Nottinghamshire Safeguarding Children Partnership

Annual Report 2022 - 2023

Nottinghamshire Safeguarding Children Partnership

Foreword from the NSCP Strategic Leadership Group Chair

I am pleased to introduce the NSCP annual report for 2022 – 2023, a year in which I joined the partnership Strategic Leadership Group (SLG) and also took over as chair. This was also a year of reflection. All partnership agencies are in a period of post-Covid recovery with financial challenges also creating a challenging operational environment. We welcomed Donna Ockenden commencing her review of maternity services at Nottingham University Hospitals and this reporting period also saw the lead up to the CQC and Ofsted inspection of the partnership's provision for children with Special Education Needs and Disabilities (SEND). Alongside these local developments, several national reviews (particularly the Child Protection in England and Stable Homes, Built on Love reports) prompted us to reflect how we might want to build on our strong safeguarding partnership work in Nottinghamshire.

In my opening remarks at a recent partnership half-away day where we were developing our new business plan I reflected on what makes us a strong partnership:

1. We recognise that our organisations are different and we value and understand these differences.
2. We have a shared sense of purpose and direction about what we are collectively striving to achieve.
3. We think about capacity not just in terms of physical resource, but in terms of passion, commitment and dedication to safeguarding children.
4. We focus on developing the togetherness of our relationships across the partnership.

Our independent scrutineer reflects in his review of the year on how he has observed this (p. 15). He considers both the operational response to a particular situation for a young person in distress and in the strategic decision to conduct a transparent review of the safeguarding partnership response to events at Harlow Academy. I would add to this the partnership decision to commission a strategic review of the Nottinghamshire Multi-Agency Safeguarding Hub (MASH), demonstrating our drive to develop a shared strengths-based vision of how we provide the right help, at the right time, to the right children and their families in Nottinghamshire.

SLG are collectively very proud of the training offer by our partnership. The NSCP learning and Workforce Development Group's commitment allows us to have an expert local training pool, giving their time without renumeration to ensure an extensive training offer. One of many training highlights in this reporting period has been the launch of the Anti-Racist Practice training (p. 11), take up and feedback for this course has been one part of moving froward our objective of improved understanding and practice around diversity in Nottinghamshire. I also highlight the work of the Child Safeguarding Practice Review Group (p.8), which, despite various changes of professional membership through this period, has worked very hard to publish three Local Child Safeguarding Practice Reviews with consistently positive feedback from the national panel.

I am also pleased to be able to introduce the NSCP's business plan for 2023-2027 alongside this annual report. This is the product of a good deal of hard work by the NSCP's Safeguarding and Improvement Group and I believe it demonstrates the journey of reflection we as a partnership have undertaken in 2022-2023 and lays out clearly how we intend to continue.

Rob Griffin (*Assistant Chief Constable, Chair of SLG)*

Nottinghamshire Safeguarding Children Partnership

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Introduction

Nottinghamshire Safeguarding Children Partnership (NSCP) provides the safeguarding arrangements required under the Children and Social Work Act 2017 and the statutory guidance 'Working Together to Safeguard Children 2018'. The purpose of safeguarding arrangements is to support and enable local organisations and agencies to work together to safeguard and promote the welfare of children.

Vision and values

The Partnership set out its vision in the safeguarding arrangements: -

'That children and young people in Nottinghamshire grow up in a safe and stable environment and are supported to lead healthy, happy, and fulfilling lives'

The Nottinghamshire Safeguarding Children Partnership will:

- Work effectively as a partnership to protect children from harm.
- Build working relationships between partners which support a culture of high challenge and high support.
- Be transparent and self-critical.
- Learn from local and national safeguarding practice and improve the way children are safeguarded.
- Listen and respond to children and young people and adult victims and survivors of child abuse to guide how services are delivered.
- Ensure services for children and families in Nottinghamshire support children and young people to stay safe, healthy and happy.
- Ensure services for children and families in Nottinghamshire support parents and carers to provide the best possible care for their children.

This report sets out what the Nottinghamshire Safeguarding Children Partnership has achieved over the past year, including the following:

- An update on progress in relation to the safeguarding priorities for 2020-23 and the key areas of work to take forward.
- A summary of the decisions made in relation to local case reviews and the learning and actions taken from those reviews and national reviews.
- The effectiveness of the safeguarding arrangements in practice.

- Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers.
- Examples of the ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

The safeguarding arrangements in Nottinghamshire are fully detailed in our document published in line with national requirements, and available on the NSCP website https://nscp.nottinghamshire.gov.uk/about-the-partnership/. The arrangements were last updated in January 2020. They include details of the partners to the arrangements and explain how the functions of the Partnership are carried out through several different groups and led by the Strategic Leadership Group (SLG).

Safeguarding partnership activities and progress

What we said we would do	What we did
Understanding and developing the role of the Safeguarding Partnership in evolving system arrangements	
Continued engagement with key initiatives such as the Integrated Care System and the Domestic Abuse Partnership Board to ensure a strategic approach for the safeguarding of children and families.	The local needs assessment in relation to children and young people who are victims of domestic abuse has been completed. A face-to-face meeting of the relevant subgroup to be held in September 2023 will take forward a detailed plan for the next 12 months, including our new domestic abuse strategy. The subgroup will continue to report to the Domestic Abuse Partnership Board and the Safeguarding Assurance and Improvement Group and will continue to be subject to oversight within the partnership in addition to independent scrutiny. In the first quarter of 2022/23 Nottingham & Nottinghamshire (N&N) CCG and Bassetlaw CCG continued to align their safeguarding arrangements with the establishment of the Integrated Care Board (ICB) and partnership working across the Integrated Care System (ICS) on 1st July 2022. The ICB with health partners developed safeguarding health system arrangements across the ICS through the establishment of the Safeguarding & Public Protection Assurance Group (SPPAG) with the first meeting taking place in August 2022. This group has continued bringing partners together to: a) share and reflect on new or revised policy, practice and procedural issues relating to safeguarding across the Nottingham and Nottinghamshire system b) discuss and achieve consistency across safeguarding work across the N&N ICS c) share learning and best practice d) provide an opportunity to identify blocks to interagency working and solutions to mitigate these. e) The ICB Safeguarding Children team report to the Chief Nurse and Designated Professionals quarterly meeting. Similarly to this there is now an established ICS Looked After Children Assurance Group and an ICS SEND Assurance Group; any safeguarding issues or concerns from these groups are escalated to the SPPAG and within the ICB.
Develop the cross-authority Neglect Steering Group to drive, monitor and evaluate the Neglect Strategy.	A terms of reference has been agreed for the relaunched cross authority neglect steering group, with the aims of supporting and monitoring the implementation of the strategy, evaluating the impact of the strategy and promoting the strategy. A working group drawn from the steering group membership is currently engaged in revising the toolkit and guidance in the light of feedback from practitioners and

	the need to incorporate strength based language and approaches. A set of measures aimed at assessing the prevalence of neglect in the partnerships is under development, and members of the steering group have been invited to participate in the forthcoming audit of organisation responses to neglect in the partnerships.
Conclude the work to fully align the CCE response across City and County and develop a plan to evaluate progress.	This piece of work has not developed as previously anticipated, in light of new research and development of practice with regard to child exploitation; stressing the benefit of a holistic response to child exploitation. On this basis the cross authority steering group has reorganised its governance and has made a commitment to embedding the Tackling Child Exploitation principles (Research in Practice) into practice, with the police also agreeing to reorganise their response teams into one child exploitation team. The partnership is therefore now committed to (i) complete a partnership self-assessment using the TCE tool, (ii) agree a joint strategy with Nottingham City and partners and (iii) to embed the principles into practice and to achieve co-location within the police exploitation team. There will also be a NSCP audit with Nottingham City in respect of exploitation which will further inform our knowledge of practice.
To consider the government's Green and White papers and recommendations in respect of how better to engage schools and academies within the NSCP.	There have been changes in the government messaging about this through 2022/23, however it is clear both locally and nationally that the involvement of education provisions at all levels of partnership decision making is key. The partnership has a well-developed network of 7 designated safeguarding leads (DSLs) who attend partnership forums and the partnership service manager co-facilitates county-wide DSL forums and safeguarding governor focus groups throughout the year. There are therefore good mechanisms in place for updating operational leads from education settings on safeguarding learning and developments, or for their views to be taken back to partnership meetings. However, a consultation is underway on development of a formal education sub-group in the partnership and representation on the strategic leadership group to develop better education influence in partnership strategic decision making.
Preventing abuse and neglect	
Delivering the faith groups, sports clubs and voluntary sector action plan and embedding the recommendations to improve information sharing and offer annual	A wider group of representatives from relevant agencies attended the partnership forum in November 2022. This provided a space for the statutory partners to explain the very significant changes in the health space following the move to Integrated Care Systems, developing an overarching strengths based framework in the Local Authority and reflections on safeguarding in policing from the Assistance

