.1:

Looked After Children General Statistics

		2012/13	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
	Number of children who are looked after	875	894	905	868	830
	LAC rate per 10,000 (Annual) added to report	54.0	55.1	55.8	53.5	51.2

		Good	Target	2012/13	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
NI 66	Looked after children cases which were reviewed within required timescales (%)	Higher	98.0	85.0	94.9	93.5	91.7	90.3
NI 62 **AP09**	Looked after children with 3 or more placements in any one year (%)	Lower	8.5	6.2	7.0	7.5	9.7	11.6
NI 63	Stability of placements of looked after children: length of placement (%)	Higher*	N/A	75	69.8	70.0	71.4	73.6

The timescale definitions for NI66 and NI63 are complex and follow the original definitions set out by the Department for Education

Indicator Commentaries

Commentary: Looked After Children – rate per 10,000

There has been an overall decrease in numbers of looked after children during the year, from 892 at the beginning of April to 830 at the end of March 2014; the drop in numbers has been consistent since September 2013 when the number of looked after children stood at 906. Timely progression of children's cases through to permanency by adoption, Special Guardianship and Residence Orders is seen as a significant factor in this stablising and gradual decrease in numbers. Over the previous 4 years, Nottinghamshire's rater per 10,000 looked after children had increased from 36 to 53.9; as at the end of March 2014 this has dropped slightly to 51.2 and remains below that of statistical neighbours and England averages of 60.6 and 60 (figures as at end of 2012-13).

Commentary: NI 66: Looked after children cases which were reviewed within timescales (%)

The NI66 indicator considers the cohort of children looked after at the end of March for more than 4 weeks and who have had all their reviews completed within timescale during the year. Using this calculation, at the year-end 90.3% of such children had had all reviews within timescale. Whilst this is below the locally set target of 98%, it represents an improvement in practice from the previous year where the year-end figure had been 84.5%. There is no update benchmarking for this indicator as the DfE has not published figures since 2009-2010. It is understood that this has been due to some concern regarding data accuracy from some authorities, although not Nottinghamshire. Information continues to be submitted to the DfE. During the year, a total number of 2,439 LAC reviews were held; using a calculation of how many of these were completed within timescale gives a year end figure of 96%. Work has been undertaken during the year to improve the timeliness in particular of first reviews and those where children have become looked after following placements within family/friends.

Table 9.2: Care Leavers**		**Good**	**Target**	**2012/13**
NI 147 AP11	% of care leavers in suitable accommodation	Higher	N/A	87%
NI 148	% of care leavers in EET	Higher	N/A	63%

****n.b. Figures for 2013/14 have yet to be validated and released by the DfE**

Table 9.3: Adoption		**Good**	**2012/13**	**2013/14**			
				Q1	**Q2**	**Q3**	**Q4**
AP 07A (1)	Average time between a child entering care and moving in with their adoptive family, for children who have been adopted (days)	Lower	625 (days)	532 (days)	580 (days)	587 (days)	574 (days)
AP 07B (1)	Average time between a LA receiving Court authority to place a child and deciding on a match to an adoptive family (days)	Lower	217 (days)	249 (days)	280 (days)	277 (days)	283 (days)
(1)	% of children who wait less than 20 months between entering care and moving in with their adoptive family	Higher	57%	57%	68%	65%	59%

(1) All quarterly figures on these indicators are year to date (cumulative) and are currently provisional figures undergoing validation and could be subject to change.

Indicator Commentaries

Commentary: Average time between a child entering care and moving in with their adoptive family, for children who have been adopted (days)

The average time between a child entering care and moving in with its adoptive family continues to remain below the target set for 2013/14 representing good performance. The number of days between a child entering care and moving in with its adoptive family fell in the fourth quarter to 574 days which is a three month reduction in time compared to the same quarter last year.

Commentary: Average time between a Local Authority receiving Court Authority to place a child and deciding on a match to an adoptive family (days)

Performance for this measure continues to remain above the 213 days target representing an area for improvement. During the last three quarters outcomes for this measure have remained relatively static at around 280 days after witnessing an increase from the 249 days reported in quarter one. However, the service has seen significant increases in the number of children being adopted and is yet to see the impact of a reorganisation on this indicator due to a number of older cases still being actioned during the last year. Early indications show an improving picture on this measure which should be reflected in future reporting periods.

Commentary - % of children who wait less than 20 months between entering care and moving in with their adoptive family.

After an introduction of a revised performance measure of 20 months between entering care and moving in with their adoptive family in 2013-14 (formerly 21 months), outcomes for this measure have remained relatively static (with the exception of quarter 2) over the year at around 59%. This is nine percentage points above the target set for the year which represents good performance.

10. Youth Offending

		Good	Target	2012/13	2013/14			
					Q1	Q2	Q3	Q4
NI 111 **EP02**	First time entrants to the youth justice system aged 10-17 (per 100,000)*	Lower	295	351	64	125	207	*
	Custodial Remands Actual numbers (young people)	Lower	Lower than or equal to 2012-13	N/A	2	4	11	*
	Custodial Sentences Actual numbers (young people)	Lower	Lower than or equal to 2012-13	N/A	3	7	15	*

* Data is one quarter in arrears

Indicator Commentaries

Commentary: NI 111 – Reduce the number of first time entrants to youth justice system aged 10-17

There has been a slight increase in the number of first time entrants to the youth justice system. There were 60 actual FTEs (compared to 47 and 44 in quarters 1 and 2 respectively and 52 for the same period in 2012/13). This equates to 82 young people per 100,000 10-17 population.

When broken down by district Ashfield continues to have the highest number of FTEs by population, although this is attributable to a higher number of FTEs in quarter one of the year. For the first 6 months of the Newark and Sherwood and Broxtowe had the next highest proportion of first time entrants per 10-17 population (as reported in the performance report for Quarter 2). However these appear to have levelled off and during quarter 3 Gedling had a high number FTEs entering the YJS.

