Nottinghamshire
SAFEGUARDING
CHILDREN Board

Working in Partnership to Safeguard
Children & Young People

ANNUAL REPORT

2015 – 2016

TABLE OF CONTENTS

Contents

Essential information

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

The report will be published in October 2016 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 2015/16 Nottinghamshire Safeguarding Children Board Annual Report.

This year's report is in a new shorter format that is designed to make it more accessible and, by providing links to relevant information already published through the new NSCB website, more concise. Please take a look at the website to find out more about the day to day activities of the Board.

The report outlines changes that have been made to the way that the NSCB operates as well as setting out what we have learned about the effectiveness of safeguarding arrangements in Nottinghamshire.

The past year has seen continued improvements in this regard and I am satisfied that organisations are working effectively to keep our children and young people safe. This was reflected in the findings of an Ofsted review of the Board's effectiveness and inspection of safeguarding and looked after children services in 2015, with both judged to be good, I am immensely pleased with this recognition and proud of the efforts made by staff across the partnership to reach that position.

There is however always more to be done and details of the main areas of work that the Board will focus on during 2016/17 are identified in the final section of this report. I am confident that with the commitment of frontline staff and their managers further progress towards making our safeguarding arrangements outstanding will be made during 2016/17.

Finally, we are now entering a period of significant change following from the publication of the Wood Report: Review of the role and functions of Local Safeguarding Children Boards and the government's response to this in May 2016. Significantly, the duty to establish arrangements which ensure partners work together to protect and safeguard children and to embed improved multi-agency behaviours and practices will be placed on the police and health services as well as the local authority. The NSCB will be working with partners to prepare for implementation of new statutory guidance on this when it is published. In doing so we will ensure that in seizing the opportunities that the new arrangements present we also retain and build upon the good current arrangements.

Chris Few
NSCB Independent Chair

INTRODUCTION

Introduction

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

The NSCB has three strategic priorities:

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

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

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

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

- the constitution describes partnership relationships, roles and responsibilities
- the business plan 2014-16 outlines objectives for the Board under the three strategic priorities
- minutes of Board meetings provide details of the issues that have been dealt with by the Board over the past year
- a description of the roles of the NSCB Executive and sub groups including the Child Death Overview Panel (CDOP), Serious Incident Review Sub Group (SIR), Multi Agency Audit Sub Group and Learning and Development Sub Group

The NSCB is funded by contributions from partner agencies and this enables a small team to facilitate the work of the Board, coordinate and deliver multi agency training and provide high quality

INTRODUCTION

safeguarding procedures and guidance. A list of NSCB members is attached to this report (**Appendix A**).

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

A review of the effectiveness of the NSCB was undertaken by Ofsted between 11 May 2015 and 4 June 2015 and their report was published on 20 July 2015. The review concluded that the arrangements in place to evaluate the effectiveness of what is done by the authority and Board partners to safeguard and promote the welfare of children are good. An LSCB that is good coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services. A full copy of the report is available at
http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/nottinghamshire

CHANGES TO THE WAY THE NSCB OPERATES

Changes to the way the NSCB operates

During 2015/16 the NSCB sought to continue to improve the way it operates in a number of ways. A new risk log was introduced to ensure that the NSCB effectively identified and mitigated risks and the log was reviewed by the NSCB Independent Chair and Vice Chair at their 6 weekly meetings.

STRATEGIC FOCUS

In order to more effectively guide the work of the Board in relation to improving the response to child neglect a new neglect strategy was developed which established a strategic aim and objectives for tackling neglect of children in Nottinghamshire. The stated aim is that '*Nottinghamshire Safeguarding Children Board will be assured of the early recognition of neglect and timely responses from agencies with appropriate escalation when needed to secure the health, development and safety of children experiencing neglect'*. This strategy will be realised by NSCB procedures and quality assurance processes.

Similarly a strategy has been agreed to focus the work of the task and finish group formed to review the safeguarding of children exposed to parental substance misuse and/or mental ill health. The stated aim is '*To assure the NSCB that adult mental health services and drug and alcohol services appropriately consider the impact on children when their parents or carers have mental ill health and/or drug and alcohol problems; and that adult and children's services work together to ensure that children affected by their parents' or carers' difficulties are supported and safe*'. This will feed into the Performance Information Report in due course.