engagement events in addition to the partnership forum.	Chief Constable from Nottinghamshire Police. The attendance at training from relevant agencies also demonstrates improved engagement with faith groups, sports clubs and the voluntary sector.
Develop our ability, through data review and auditing, to understand the impact of non-statutory support to children and families.	Nottinghamshire has a newly established Data Maturity Steering group with membership from key partners in the Early Help Executive. The priority area of work for this group is to establish regular data feeds from all parts of the partnership. This will support quick identification of issues for referred families, understanding whole community needs and evidencing impact of whole family working. NCC has invested in products that allow datasets from different systems to be matched (education exclusion, education attendance, children's social care, EHCP etc). Police and NCC have signed a new information sharing agreement (ISA) to bring police data into the matching process. In 2023 there is a plan to develop ISAs to secure housing, substance misuse and Healthy Families Team data feeds. Information will be made available to Early Help and Social Care practitioners through a dashboard to support them in their work. Ultimately information will be available through a portal for schools and other partners although this will be beyond 2024.
Further developing the partnership response to CCE, including continued training and incorporating the learning from the audit into the cross authority steering group.	Nottinghamshire's approach developed over a number of years with the SYVCCE Panel (CCEP) first being held in 2019, this was the first evaluation of the process for serious youth violence (SYV) and child criminal exploitation (CCE). A multi-agency audit was agreed in 2021 to consider the efficacy of the process and the level of interagency working from a multi-agency perspective, it focused on the multi-agency work with 10 young people considered variously at risk of CCE (low, medium and high). The audit found those young people identified as high risk have clear plans and proactive work aimed at reducing risk and safeguarding their wellbeing. Where the risk is identified as moderate, gaps were seen in information sharing, joint working and mutual understanding of the risk and limited engagement was seen with the young person. The audit report was taken to SAIG in 2022, following which an action plan was developed with recommendations in respect of the participating agencies. The action plan points presently live with agencies an these recommendations will be revisited/reviewed as part of the current multi agency review of CE practice across Nottinghamshire County and Nottingham City.
Improving safeguarding practice	
Expanding work around understanding diversity in safeguarding contexts.	The partnership has worked intensively to develop the training offer to incorporate diversity needs identified in partnership reviews and national guidance. Three new courses have been developed and delivered through 2022/23 with strong feedback (these are further considered in the multiagency training section of this report). A seconded service manager is also being funded by the partnership to focus on understanding the voices of children and their families in relation to the partnership's work and

	developing priorities. Her work through 2022/23 has significant influenced the development of the partnership's new business plan which was in development at the close of this financial year.
Continued work on safer sleep, thinking in particular about the cost of living difficulties and implications for safer sleep through the coming winter. Continuing to ensure this learning is across all safeguarding professionals.	The multi-agency Nottinghamshire and Nottingham Safer Sleep Steering Group continues to meet quarterly. Key achievements include: • Safer Sleep messaging and bulletins shared widely across health and care partnerships in July 2022 (summer message), November 2022 (winter message including links to cost of living support) and March 2023 (safer sleep week). • Extensive mapping has taken place to provide assurance that safer sleep messaging is consistent and continues to be provided by health and care agencies during pregnancy, on discharge from maternity services and in the early days, weeks and months after a baby's birth up until one year of age. A development in 2022 was the East Midlands Ambulance Service (EMAS) adding safer sleep advice to the handheld devices used by ambulance crews. • The safer sleep risk assessment tool has been updated in line with national guidance and will be re-launched following sign off from the city and county safeguarding partnerships. • From January-December 2022, 190 practitioners completed the 'safer sleeping for babies' e learning. Attendees included foster carers, children's and adult social care teams, charities, Childrens' Centre Services, private day nurseries and pre-schools, housing support for young people and Youth Offending Team workers. • Level two Sudden Unexpected Death in Infancy (SUDI) and safer sleep training has been delivered by both safeguarding children partnerships (city and county), with wide representation of services attending. Safer Sleep has been included in the workforce development and training matrix for Family Hubs in Nottinghamshire County. • A parent volunteer is a member of the safer sleep group. The group is keen to build on parental engagement and review opportunities for funding to support this.
Focussing on early intervention in the harmful sexual behaviour context along with better incorporation of the voices of children and families in this area.	The multi-agency arrangements for assessment and intervention for Harmful Sexual Behaviour continue to be overseen by the Nottinghamshire Safeguarding Children Partnership (NSCP) and HSB steering group. The NSPCC are currently undertaking a piece of work that will focus on early intervention work in respect of problematic sexual behaviour, with a focus on delivering to this work to schools across Nottinghamshire and Nottingham City. Partners have worked closely with the NSPCC