Whilst the quarter 3 increase in FTEs may be a 'blip' attributable to the festive period, it is of concern that crime prevention referrals into the Youth Justice Service have been steadily declining. Whilst diversionary activities (reported in quarter 2) are either underway or about to take the first tranche of referrals, targeting of individuals and channelling these into the Youth Justice Service for diversionary activities appears to have reduced. Work has been underway to increase the number of referrals from the police but to date there has been no discernible impact or increase in referral rates. There has also been a drop in the number of referrals from community safety teams as well as a number of cases where the Youth Justice Service has not been consulted in the making of Anti Social Behaviour Orders (ASBOs) and have only been alerted to the existence of these when the young person appears before the courts for breach of this order. Opportunities to either intervene early prior to the making of an ASBO or to offer support in the guise of an individual support order have been missed and in these cases the young person becomes a first time entrant.

Commentary: Custodial Remands Actual numbers (young people)

There were 5 remands into secure accommodation in quarter 3, making 11 remands year to date, slightly lower than the same period last year (12). Four of the remands made were as a result of either serious offending resulting in a subsequent custodial sentence, or due to persistent non-compliance coupled with further offending or offending whilst on bail. With regards to the fifth remand into custody, this was for a short period of time. The team manager reviewed the case and highlighted a number of practice points for the team which could have led to a remand on bail. A bail application was prepared for a subsequent remand but was not presented as the crown prosecution service were not prepared for a bail application. On his next appearance 4 days later before the Crown Court, bail was granted subject to stringent conditions. Out of the five remands, one could possibly have been prevented by more robust action and as identified the team manager has raised the practice points from this with individual team members and in a team meeting. It is of note that this measure presents some risk as if there is more than one remand during Quarter 4, the figures for 2012/13 will have been exceeded.

Commentary: Custodial Sentences Actual numbers (young people)

During quarter 3 there were 5 young people sentenced to custody (compared to 4 in the same period in 2012/13). To date there have been 15 custodial sentences. As with the remand target, the achievement of this target is at risk as any more than one further period of custody will place this target at a higher level than 2012/13. Of the 5 young people sentenced to custody, custody was unavoidable for two of them by virtue of already being a serving prisoner at the point of sentence or due to the very serious nature of the offences. With regards to the remaining three, all credible sentences had been exhausted due to persistent non-compliance coupled with further offending.

11. Children's Social Care Workforce

Please note: The figures below are collected as part of the DFE's Children's Social Work Data collection, year ending 30th September 2013. All figures provided within this section are provisional and subject to change.

Table 11.1: Vacancy Rate

	Qualified Social Worker	**SIP target**	**Full time equivalent (FTE) as at 30th Sept 2013**
	Vacancy rate	7%	10.2

This rate is calculated by using the number of children's social workers within Nottinghamshire (excluding the number of agency social workers) and the number of children's social worker vacancies including those covered by agency workers.

Table 11.2: Turn-over

	Qualified Social Worker	**SIP target**	**Full time equivalent as at 30th Sept 2013**
	Turnover rate	10%	14.3

The turn-over rate is calculated by using the number of new people joining a vacant social worker post and the number of people leaving a social worker post for the year ending 30th September 2013.

Table 11.3 Sickness Absence

	Qualified Social Worker	**SIP target**	**% Year ending 30th Sept 2013**
	Sickness Absence	N/A	5.8%

The number of days missed due to sickness in the previous 12 months is used to calculate this indicator against the total number of FTE social worker days.

Table 11.4 Percentage of agency workers

	% of full time equivalent social worker posts covered by agency staff	**SIP target**	**As at 30th Sept 2013**
	% of agency social workers	N/A	5.9%

The number of FTE social workers is used to work out a percentage of social workers that are agency as at the end of September 2013.

Appendix E1

Attendance by organisations in Initial Child Protection Conferences (ICPCs)

Organisation	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
CFCS - EDT	3	3	3	1	0	3	100	100
CFCS - Other social worker	190	232	211	35	19	216	90.9	93.1
CFCS - Other team manager	21	23	17	3	4	17	73.9	73.9
CFCS - Residential worker	2	2	2	1	0	2	100	100
CFCS - Responsible service manager	9	9	3	1	6	3	33.3	33.3
CFCS - Responsible social worker	571	669	611	524	51	646	91.3	96.6
CFCS - Responsible team manager	210	222	117	8	105	117	52.7	52.7
CFCS - Student social worker	28	29	28	8	1	29	96.6	100
CFCS - Trainee social worker	19	19	19	10	0	19	100	100
CFCS - Children's Social Care	**588**	**1208**	**1011**	**591**	**186**	**1052**	**83.7**	**87.1**
CFCS - Educational psychologist	6	6	1	1	5	1	16.7	16.7
CFCS - Educational Welfare Officer	7	7	6	5	1	7	85.7	100
CFCS - Other staff	47	59	48	17	9	52	81.4	88.1
CFCS - Targeted family support services	91	120	94	60	24	102	78.3	85
CFCS - Youth Offending Service	16	22	15	8	5	16	68.2	72.7
CFCS - Youth Services	2	2	0	1	2	1	0	50
CFCS - Other staff	**149**	**216**	**164**	**92**	**46**	**179**	**75.9**	**82.9**
Health (Bassetlaw) - Consultant paediatrician	23	25	0	11	19	11	0	44
Health (Bassetlaw) - GP	95	101	4	43	84	46	4	45.5
Health (Bassetlaw) - Health Visitor	79	95	74	60	19	87	77.9	91.6
Health (Bassetlaw) - Mental health worker	12	19	7	8	10	13	36.8	68.4
Health (Bassetlaw) - Midwife	17	25	18	8	7	18	72	72
Health (Bassetlaw) - School nurse	52	72	54	43	16	62	75	86.1
Health (Bassetlaw) - Substance misuse worker	22	28	14	17	13	23	50	82.1
Health - Bassetlaw	**137**	**365**	**171**	**190**	**168**	**260**	**46.8**	**71.2**
Health (County) - Consultant paediatrician	51	60	18	25	36	38	30	63.3
Health (County) - GP	383	406	12	119	314	126	3	31
Health (County) - Health visitor	290	363	299	237	54	333	82.4	91.7
Health (County) - Mental health worker	34	48	24	9	15	28	50	58.3
Health (County) - Midwife	84	128	88	50	35	99	68.8	77.3
Health (County) - School nurse	264	334	266	229	61	299	79.6	89.5
Health (County) - Substance misuse worker	52	74	43	44	27	55	58.1	74.3
Health - County	**487**	**1413**	**750**	**713**	**542**	**978**	**53.1**	**69.2**
Police - CAIU	110	124	59	29	53	73	47.6	58.9
Police - Divisional	119	141	67	20	57	79	47.5	56
Police - Domestic Abuse Unit	24	25	10	4	11	11	40	44
Police staff	**241**	**290**	**136**	**53**	**121**	**163**	**46.9**	**56.2**
OLA - Foster Carer	1	2	2	0	0	2	100	100
OLA - GP	6	7	0	3	6	3	0	42.9
OLA - Health visitor	4	5	1	2	3	2	20	40
OLA - Midwife	4	5	4	3	1	4	80	80
OLA - Other involved professional	67	113	79	34	30	83	69.9	73.5
OLA - Police	7	9	5	2	2	6	55.6	66.7
OLA - School	11	16	9	9	7	11	56.3	68.8
OLA - Social Care	21	22	18	11	4	20	81.8	90.9
OLA - Voluntary organisation	3	4	3	2	1	3	75	75
Staff from other LAs	**105**	**183**	**121**	**66**	**54**	**134**	**66.1**	**73.2**
Probation	79	92	54	51	30	71	58.7	77.2
School	389	624	468	377	126	522	75	83.7
Voluntary organisation	21	23	11	11	9	16	47.8	69.6
Legal Services	31	38	37	0	1	37	97.4	97.4
Total	**589**	**4452**	**2923**	**2144**	**1283**	**3412**	**65.7**	**76.6**