The Child Sexual Exploitation Cross Authority Group is now chaired by a Detective Chief Inspector who has reviewed and revised the CSE Strategy and action plan providing a clearer direction for this important area of safeguarding. The NSCB Independent Chair directly oversees the work of this group through strategic sexual exploitation meetings with the Nottingham City Safeguarding Children Board Independent Chair, representatives of the police and local authority leads.

INFORMATION SHARING

A key area of safeguarding work is the exchange of information between agencies. The Safeguarding Children Information Management Team (SCIMT), funded through the NSCB, plays a key role in the sharing of information related to the movement of children on child protection plans and preliminary information searches, for example. A review of the role and function of the SCIMT has been

CHANGES TO THE WAY THE NSCB OPERATES

undertaken and the team has recently been re-located within the Multi-Agency Safeguarding Hub (MASH). This initiative has simplified the process for sharing information with partner agencies, provided an improved service and placed the team alongside others who carry out similar roles for other purposes.

MEMBERSHIP

Nottinghamshire is a large geographic area with many different organisations providing services for children and families, in particular the health commissioner and provider landscape is complex. This has always presented a challenge in terms of ensuring appropriate representation at the Board, in accordance with Working Together to Safeguard Children (2015), whilst keeping the Board at a manageable size that can move forward business. During the year representation from Clinical Commissioning Groups (CCGs) has been streamlined. NHS England Yorks/Humber Local Area Team have been welcomed to the Board following the withdrawal of the NHS England Derbyshire and Nottinghamshire Local Area Team. Engagement with the education sector has been strengthened through representation on the Board of an Academy Head Teacher.

To enable Board members to be as effective as possible the induction process for new members has been strengthened through personal induction meetings that are used to explain the function of the Board and the role of its members.

The Section 11 self-assessment, used to gather assurance from partner organisations regarding their compliance with duties under the Children Act 2004, has been re-issued and is now extended to encompass the Governor Compliance Checklist arrangements which fulfill a similar function for schools.

COMMUNICATIONS AND DISSEMINATING LEARNING

A new NSCB website has been developed providing easier access to information about multi-agency training, policies and procedures and resources for professionals, parents and carers and children and young people. The online NSCB safeguarding procedures have been updated to ensure they remain current and include learning from local and national sources and both the website and the online procedures are now in 'mobile friendly' format. A cross authority procedures sub group has been formed to manage the update process.

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

CHANGES TO THE WAY THE NSCB OPERATES

- New guidance covering children visiting psychiatric wards
- New guidance covering the safe recruitment of staff
- Reference to Association of Directors of Children's Services (ADCS) guidance on age assessments for children from abroad
- Details of how to comply with the new requirement to report Female Genital Mutilation (FGM) to the police
- Details of the new offence of controlling or coercive behaviour in intimate or familial relationships
- An updated template for agency reports to Nottinghamshire child protection conferences.

LEARNING AND IMPROVEMENT FRAMEWORK

Learning and Improvement Framework

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

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

The sub groups that support the Learning and Improvement Framework are chaired by members of the NSCB representing different partner organisations. Annual reports on the effectiveness of these groups were presented to the NSCB for assurance in June 2016.

Learning and Development Sub Group

Over the course of the year the Learning & Development Sub Group has adopted a more strategic approach and brought a stronger focus on practice development. There is a clear learning pathway, a clear rationale for each course and good follow up and analysis of impact.

The sub group has overseen the delivery of a multi-agency training programme focussed on the key learning from case reviews and the outcomes of case audits. Training levels have been developed and introduced to further clarify which staff groups would most benefit from attending specific training events.

A Safeguarding Children Competency Framework has been developed in conjunction with the Nottingham City Safeguarding Children Board. The framework can be used by partner agencies to ensure that staff have appropriate skills for their roles and can access suitable training to support them.

The delivery of multi-agency training events relies on a training pool made up of staff from partner agencies and a small number of specialist presenters. More courses than ever have been provided and course evaluations continue to very positive. We are grateful to all those who have contributed to

the training opportunities that have been provided to over 2,300 staff working with children and families during the year - 500 more training places than the previous year.

In addition to the offer of a wide range of training events the NSCB has broadened the E-learning modules available to partner organisations. Over 4,500 staff completed E learning modules on safeguarding issues including; awareness of abuse and neglect, child sexual exploitation and safe sleeping for babies. The NSCB has used its links with schools to promote safeguarding awareness in the community, encouraging parents and carers to complete an E-learning module on the risks of CSE and providing information regarding FGM.