	in respect of this and will continue to do so. Head2Head CAMHS provide specialist assessment and intervention for young people with complex unmet needs that present with Harmful Sexual Behaviour. As part of the commissioning arrangements for the above work public health has supported the Steering Group to undertake a needs assessment across the partnership and Nottingham City. This assessment is not yet completed but will be used to develop work moving forward including working more closely with the Police and Crime Commissioners Office in respect of early intervention. The voices of children and young people presenting with harmful sexual behaviours is an area of focus for development over the next 12 months to work with children and young people to gain their experience of our services and to use this to inform improvement and development of practice and services across the system.
Continued work towards a finalised review and recommendations for the MASH and continued partnership work to manage short-term demand.	The review of the MASH was concluded with 9 recommendations which have been full endorsed by the Strategic Leadership Group. The review endorsed the strength in the partnership and commitment to working together towards a modernised front door and identified some of the challenges about a lack of joint partnership understanding of thresholds. They key partnership priority in 2023/24 is the delivery of a new front door for children and families to access support and help in Nottinghamshire.

Case reviews

There is a statutory requirement on safeguarding partners to conduct a 'Rapid Review' when serious child safeguarding cases are identified. The reviews should be completed within 15 working days and a report provided to the National Child Safeguarding Practice Review Panel (National Panel). The NSCP remains committed to gathering as much learning as possible during the rapid review process and to only progressing to a Local Child Safeguarding Practice Review (LCSPR) where necessary.

The NSCP has completed 6 rapid reviews during this reporting period. Of note is that all 6 have involved significant contributions from other areas, and the NSCP has also contributed to the rapid review for a child who was looked after by Derbyshire and placed with carers from an independent fostering agency in Nottinghamshire. Two of the rapid reviews were for children under 1 due to physical harm, two related to harm to looked after children and in one the mother who caused the harm was recently care experienced. The National Panel agreed with the outcomes of all six rapid reviews that progression to LCSPR was not appropriate, but for one review related to suspected fabricated and induced illness the National Panel requested deeper consideration of the learning from a health perspective.

Professional curiosity and **effective strategy discussions** were identified as key elements for improvement of both practice and partnership, and a 'review of reviews' is presently being undertaken by the Independent Scrutineer and the partnership Development Manager such that any repeated and/or linked issues from individual reviews can be identified and responded to in a joined up way and in terms of future learning and development.

Three LCSPRs were published in this reporting period:

TN20 "Tom"

This review was for an 18-day old baby who died when co-sleeping with a parent who was under the influence of drugs. Both parents were subsequently convicted of neglect offences. The baby's parents and his five siblings had been known to services, including Childrens Social Care, for many years in relation to parental neglect. The review has focused on how agencies work together to deal with cumulative neglect and how we can embed the "safer sleep for babies" message into the routine work of all agencies

Some **key areas of learning** from the review included stressing safe sleeping is an issue for services broader than health visiting and midwifery. It identified a need to see and record the world as seen through the eyes of children and work with families being framed within relationship-based practice; acknowledging the importance of parents having an effective relationship with key health and social care professionals. Some learning points were focused on professional assessments, including the use of chronologies, enquiring into history and around domestic abuse, and using tool kids and evidenced based frameworks.

"We welcomed the approach relating the report findings to relevant literature and reviews. We thought it contained some interesting analysis" (National Panel).