Attendance by organisations in Review Child Protection Conferences (RCPCs)

Organisation	No. of Conferences	No. Invited	No. Attended	No. Sent Report	No. Sent Apologies	No. Participated	% Attended	% Participated
CFCS - EDT	2	2	2	0	0	2	100	100
CFCS - Other social worker	161	172	149	29	18	152	86.6	88.4
CFCS - Other team manager	11	11	8	1	1	8	72.7	72.7
CFCS - Residential worker	2	3	3	0	0	3	100	100
CFCS - Responsible service manager	16	17	8	4	9	8	47.1	47.1
CFCS - Responsible social worker	1061	1102	998	956	86	1067	90.6	96.8
CFCS - Responsible team manager	259	262	66	10	192	68	25.2	26
CFCS - Student social worker	20	20	17	6	3	19	85	95
CFCS - Trainee social worker	14	14	13	3	0	13	92.9	92.9
CFCS - Children's Social Care	**1089**	**1603**	**1264**	**1009**	**309**	**1340**	**78.9**	**83.6**
CFCS - Educational psychologist	16	17	8	2	8	9	47.1	52.9
CFCS - Educational Welfare Officer	9	9	9	5	0	9	100	100
CFCS - Other staff	112	138	107	32	17	112	77.5	81.2
CFCS - Targeted family support services	187	220	157	111	52	173	71.4	78.6
CFCS - Youth Offending Service	24	28	23	14	4	23	82.1	82.1
CFCS - Youth Services	12	12	7	3	4	8	58.3	66.7
CFCS - Other staff	**310**	**424**	**311**	**167**	**85**	**334**	**73.3**	**78.8**
Health (Bassetlaw) - Consultant paediatrician	30	34	1	7	22	7	2.9	20.6
Health (Bassetlaw) - GP	197	200	3	65	167	66	1.5	33
Health (Bassetlaw) - Health Visitor	127	150	132	109	16	145	88	96.7
Health (Bassetlaw) - Mental health worker	22	28	8	5	17	11	28.6	39.3
Health (Bassetlaw) - Midwife	10	10	3	2	7	4	30	40
Health (Bassetlaw) - School nurse	148	187	146	106	36	163	78.1	87.2
Health (Bassetlaw) - Substance misuse worker	35	43	23	25	19	33	53.5	76.7
Health - Bassetlaw	**260**	**652**	**316**	**319**	**284**	**429**	**48.5**	**65.8**
Health (County) - Consultant paediatrician	85	96	15	14	59	26	15.6	27.1
Health (County) - GP	682	722	16	174	541	182	2.2	25.2
Health (County) - Health visitor	526	655	568	484	80	619	86.7	94.5
Health (County) - Mental health worker	76	85	40	22	34	45	47.1	52.9
Health (County) - Midwife	58	69	41	26	23	46	59.4	66.7
Health (County) - School nurse	512	615	498	457	105	557	81	90.6
Health (County) - Substance misuse worker	119	153	93	89	49	116	60.8	75.8
Health - County	**886**	**2395**	**1271**	**1266**	**891**	**1591**	**53.1**	**66.4**
Police - CAIU	44	49	16	4	24	18	32.7	36.7
Police - Divisional	119	135	69	12	49	76	51.1	56.3
Police - Domestic Abuse Unit	12	12	4	0	6	4	33.3	33.3
Police staff	**171**	**196**	**89**	**16**	**79**	**98**	**45.4**	**50.0**
OLA - Foster Carer	2	2	2	0	0	2	100	100
OLA - GP	13	13	0	4	11	4	0	30.8
OLA - Health visitor	9	9	9	5	0	9	100	100
OLA - Midwife	0	0	0	0	0	0	0	0
OLA - Other involved professional	117	207	118	59	84	134	57	64.7
OLA - Police	3	3	0	1	2	1	0	33.3
OLA - School	35	46	37	28	6	40	80.4	87
OLA - Social Care	14	14	8	2	3	8	57.1	57.1
OLA - Voluntary organisation	2	3	1	0	2	1	33.3	33.3
Staff from other LAs	**163**	**297**	**175**	**99**	**108**	**199**	**58.9**	**67.0**
Probation	176	200	111	110	75	146	55.5	73
School	793	1274	1001	747	230	1090	78.6	85.6
Voluntary organisation	40	53	37	16	15	38	69.8	71.7
Legal Services	45	53	53	0	0	53	100	100
Total	**1104**	**7147**	**4628**	**3749**	**2076**	**5318**	**64.8**	**74.4**