Whilst attributing improved outcomes for children directly to training is challenging we do know that during the period that specific multi-agency training was delivered on CSE and Fabricated or Induced Illness (FII) there were strong indications that both issues were being increasingly recognised and robustly managed. Compared with the previous year, the number of CSE strategy meetings increased from 140 to 238 and the number of FII strategy meetings increased from 6 to 19. Through post course evaluations it is known that levels of confidence to deal with safeguarding issues continue to show significant improvement as a result of the training provided through the NSCB.

Serious Case Reviews

During the year six cases were referred to the Serious Incident Review (SIR) Sub Group for consideration. A recommendation was made to the NSCB Independent Chair that a serious case review (SCR) be conducted in four of the cases. In a fifth case the SIR subgroup were unable to reach a majority view as to whether a review should be undertaken and the sixth case resulted in a recommendation of no further action. The NSCB Independent chair agreed with all of the recommendations made by the SIR and commissioned a SCR on the case where the SIR subgroup was undecided. All five SCRs commissioned in 2015/16 are ongoing and at various stages of completion.

In addition to the above cases two SCRs (IN14 and JN15) which commenced during the previous reporting period were completed and signed off by the Board during this year and a Learning Review was completed regarding a further case.

The SIR sub group has actively monitored the action being taken in relation to competed reviews on a regular basis. During the reporting period the sub group monitored the completion of 28 out of 30 outstanding actions from serious case reviews.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – IN14

This review examined how organisations worked with a family that had contact with a number of services over an extended period of time in connection with the health needs of mother and indications of emotional, physical and sexual abuse of children within the household. Although concerns were raised on several occasions professionals involved with the family were unable to fully identify or understand the risks to the children. Following disclosures by the children of abuse in 2013 child protection medicals were undertaken showing signs of sexual abuse. A joint investigation followed and this led to an adult male being convicted of sexual offences.

The Serious Case Review identified the following key themes regarding the effectiveness of safeguarding practice:

- Education professionals listened to the children and raised concerns but these were not always responded to by other professionals and the escalation process was not used
- High turnover of staff did have an adverse impact on the work with the family
- Workers were intimidated by a dominant man and manipulated by his partner
- Joint working was not always effective – on occasions work was not coordinated and core groups did not follow through the more detailed work required
- There was an over reliance on written agreements, an absence of effective contingency planning and an insufficiently robust approach to non-compliance.

Response by the NSCB:

The escalation process has been reviewed, additional guidance has been provided and multi-agency audits now look for evidence of the effective application of the procedure. This issue continues to receive the attention of the NSCB.

The process for undertaking child medical assessments has been reviewed by the NSCB and found to be appropriate – the application of the procedure through appropriate strategy discussions involving health professionals continues to be monitored by the NSCB through audit and work to strengthen joint working between the police and children's social care is ongoing.

LEARNING AND IMPROVEMENT FRAMEWORK

Serious Case Review – JN15

This review relates to a 5 month old boy who died from an unascertained cause in 2013. At the time of death the baby was in the care of his mother who had a previously unrecognized or diagnosed mental health illness. The review identified many examples of good practice by universal services provided to the family. Indeed there was nothing professionals could do to prevent the death as they were not alerted to the deterioration in mother's mental health on the day that the baby died. Had they been, there is an established process of caring for the mother and child in such cases, and it is likely they would have been followed.

The Serious Case Review identified the following key themes regarding the effectiveness of safeguarding practice:

- Practice was good in this case – individually and systemically things worked well
- Professionals could do nothing about the deterioration in mother's mental health as they were not alerted
- The perceived stigma of mental illness should be challenged by all organisations.

Response by the NSCB:

The learning from this review was shared with staff across all partner agencies and with another LSCB which covered the area where the family lived at the time of a report of domestic abuse.

The NSCB Independent Chair requested the MASH Operational Management Group consider expanding the process of police notifications of domestic abuse incidents to include those graded as standard risk. The outcome of the review was presented to the NSCB and it was agreed that the current process for notifications was proportionate bearing in mind resource implications and data protection requirements; however the Board recommended that a process to notify midwifery services of standard risk incidents relating to pregnant women should be explored.

LEARNING AND IMPROVEMENT FRAMEWORK

The learning identified through SCRs has been incorporated into existing multi-agency safeguarding courses and where required bespoke training events have been devised and delivered during the year. These include, Decision Making and Disguised Compliance, Responding Effectively to the Impact of Domestic Violence and Working with Intimidation, Resistance and Avoidance. The 'What's New in Safeguarding' half day events are also used to disseminate learning from case reviews.