UN21 - "David and Daniel"

This review addressed how professionals responded to harmful sexual behaviour (HSB) between two siblings, 11 year old David and 14 year old Daniel. The boys were in a long-term foster care placement with three other siblings. Two of the siblings were assessed as having learning difficulties and the disclosures involved Daniel harming David. There had been a history of involvement from children's social care due to concerns about neglect. David disclosed sexual harm from Daniel in December 2020, this had not been the first disclosure. Restrictive practices were put in place in the foster placement to try and manage this.

Some **key areas of learning** focused on how professionals responded to disclosures of sexual behaviour between siblings and the need for the use of expertise, toolkits and best practice guidance. Assessments should take previous traumatic events and other significant factors into account, and also consider the needs of all children in a sibling group. This includes consideration of whether a sibling group should be placed together. Professional roles were covered in the learning points, including the degree of influence of foster carers with professionals, the role of the independent reviewing officer and for professional curiosity across all involved professionals.

A "good review", "grounded in evidence informed understanding of harmful sexual behaviour" (National Panel).

VN21- "Alison"

This review concerns a four-year-old girl and her unexplained serious injuries while in foster care with her two older siblings. The children had complex needs as they had experienced many traumatic events in the care of their birth parents. The foster carers were new and inexperienced, they had no children of their own and this was their first placement. There was no single 'trigger' incident for the SIN and rapid review, and it followed an analysis of a number of incidents involving injuries to the girl whilst in the care of her foster carers from April 2020 to February 2021.

Some **key areas of learning** included the importance of recognising when to follow safeguarding processes on open cases when there is uncertainty about the cause of an injury or other harm that a child has suffered was a learning point. It was highlighted that staff or carer inexperience may affect service delivery and that additional support and systems may be necessary to maintain service standards and quality. The importance of the availability of services that address adverse childhood experiences, and which can help mitigate the impact on children of those experiences.

"A thorough analysis with relevant learning points" (National Panel).

The National Panel expressed some frustration with regard to delay in all three of the LCSPRs, but acknowledged good reason for this, and that the learning in two of the three was evidently being addressed as the review was ongoing, with updates included from the independent authors.

In January 2022 a special school in Nottinghamshire named Harlow Academy was temporarily closed following an Ofsted inspection which found that pupils were at risk of immediate and imminent harm. In the 2022/23 reporting period the safeguarding partners considered very carefully whether the safeguarding response to concerns raised about the school prior to the inspection had been adequately responded to. The partners together concluded that there would be learning gained from an independent review and this was commissioned, with publication due in June 2023.

The 2022/23 period has proven very busy for the partnership in terms of statutory reviews. Our independent scrutineer describes a mature partnership, with a willingness to examine our multiagency practice. The partnership decision to commission and publish a review about the safeguarding response to events at Harlow Academy demonstrates this continued commitment to reflecting and learning. The timeliness of our rapid reviews and LCSPRs is an area requiring improvement and we acknowledge this is for the second year. Having now stabilised the partnership team after significant changes, and changes to safeguarding partner representation, we are confident of a better position to achieve this over the coming financial year.

Multi-agency training, guidance and procedures:

Providing high-quality multi-agency training, linked to learning and improvement objectives

KEY ACHIEVEMENTS

11,629 training opportunities were accessed, an increase of 1,275 from last year.

Delivery of 4 new courses directly responding to training needs about changing risk (e.g. safeguarding children in a connected world).

Despite Covid pressures, the partnership has maintained a committed training pool with 41 partners delivering this year's training programme.

This has been the third year of offering training following the Covid 19 pandemic, with many organisations feeding back that they are now *on catch up* following the pandemic. With consequent effect staffing levels and capacity. Whilst we anticipated that there will be a consequent decrease in demand and attendance at our multi-agency training. It is very positive to report that this has not been the case and we have in fact delivered 1,275 MORE training opportunities this year. Training has continued to be via Microsoft Teams and E-learning in response to partner feedback that this remains the preference, however we have some in person training events scheduled for the next financial year to start to move towards a more hybrid post-pandemic model.

It is notable that there has been a slight decrease in attendance by the Police alongside a significant decrease from health colleagues (from 360 in 2021-22 to 209 this year) possibly suggesting that it is health who have struggled the most with capacity issues. In comparison we have seen a rise in attendance overall from Nottinghamshire County Council staff from 1749 to 1868, so 119 more places have been taken up. Additionally, there has been an increase again in attendance from schools and colleges from 578 course completions last year to 643. Total attendance from other relevant partner agencies has remained the same. So overall a very positive picture of increased awareness of the training offer amongst partners and relevant agencies. Despite the reduction in health and police attendance, this is in comparison to the last financial year when we know several partners increased their e-learning through lockdown periods. When we compare the figures to pre-pandemic levels attendance for this financial year remains favourable.