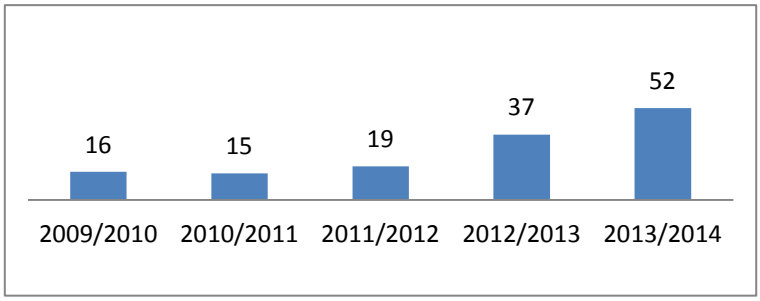
Appendix F

Child Deaths Data

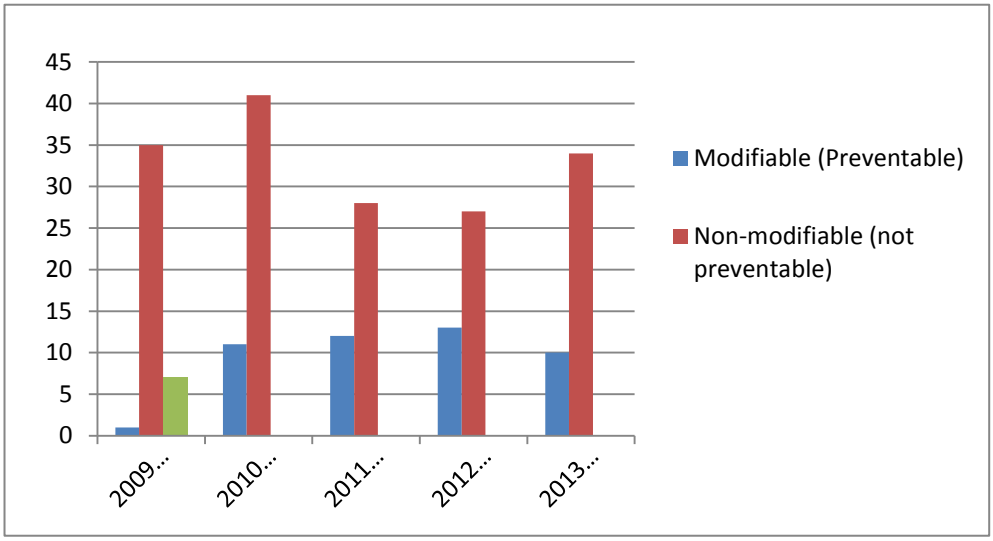
Number of child deaths notifications April 2009- March 2014

	2009-10	2010-11	2011-12	2012-13	2013-14
Expected Deaths	**33**	**31**	**30**	**33**	**40**
Unexpected Deaths	**15**	**18**	**15**	**24**	**19**
Total notifications	**48**	**49**	**45**	**57**	**59**

Number of child death reviews which were ongoing at year end



Number of child deaths reviewed in the reportable year which were deemed to have modifiable/non-modifiable factors (2009-2010 reviews were defined as preventable/potentially preventable/not preventable)



Category of child deaths reviewed during reporting period

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Category 1: Deliberately inflicted injury, abuse or neglect	0	1	0	0	0
Category 2: Suicide or deliberate self-inflicted harm	0	1	1	1	1
Category 3: Trauma and other external factors	3	3	4	4	7
Category 4: Malignancy	2	2	2	0	4
Category 5: Acute medical or surgical condition	3	3	2	3	1
Category 6: Chronic medical condition	4	0	1	0	1
Category 7: Chromosomal, genetic and congenital anomalies	11	16	7	10	9
Category 8: Perinatal/neonatal event	11	19	17	14	16
Category 9: Infection	5	3	2	2	3
Category 10: Sudden unexpected, unexplained death	4	4	4	6	2

Age groups of children whose deaths were reviewed during the reportable year

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
0-27 days	16	26	19	15	20
28-364 days	10	12	9	12	8
1 – 4 years	3	2	3	2	5
5 – 9 years	2	3	1	1	1
10 – 14 years	6	1	3	5	6
15 – 17 years	6	8	5	5	4

Number of deaths which were caused by the events below which were reviewed during the reporting period.

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Neonatal death	11	20	18	20	17
Known life limiting condition	16	7	8	5	18
Sudden Unexpected Death in Infancy (SUDI)	4	3	4	7	4
Road traffic Accident/collision	2	1	2	3	4
Drowning	0	1	1	0	0
Fire and burns	1	0	0	0	0
Other non-intentional injury/ accident/trauma	0	1	1	1	0
Apparent suicide	0	1	1	1	0
Other	9	18	5	3	1