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

LEARNING AND IMPROVEMENT FRAMEWORK

Child Death Reviews

The Child Death Overview Panel (CDOP) has continued to strengthen its role within the Learning and Improvement framework to ensure relevant learning from child deaths is disseminated appropriately. During the reporting year 50 children who were normally resident in Nottinghamshire unfortunately died (expected and unexpected deaths). The CDOP reviews the death of a child after the completion of other processes (e.g. Inquests and criminal proceedings) and undertook 37 reviews in this period.

Identifying trends or patterns in child deaths with a relatively small population is recognised nationally as a challenge. The number of child deaths has remained fairlyNottinghamshire has linked in with neighbouring areas and contributed to a regional CDOP where learning was shared across the East Midlands. Examples of the work undertaken in by the Nottinghamshire CDOP to prevent future child deaths and improve the effectiveness of practice are provided below:-

Safer sleep for babies

In response to an identified increase in deaths where the circumstances of the babies sleeping arrangements were thought to be a contributory factor a joint working group with Nottingham City CDOP has been formed to promote safe sleeping. A media campaign has taken place and training events have included inputs aimed at equipping all professionals with the knowledge required to offer safe sleeping advice to families particularly when working with vulnerable families.

Sepsis

The early identification and response to sepsis has been raised as an issue both locally and nationally. Partner organisations have developed action plans to improve practice and a “Confirm and Challenge” event was used to provide assurance around the progress being made. A follow up event is planned.

Crohns disease

A Learning and Improvement bulletin has been produced and disseminated following the review of a child death which featured complications from Crohns disease. The bulletin focuses on GP “responses to weight loss and abdominal pain in children” and is available in the learning from practice section of the website.

LEARNING AND IMPROVEMENT FRAMEWORK

Multi-agency audit

The Multi-Agency Audit sub group developed an audit programme for 2014/15 taking into account the NSCB priorities and learning through the learning and improvement framework. Two NSCB multi-agency audits were completed and presented to the Board during the reporting period: -

- Initial Child Protection Conferences (repeat audit)
- Adult and children's services joint working

In addition details of the audit and quality assurance arrangements in place concerning the MASH and the Early Help Unit (EHU) were presented to the NSCB along with the findings from a range of audit activity. It was agreed that the existing quality assurance arrangements for the MASH and EHU require development and structure to ensure on-going scrutiny and improvement in key areas.

Initial Child Protection Conferences (repeat audit)

Findings regarding the effectiveness of safeguarding practice:

- A significant improvement in the quality of information which is shared at the ICPC and how this information is analysed and understood at the conference
- Evidence of better attendance of relevant professionals at ICPC's compared to previous years
- Good practice noted in how invitations were sent in a timely way which were then followed by a telephone call and clearly recorded on the child's social care file
- Variation in the quality of reports presented to conference by professionals
- An evident decline in the number of children whose wishes, feelings and views were presented to the conference. This was the most significant issue which was identified by auditors which led to fewer 'good' overall grades being given than the previous year.

Response by the NSCB and its partners to the audit findings:

The multi-agency responsibility to promote the participation of children and young people in their ICPC has been strengthened through reminders being included in invitations to child protection conferences and by amending the conference report template. A series of workshops for social workers have taken place regarding communicating with children and the NSCB training programme has been updated. A Learning and Improvement bulletin has been published (learning from practice).

LEARNING AND IMPROVEMENT FRAMEWORK

Adult and children's services joint working

Positive work was identified in the majority of cases, for example the recording and identification of children within households and the use of home visits.

3 main areas for improvement were identified:

- Need to ensure a common understanding of family compositions across agencies
- Need to ensure that agencies are aware of which other agencies are involved with a family
- Need to ensure a multiagency approach to assessing safeguarding risks to children where the adults are experiencing Domestic Abuse, Mental Health or Substance Misuse issues.

As a result of the audit all adult mental health teams were contacted to ensure records included details of children living within the household. Training was used reinforce the importance of considering the impact on children of parental/carer mental health and substance misuse.

Positive feedback from participants in multi-agency audits indicates these are learning opportunities for those involved and this has been recognised through the provision of participation certificates.

In addition to the NSCB multi-agency audit programme, the 'section 11[1] audit' is used to provide assurance about partner organisations compliance with key safeguarding standards through a two year cycle of self-assessment and progress checks.