2022/23 has seen the development of three new courses: Anti-Racist Practice, Radicalisation and Counter-Terrorism and Understanding Trans Youth. These have all moved forward the partnership's priority of providing inclusive and accessible services, with all of the courses being oversubscribed and the Anti-Racist Practice having a fourth date added to try and accommodate the demand. Feedback has been resoundingly positive with practitioners giving examples of impact on practice such as:

"Since the course I have supported a colleague in what I feel was a situation whereby racism was used to disempower a social worker".

"I have used knowledge gained during personal supervision when supporting colleagues in their work with families".

The partnership has also developed a training course in response the National Child Safeguarding Practice Review Panel's report 'The Myth of Invisible Men'. 4 courses have been offered through 2022/23, all were oversubscribed and on one of the courses 35% rated themselves as good/very good in their practice with Hidden Men, which then improved to 95% after completing the course. Examples of impact on practice included:

"I have visited the dad of a child who was not living in the home to make him part of the assessment."

"During a home visit I enquired about a male visitor in the kitchen and then went on to check what I had been told with all children on a school visit."

"I began working with a Mum and her daughter to improve teenage conflict. After being in the home, it was very evident that the child's stepfather was also playing a large part in conflict resolution too. So, I then did sessions with Mum and stepdad".

The partnership continues to routinely deliver the Working Together to Safeguard Children course in two parts (E-learning followed by a 3 hour virtual session). This is a well embedded part of induction for safeguarding professionals across the statutory partners and relevant agencies in Nottinghamshire. 11 courses were delivered in 2022/23 with the evaluations being very positive. The same is true for the Safeguarding Children Today seminars which are delivered quarterly and this year have contained a guest slot about safeguarding Looked After Children which attracted attendance from foster carers who were very positive about the seminar.

The partnership's learning and development offer has expanded over 2022/23, demonstrating our ability to respond to national and local learning from reviews and our own training needs analysis. Our delivery is greatly assisted by the training pool, commitment to which is exceptional from across the partnership.

Review of use of restraint within Clayfields:

As a safeguarding partnership with a secure children's home in our area, the NSCP is required to have oversight of the use of restraint in the setting.

Clayfields House provides secure accommodation for up to 20 children and young people between the ages of 10 and 17 years of age. It is licensed by the Department of Education and inspected by Ofsted. The contract for the provision of services is reviewed through HM Prison and Probation Service and the Youth Custody Service. The NSCP is required to review the use of restraint at Clayfields House and include the outcome within its yearly report.

A comprehensive report and presentation have been provided to the Partnership by the Clayfields Service Manager and Support Services Manager providing details of the legal framework for Restrictive Physical Interventions (RPI), data on the use of restraint, quality assurance governance and staff support. It was noted that the number of RPIs has reduced over the 2022/23 year compared to the previous year, in line with similar levels of bed occupancy. The SAIG agreed with the conclusions that:

- Staff are trained to a high standard using the Safety Intervention (CPI) form of physical intervention. This replaced the previously used MAPA system with an increased emphasis on the safety of all involved in an RPI.
- Internal and external monitoring of physical interventions are thorough, and the internal quality assurance regime is robust.
- External scrutiny continues through the Regulation 44 visitor, independent Advocate, YCS Performance Contract Manager and twice-yearly Ofsted interim and full inspections.
- In addition, where there are concerns, the Local Authority social workers or Youth Offending Team officers or the Local Authority Designated Officer (LADO), can review individual incidents, which can include the review of CCTV.

Ofsted completed a 3 day inspection July 2022 in which the provision was graded as Good in all areas. This remained the case at the assurance visit in February 2023 where Ofsted reflected that 'strong leadership and support to staff overall and relationships between staff and young people continue to be strong'. Over the coming year a focus will be on reviewing the quality assurance officer role to incorporate more of a safeguarding element thereby strengthening the safeguarding focus of assurance in the setting.