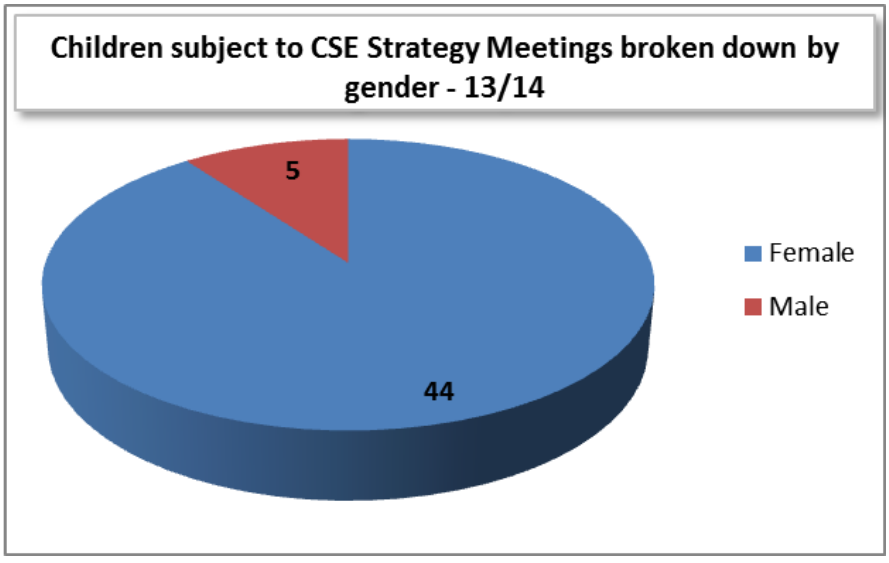
Appendix G

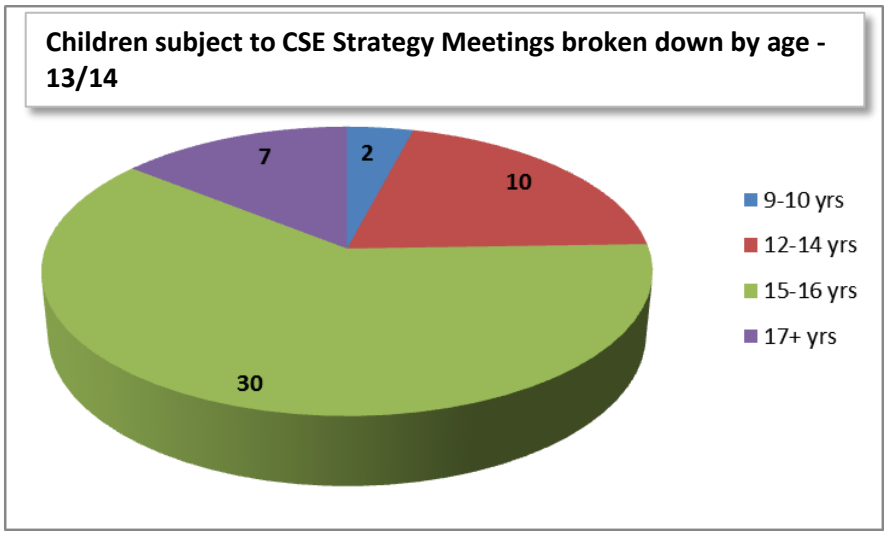
Child Sexual Exploitation Data

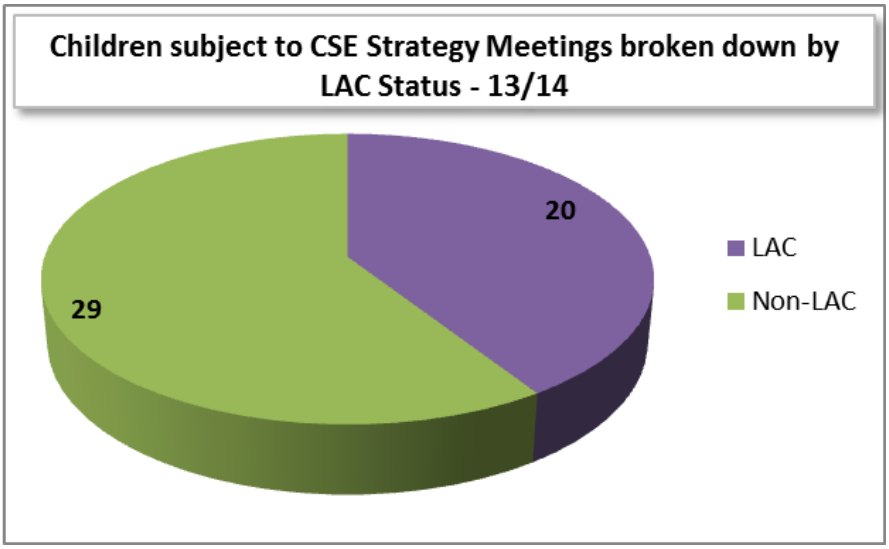
From NCC CSE strategy meeting for 2013/14 and for the Police open cases:
CSE strategy meetings: 47 children – 105 meetings.