The audit programme for 2016/17 has been agreed and will examine practice related to:

- The detention of young people under s.136 Mental Health Act 1983
- CSE
- Sexual abuse referrals
- Early help
- Neglect
- Child protection enquiries including strategy discussions.

[1] Section 11 of the Children Act, 2004

LEARNING AND IMPROVEMENT FRAMEWORK

INSPECTIONS

Ofsted – Inspection of Nottinghamshire services for children in need of help and protection, looked after children and care leavers

In May and June 2015, Ofsted undertook a comprehensive inspection of children's services in Nottinghamshire. The full inspection report was published on 20 July 2015 and can be viewed at: http://reports.ofsted.gov.uk/local-authorities/nottinghamshire

At the same time as the inspection of children's services, a review of the effectiveness of the Nottinghamshire Safeguarding Children Board (NSCB) was undertaken. This found the effectiveness of the Board to be good.

The judgements achieved by Nottinghamshire County Council under the new Ofsted inspection framework were as follows:

- Overall effectiveness – **good**;
- The experiences and progress of children who need help and protection – **good**;
- The experiences and progress of children looked after and achieving permanence – **good**; including graded judgements on:
    - Adoption performance – **good**;
    - the experiences and progress of care leavers – **requires improvement**;
- Leadership, management and governance - **good**.

The following areas for improvement were identified:

- Better understanding and response to the health needs of care leavers and the provision of health histories
- Pathway plans for Looked After Children (LAC) and care leavers
- Use of management information to understand and respond to the risks of care leavers who go missing or who are at risk of CSE
- Implement, monitor and review the 16+ accommodation strategy
- Review the effectiveness of the Corporate Parenting Sub-Committee
- Raise awareness of private fostering and improve the response and timeliness of assessments
- Collection and analysis of early help information
- Ensure relevant partner agencies are included in child protection strategy discussions and child protection conferences

- Improve the quality of analysis in social work assessments
- Work with partners to ensure mental health services for vulnerable children are provided promptly
- Work with partners to timeliness of dental checks and immunisation of LAC

A post inspection improvement plan was developed to address the recommendations and this was presented to the NSCB for scrutiny. Relevant actions for the NSCB concerning private fostering and partner agency engagement with child protection processes were identified and incorporated into the NSCB business plan.

HM Inspector of Probation - Inspection of Nottinghamshire Youth Offending Work

This inspection took place between 11 and 13 May 2015 and a copy of the full report is available at https://www.justiceinspectorates.gov.uk/hmiprobation/inspections/nottinghamshiresqs/. The inspection found that work to reduce reoffending, to protect the public, children and young people, and to ensure sentences are served was of good quality. The report states that 'it is clear that Nottinghamshire Youth Justice Service (YJS) have continued to work hard and successfully in their work with children and young people since our last inspection in 2012. We found the performance of the YJS to be very creditable'.

It was noted that the reoffending rate for Nottinghamshire, published by the Ministry of Justice in January 2015, based on binary reoffending rates after 12 months for the April 2012 – March 2013 cohort was 25.4%. This was better than the previous year (28%) and significantly better than the England and Wales average of 36.1%.

HM Inspectorate of Constabulary (HMIC)

Between 1 and 11 September 2014 HMIC undertook an inspection of Nottinghamshire Police child protection work. A report on the inspection findings was published in February 2015 which identified the following concerns raised by inspectors:

- significant delays in some child protection investigations;
- a lack of supervisory oversight and management of cases;
- children were being unnecessarily detained in police custody overnight; and
- lack of awareness of child sexual exploitation in some parts of the force leading to an inconsistent response.

LEARNING AND IMPROVEMENT FRAMEWORK

The Head of Nottinghamshire Police Public Protection provided an update to the NSCB in December 2015 on progress with the action plan developed in response to the inspection. Work is continuing in conjunction with children's social care to improve practice issues around joint working particularly strategy discussions, joint/single investigation decision making and involvement in child protection conferences.

The outcome of a HMIC thematic inspection covering Female Genital Mutilation (FGM) and forced marriages was also reported to the Board. Actions identified by the police included the completion of profiling work to provide an understanding of the community and multi-agency working and pathways to services.