Reflections, next steps and priorities:

The 2022/23 period was one of significant change within the partnership, along with national developments and new legislation. The Integrated Care Board continued to develop with the wider partnership working to understand the responsibilities of provider organisations and how to best ensure continued strong relationships. All of the individuals fulfilling key senior policing roles in the partnership have changed in the 2022/23. A positive outcome of this period of change is the Assistant Chief Constable with responsibility for Public Protection is now the Chair of the SLG and subsequent appointments within his areas of responsibility have brought a renewed commitment to the Partnership and improved stability. However this follows a significant period of change which has impacted on progression and a need to build new working relationships. There have been changes in three key Service Director posts within the Local Authority which has also necessitated getting up to speed for partnership meetings and building relationships. Finally, a new partnership Service Manager came into post in March 2022 along with an interim partnership Development Manager who then handed over to the permanent appointee in January 2023.

It is in the above context that partners reflect on the achievements of publishing three Local Child Safeguarding Practice Reviews, completion of 6 rapid reviews and initiation of a significant independent review despite these changes in key members of the Child Safeguarding Practice Review Group (CSPRG). The training programme has continued to go from strength to strength, with the learning loop from the CSPRG to Learning and Workforce Development Group evidenced in the development of new training in response to national and local learning. The decision to allocate responsibility for SLG to the Assistant Chief Constable has been welcomed and creates a base of strong leaders at a level to agree strategy and allocate resource to continue to lead the partnership through the coming period. This report evidences progress against all of the actions identified in the 2021/22 period but for several these have not developed at the pace the partnership intended. The partnership is mindful of this and a new business plan is being developed at the time of writing, specifically designed as a dynamic document with SMART actions and built in reviews through the SAIG.

Priorities for 2023 – 2024:

The NSCP business plan for 2023-2027 is being published alongside this annual report. After reflecting on what some children, young people, parents and carers told us when we asked about the partnership's priorities partners have chosen to develop 3 commitments:

Commitment 1: We will work together to keep young people safe in their homes and communities

Commitment 2: We will work together to ensure each child who needs support or help receives the right service at the right time for them and their family.

Commitment 3: We will work together to ensure the partnership reflects, learns from and acts on the experiences and feedback from children, young people and their families.

Independent Scrutineer Overview

Every type of working arrangement based on partnership, I would suggest, fundamentally rests on the strength and quality of the relationships between the people involved. For, whilst agreements, contracts, policies and procedures all help to 'set the scene' and coordinate how and by whom work is done, the overall worth and creativity of a partnership will ultimately reflect the quality of relationships and degree of trust between the people involved.

In this sense, a safeguarding Partnership like the NSCP represents an especially complex web of relationships requiring agencies, (with very different structures and cultures) professionals, (with very different skillsets) children and their families (with often very different circumstances and needs) to work together seamlessly. Indeed, if we were to 'add up' all of the people potentially involved in safeguarding on any single day in Nottinghamshire the total would be difficult to calculate, but would certainly run to thousands of individuals with children's best interests at heart.

I am going to take some time here to ask some questions in order to evaluate the relationships that underpin the NSCP and, on the basis of the evidence I will present, give an overall picture of the 'health' of our Partnership.

Q. if we know how difficult it is to maintain good relationships relationships generally, how can we ensure and maintain good relationships between all involved in a safeguarding Partnership?'

The Senior Leadership Group (SLG) of the NSCP brings together officers from Police, Health and Local Authority, with the role of Chair rotating between members, such that all perspectives are addressed, and none of the agencies can dominate or 'dodge' their responsibilities.

SLG is the decision-making forum which leads safeguarding in Nottinghamshire, negotiating and setting out the vision of how the Partnership should work, and strong, trust-based relationships in SLG are essential here as they serve as a model, cascading down through the respective agencies, of how relationships throughout the Partnership should be conducted.

Q. Are strong trust-based relationships in place in SLG?

I regularly attend SLG and can confirm that strong trust-based relationships are in place, and that this permits robust, but respectful and constructive discussions, and underpins informed, creative decision making. There is evident trust and a sense of common purpose between members, especially where complex safeguarding issues present, that require imaginative solutions, beyond the scope of established policies and procedures.

ACC Rob Griffin joined SLG as the Police representative earlier this year, and is presently Chairing the group. I see the rotation of the SLG Chair working effectively (as outlined above) and, in the present circumstance, the considerable advantage of affording better insight of the Police perspective of safeguarding.