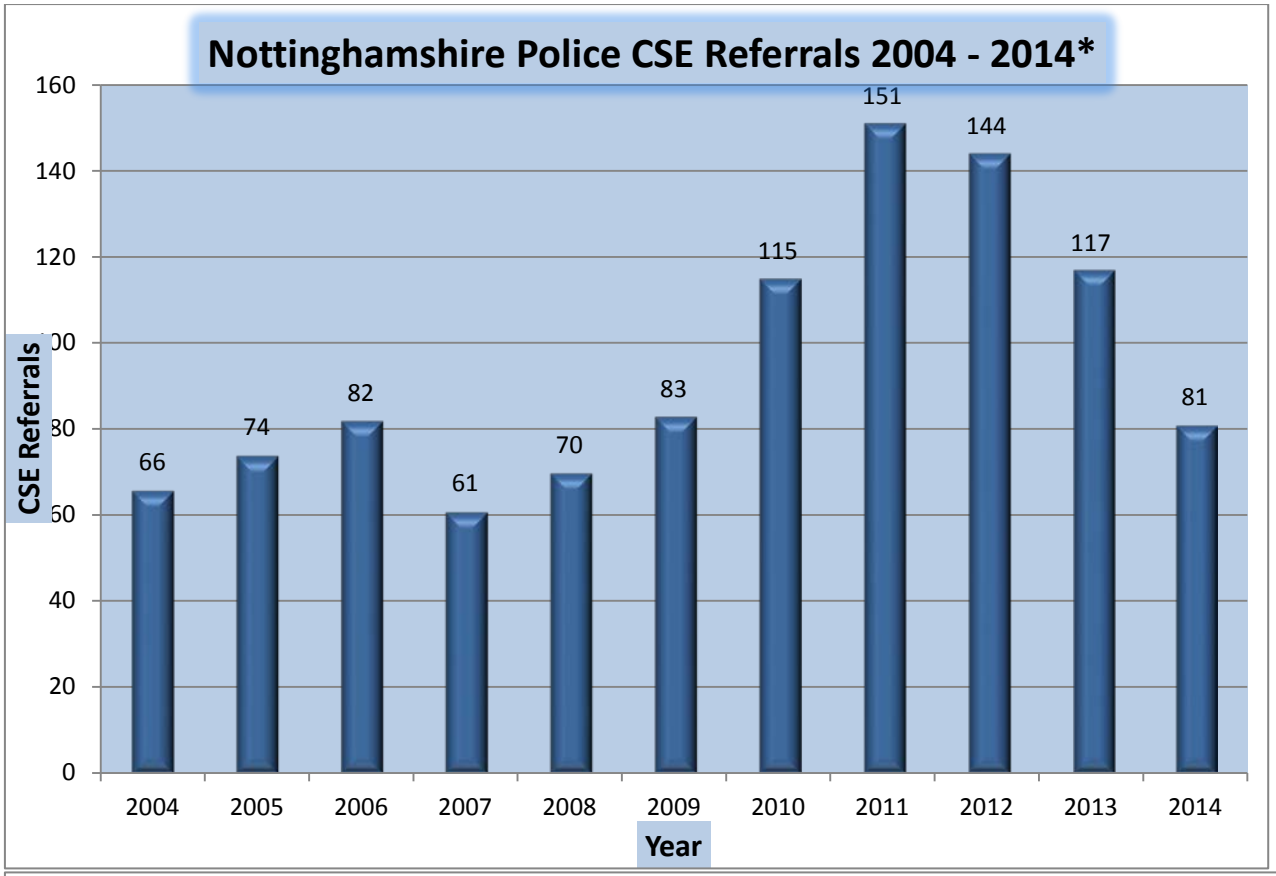
CSE strategy meetings 2013/14 (where locality clear)	
Ashfield	3
Bassetlaw	4
Broxtowe	13
Gedling	4
Mansfield	13
Newark	3
Rushcliffe	3

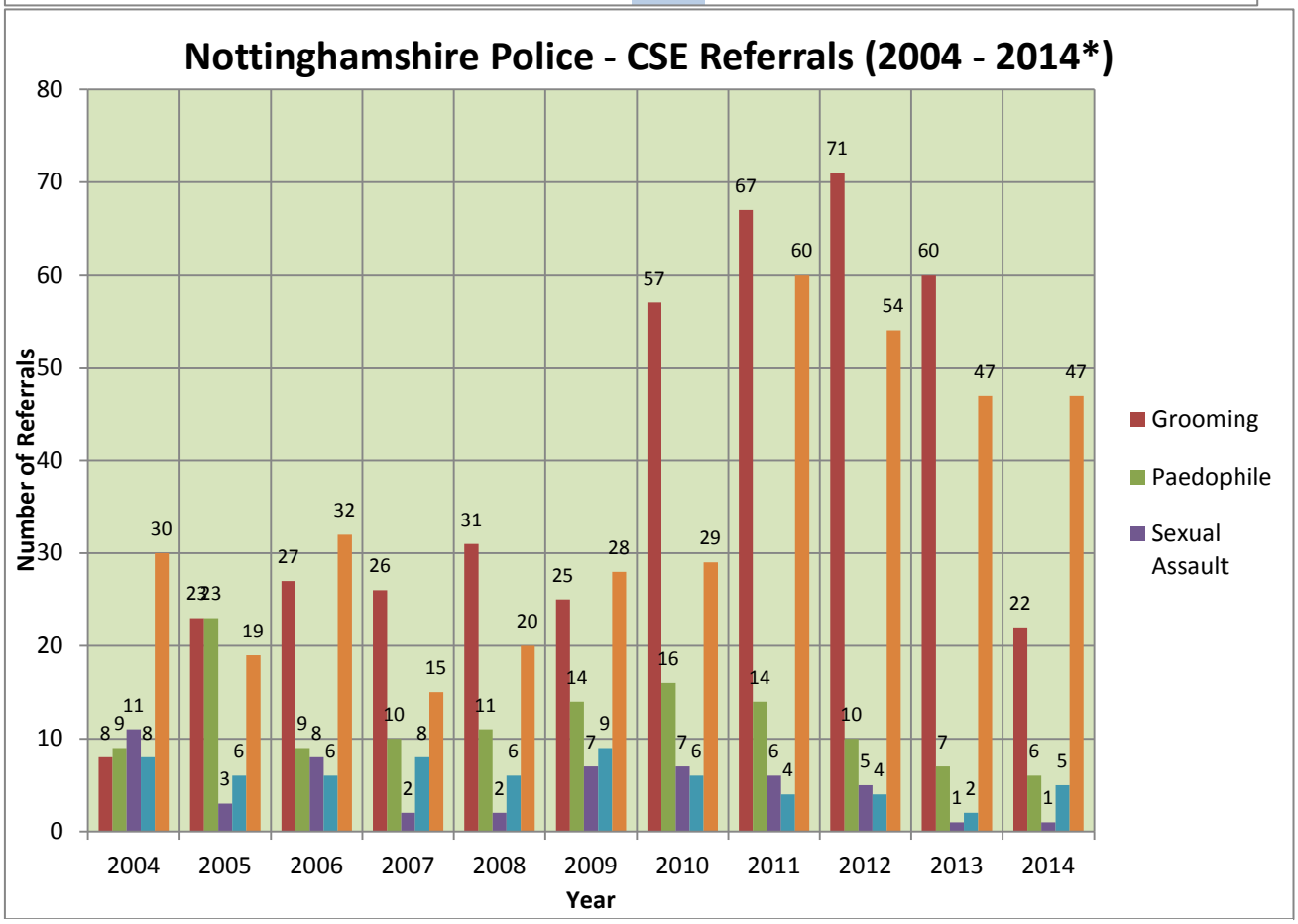
Open Police cases (June 2014)		
Type	**Number**	**Location**
Organised abuse	**3**	Wollaton
		Broxtowe
		Ashfield
High risk /organised	**1**	Broxtowe
Low level grooming	**15**	
	1	Arnold
	5	Ashfield
	1	Eastwood
	1	Gedling
	3	Mansfield
	1	Newark
	3	Rushcliffe