Care Quality Commission (CQC) Review of Services for Looked After Children and Safeguarding in Nottinghamshire

In October 2015 the CQC undertook a review of services for Looked After Children and Safeguarding in Nottinghamshire. The review visited a range of health services including; Doncaster and Bassetlaw NHS Hospital Trust, Sherwood Forest NHS Hospital Trust, a sample of GP practices, school nursing and health visiting, midwifery, child & family mental health, contraceptive & sexual health, adult mental health, adult drug and alcohol and children in care health.

The CQC Review Report was published in March 2016 and an overview of the key findings was provided to the Board. Health organisations involved in the review have submitted action plans to the CQC outlining how they will respond to the recommendations and a confirm and challenge event, which included involvement from member of the Board, took place in May 2016 to provide assurance that the right actions are being taken and progress being made.

Clayfields House Secure Children's Home

Clayfields House is a secure children's home provided by Nottinghamshire County Council. In March 2016 it was reported to the Board that an Ofsted Inspection graded Clayfields House as outstanding. An annual report for 2015/16 has been presented to the NSCB Executive to enable the Board to assure itself that the use of restraint is appropriate within the unit. Details of the Restraint Minimisation Strategy and its application were provided along with analysis on the use of restraint and injuries to young persons and staff.

AREAS FOR DEVELOPMENT

Areas for Development

The NSCB business plan referred to in the introduction to this report has guided the work of the Board and provided the means by which the Executive has reviewed progress against key objectives. Whilst a great deal was achieved during the year, thanks to the support and commitment of partner agencies, it was not possible to fully resolve the following issues and these have been carried forward into the 2016/18 business plan.

A 'Meeting the Challenge' event was held to enable NSCB members to reflect and agree on what they want to achieve through the Board during 2016/17 and to provide an opportunity for improving understanding of the challenges faced within other organisations. In particular the event was used to help identify what needs to be done to improve outcomes for children in Nottinghamshire.

VULNERABLE CHILDREN

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

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

Specific actions related to these groups are identified within the business plan.

PERFORMANCE INFORMATION

The Ofsted Inspection in May 2015 concluded that '*The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services*'. It recommended that the Board '*Revise and refresh the Board's data set to ensure a wider focus on the performance of partner agencies*'. The Performance

AREAS FOR DEVELOPMENT

Information Report (PIR) has been revised during 2015/16 but further improvements will be made to enable greater scrutiny of partner organisations' performance in key safeguarding areas. Data and analysis related to CSE will be improved and information about Fabricated or Induced Illness, Female Genital Mutilation, Looked After Children's health care, and parents/carers who abuse substances will be included into the PIR.

A Performance Management Framework will be developed to clearly articulate how performance is monitored through subject specific reports and the PIR.

CHILD PROTECTION ENQUIRIES

The NSCB will further develop it's scrutiny of key elements of child protection enquiry work and seek to support improved practice, in particular:-

- strategy discussions need to involve the right professionals and be used to effectively coordinate and guide multi-agency work – in particular decisions around the need for medical assessments
- influence appropriate partner input from relevant agencies in Initial and Review Child Protection Conferences

Audit work will include an examination of these issues, procedures will be reviewed and business processes revised to support improved practice

COMMUNICATION AND ENGAGEMENT

Whilst some positive progress was made during the year in relation to communication and engagement, with a new website and improved dissemination of learning, the development of a strategy to draw together this work and set out how the NSCB will engage with its stakeholders had to be delayed due to resource issues. This work will now be completed during this year.

The NSCB has also agreed to support the development of a young people's health website which is being led by public health and will be linking in to identify opportunities to strengthen communications with young people.

OTHER ISSUES CARRIED FORWARD FROM 2015/16

- Monitoring developments around the provision of a Sexual Abuse Referral Centre
- Private fostering awareness raising and monitoring of assessments
- Reassurance regarding effectiveness of CAMHS provision
- Completing an assessment of the level of Fabricated and Induced Illness.

AREAS FOR DEVELOPMENT

LEARNING AND IMPROVEMENT

Case reviews

The SIR sub group will work to provide clarity in terms of alternative review methodologies which allow for learning to be achieved in a proportionate, cost efficient way and which fully engages practitioners and families in the process.

Increased focus will be placed on what has worked well with feedback provided to agencies that includes the impact on outcomes for children.

Child death reviews

Work will be undertaken to implement the changes recommended by the National Review of LSCBs which relate to CDOPs and which are agreed by NSCB. In particular options for contributing to improved analysis of child death information will be explored and preparations will be made to take account of the proposed new governance arrangements under the Department of Health.