Q. All very well, but what about when things get difficult in SLG, are relationships quite so good then?

Here I am going to use the SLG decision to commission an independent review of circumstances with regard to Harlow Academy (the completed review is now in the public domain) as evidence of good relationships and strong decision-making being consistent in SLG, even in complex, sensitive and difficult circumstances.

Safeguarding issues raised with respect of Harlow Academy were of considerable concern as they related to exceptionally vulnerable children, with the most complex needs in a residential setting. Very careful consideration was given to whether, in this circumstance, the guidance (in place at the time) would suggest that a Serious Incident Notification (SIN) should be made to the Child Safeguarding Practice Review Panel and to OFSTED, triggering the requirement to complete a statutory Rapid Review within fifteen working days of notification.

Despite the level of concern however it was evident that the reported issues at Harlow Academy did not meet the test for SIN and that, as a result, a Rapid Review would consequently not be required. That might very well have been the end of the story, but SLG took the view that whilst they agreed that the test for a SIN had not been met, and understood that a line could be drawn at this point which would satisfy statutory responsibilities, that this was not the 'right' thing to do in the circumstances. As a result, SLG agreed to commission an independently led review of Harlow Academy, not because they were obliged to do so, but in the best interests of the children and families concerned, and as a mechanism to learn from what happened, even if that proved to be challenging and uncomfortable.

The decision by SLG to review Harlow Academy to learn and because it was 'the right thing to do' reveals, in my opinion, the depth, strength and quality of relationships of inter-agency relationships and trust directly. There was clear agreement that there could be no question of such concerns being 'swept under the carpet', and an understanding also that, whatever the outcome, this was not only in the best interests of the children concerned, but for the Partnership also.

Q. Is there any evidence that good, trust-based relationships at the top of the Partnership cascade throughout agencies?

I could give many, many examples here of safeguarding in Nottinghamshire that goes 'above and beyond' what's in the job description, but will confine my remarks to the Police (reflecting the Chair role in SLG) and to two specific circumstances.

Firstly, the residential placement for a young woman placed in Nottinghamshire by an out of County agency broke down in circumstances that, for a time, left her especially vulnerable and with nowhere to go. For complex reasons, and in a wholly unsafe setting, Police officers had to step up to ensure her safety, engaging with all other agencies for as long as it took to find the best outcome. In a very sensitive situation, the actions of the officers concerned is to be commended, and demonstrates directly their commitment not just to this young woman but also to the Partnership more generally.

Secondly, a team of female officers has for some time now run a boxing club for young women. In the first instance this was largely done in their own time and on a shoestring budget

sometimes out of their own pockets. (Latterly, modest financial support has been offered by NSCP) The officers realised that the boxing club offered vulnerable young women a number of tangible benefits. Bringing young women together afforded friendship and mutual support, boxing built a sense of self-confidence and resilience and the club meant that, often hard to reach isolated young women potentially at risk of abuse and exploitation, were kept in view and safe. This outstanding group of officers continue to make a major contribution to safeguarding in Nottinghamshire. This of course reflects well on them individually and on the Force more generally. But is now also, supported and understood as part of a 'portfolio' of ways in which we can proactively effect safeguarding.

Q. Even with good trust-based relationships within the Partnership, how do we ensure we continue to learn from our combined experience and don't lose this through normal staff turnover?

Relationships of any kind require constant work to remain positive, and if that's true for individuals, it's even more relevant in safeguarding that often requires people, who might not know one another in any other context, to work in Partnership.

A key mechanism for development and maintenance of strong professional relationships in Nottinghamshire continues to be, in my assessment, the very strong training offer made to all those involved in safeguarding. Demand for safeguarding training remains very high and user feedback exceptionally positive. Additionally, it is possible to directly link recommendations from reviews to training subsequently offered.

It is my view, based on this evidence, that NSCP remains committed to learning and improvement, and that the quality and range of training on offer is second to none. Normal staff turnover similarly underscores the vital importance of maintaining the training offer and, of course, brings new staff from all agencies together in a collegiate and supportive way.

In conclusion, I would argue there is strong evidence that NSCP does exhibit strong trust-based professional relationships from SLG cascading throughout agencies into day- to-day safeguarding practice. That the NSCP is an open, transparent Partnership with a good commitment to learning and improving safeguarding for all local children and young people.

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