Children subject to CSE Strategy Meetings broken down by age - 13/14
7
2
10
30
9-10 yrs
12-14 yrs
15-16 yrs
17+ yrs


Children subject to CSE Strategy Meetings broken down by LAC Status - 13/14
20
29
LAC
Non-LAC



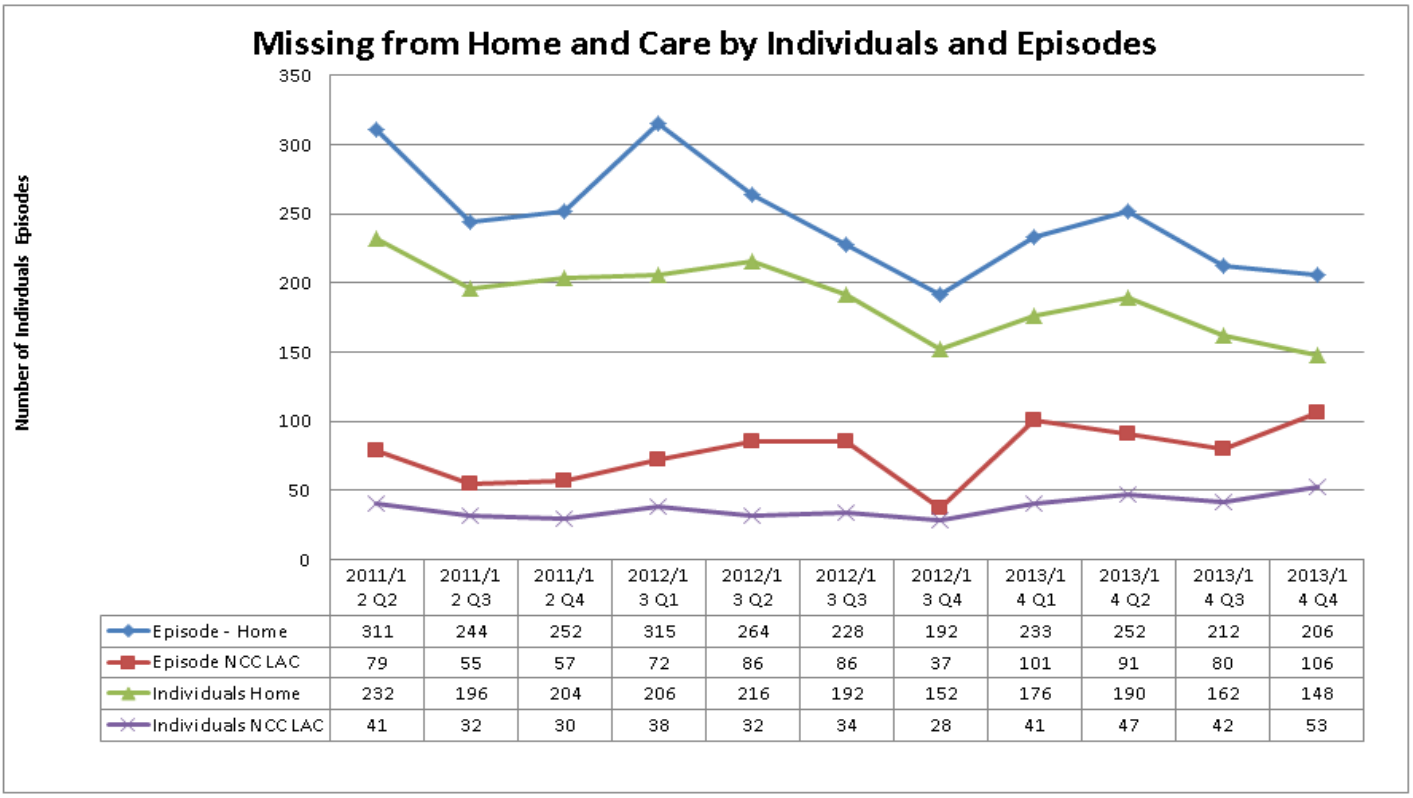


*This data includes Nottingham City and Nottinghamshire CSE referrals to the police, 2014 data is upto the end of September 2014