The CDOP contribution to the NSCB Learning and Improvement Framework will be strengthened by further utilisation of training events to disseminate learning identified through child death reviews. The promotion of the “safer sleep for babies” message amongst professionals and the general public will continue with further awareness raising work and the implementation of risk assessment tool

Learning and development

The NSCB will support partner agencies to promote and embed the Safeguarding Children Competency Framework across all organisations. The training quality assurance scheme will be further streamlined.

The multi-agency training offer provided through the NSCB will be expanded further through increased availability of E Learning modules and the training pool will be reviewed to ensure appropriate representation from partner organisations.

Appendix A

NSCB Membership List (at 1/7/16)

NAME	ORGANISATION
Chris Few **Independent Chair**	
Julie Gardner **Vice Chair**	Associate Director for Safeguarding and Social Care, Nottinghamshire Healthcare NHS Foundation Trust
NCC Representatives	
Derek Higton	Service Director, Youth Families and Cultural Services, Nottinghamshire County Council
Colin Pettigrew	Corporate Director, Children's Families and Cultural Services, Nottinghamshire County Council
Steve Edwards	Service Director, Children's Social Care, Children, Families & Cultural Services, Nottinghamshire County Council
Marion Clay	Acting Service Director - Education Standards and Inclusion, Children, Families & Cultural Services, Nottinghamshire County Council
Laurence Jones	Group Manager, Targeted Support & Youth Justice Service, (Also covers Early Years) Nottinghamshire County Council
Pam Rosseter	Group Manager, Safeguarding and Independent Review & Quality Assurance, Children's Families and Cultural Services, Nottinghamshire County Council
Caroline Baria	Service Director, Personal Care and Support, South Nottinghamshire, Adult Social care, Health and Public Protection, Nottinghamshire County Council
Kate Allen	Consultant in Public Health, Adult Social Care, Health and Public Protection,

APPENDIX A

Health representatives - advisors to the Board	
Cathy Burke	Nurse Consultant, Safeguarding, NHS Bassetlaw CCG
Val Simnett	Designated Nurse Safeguarding Children, (Nottinghamshire) 5 CCGs,
Dr Fiona Straw Dr Rebecca Sands	Designated Doctors for Safeguarding, NHS (Nottinghamshire) 5 CCGs.
Bushra Ismaiel	Consultant Community Paediatrician, Designated Doctor for Safeguarding, Lead Clinician for Community Services, Doncaster & Bassetlaw Hospitals
Health - providers	
Moira Hardy	Director of Nursing and Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Mandie Sunderland	Chief Nurse, (Executive Lead for Safeguarding), Director, Nottingham University Hospital NHS Trust
Wendy Hazard	Locality Quality Manager, Nottinghamshire Div. HQ, EMAS
Suzanne Banks	Interim Chief Nurse for Sherwood Forest Hospitals NHS Foundation Trust
Health - commissioners	
Denise Nightingale	Head of Service Improvement, NHS Bassetlaw
Elaine Moss	Chief Nurse and Director of Quality and Governance, Newark and Sherwood and Mansfield/Ashfield Clinical Commissioning Groups
Nichola Bramhall	Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups
Carole Lavelle	Assistant Director of Nursing - NHS England, South Yorkshire & Bassetlaw
Other agency representatives	
Bob Bearne	Head of Nottinghamshire Local Delivery Group, Community Rehabilitation Company

APPENDIX A

Nigel Hill	Head of Nottinghamshire, National Probation Service
Robert Griffin	D/Superintendent, Head of Public Protection, Nottinghamshire Police
Clare Taylor	Service Manager, A11 Early Intervention Team, Cafcass
Leanne Monger	Newark & Sherwood District Council – District and Borough Councils representative
Sue Fenton	Manager, Home Start Nottingham (Voluntary Sector Representative)
Donna Trusler	Principal, Manor Academy, Mansfield Woodhouse
Lay members:	
Victoria Morley	
Peter Wright	
Participant observer	
Kate Foale	Lead responsibility for Children's Social Care, Nottinghamshire County Council
NSCB Officers	
Trish Jordan	NSCB Training Coordinator
Bob Ross	NSCB Development Manager
Steve Baumber	NSCB Business Manager (P/T)
Hilary Turner	NSCB Business Manager (P/T)
Michelle Elliott	NSCB Administrator

APPENDIX B

Appendix B

Glossary

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