Appendix H

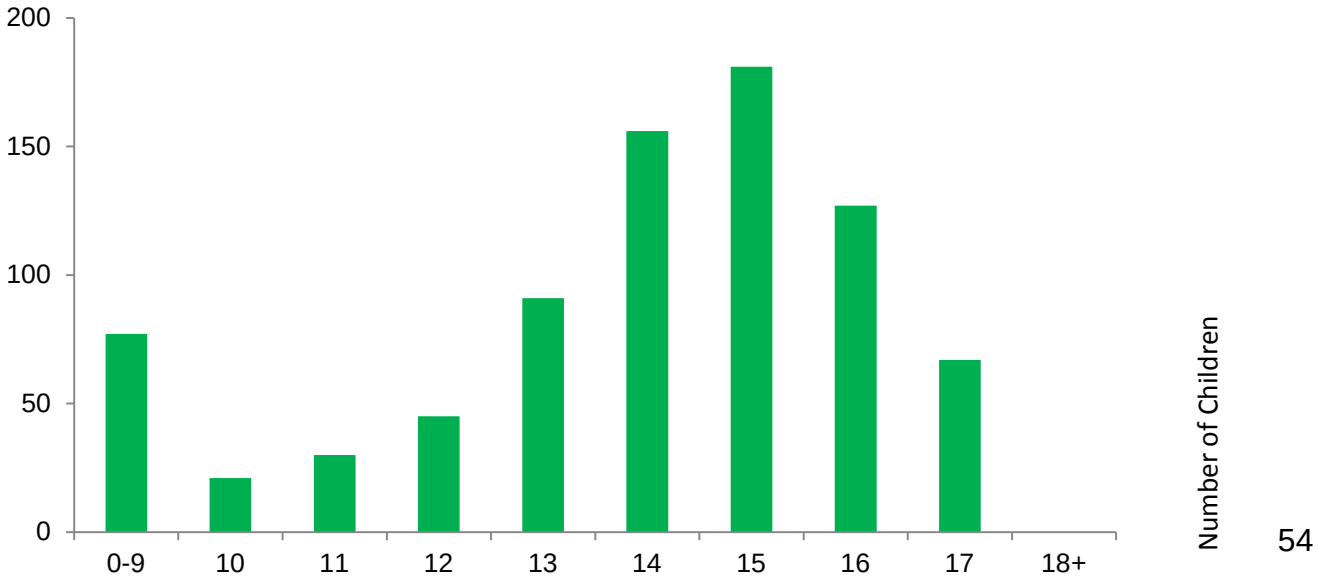
Missing Children Data for 2013 – 2014

(including previous years comparators for missing individuals and episodes)

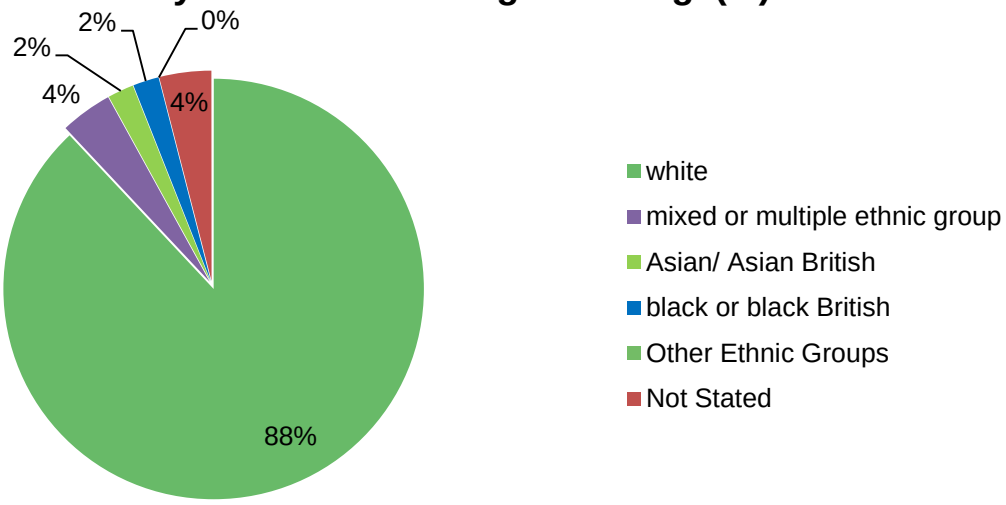


	2011/12 Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
Episode - Home	311	244	252	315	264	228	192	233	252	212	206
Episode NCC LAC	79	55	57	72	86	86	37	101	91	80	106
Individuals Home	232	196	204	206	216	192	152	176	190	162	148
Individuals NCC LAC	41	32	30	38	32	34	28	41	47	42	53

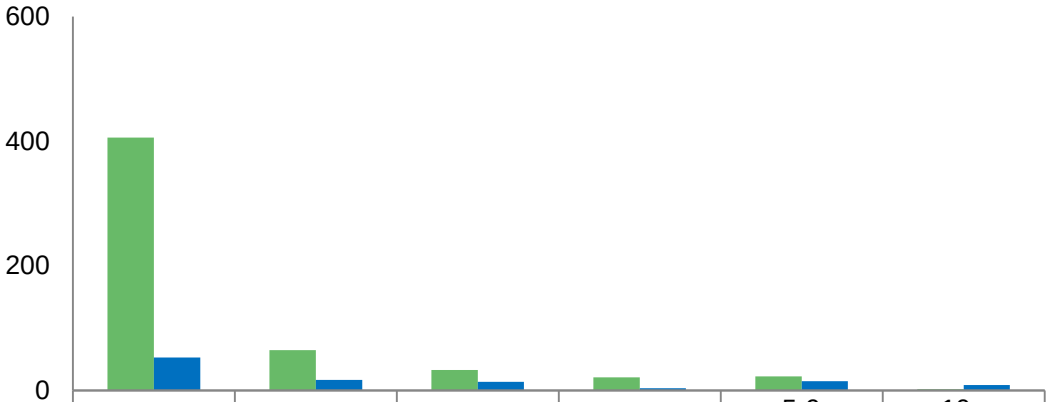
Ages of all individual children who went missing



Ethnicity of Children who go missing (%)



How many missing episodes do individual children have?



	1 Episode	2 Episodes	3 Episodes	4 Episodes	5-9 Episodes	10+ Episodes
Home	406	65	33	21	23	2
LAC	53	17	14	4	15	9

Appendix I

Private Fostering Arrangements Data

	Question	Year to 31 March 2013	Year to 31 March 2014
1	Number of notifications of new private fostering arrangements received during the year in accordance with Regulation 3(1) and Regulation 5(1) of the 2 Children (Private Arrangements for Fostering) Regulations 2005 :	17	25
2	Number of cases where action was taken in accordance with the requirements of Regulation 4(1) and Regulation 7(1) of the Children (Private Arrangements for Fostering) Regulations 2005 for carrying out visits :	17	25
3	Of these, the number of cases where this action was taken within 7 working days of receipt of notification of the private fostering arrangement:	12	21
4	Number of new arrangements that began during the year :	17	25
5	The number of private fostering arrangements that began **after** the start of the reporting year where visits were made at intervals of not more than six weeks	9	23
6	The number of private fostering arrangements that began **before** the start of the reporting year and continued into the reporting year:	10	11
7	The number of private fostering arrangements as reported in Question 6 where scheduled visits were completed in the required timescale	8	10
8	Number of private fostering arrangements that ended during the year	19	14
9	Number of children under private fostering arrangements on 31st March	9	22