Nottinghamshire County Council

Report to Children and Young People's Committee

19th April 2021

Agenda Item: 4

REPORT OF THE SERVICE DIRECTOR, COMMISSIONING AND RESOURCES

HARMFUL SEXUAL BEHAVIOUR BY CHILDREN

Purpose of the Report

1. To provide Committee with information regarding the work being undertaken by the Local Authority and relevant partner organisations regarding sexually harmful behaviour by children.

Information

2. On 18th September 2019 Policy Committee received a report on the findings of and the Council's initial response to the publication of the Independent Inquiry into Child Sexual Abuse (IICSA) report "Children in the Care of Nottinghamshire Councils". Responses to Harmful Sexual Behaviour (HSB) was one of the areas considered by IICSA. Policy Committee agreed a recommendation that a report on Nottinghamshire's response to Harmful Sexual Behaviour be taken to the Children and Young People's Committee on 16th December 2019. Prior to Nottinghamshire's involvement in IICSA the Local Authority had been working with partners through the then Nottinghamshire Safeguarding Children Board to identify and implement the very best practice in this area.

3. Nottinghamshire has adopted the NSPCC's definition of Harmful Sexual Behaviour (HSB) by children:

   'One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.'

4. In order to quantify the progress made to date the December report committed to a further multi-agency case audit under the auspices of the Nottinghamshire Safeguarding Children Partnership (NSCP) to be carried out in 2020 with a focus on both procedural compliance and the effectiveness of interventions. Initial planning for the audit took place in December 2019 and the findings of the audit were due to be reported into the NSCP in June 2020. The multi-agency 'organisational' audit (first carried out in 2017 using a tool produced nationally by the NSPCC) was also due to be repeated and reported into the partnership in the same timescale.

5. The multi-agency audit was originally due to be completed by April 2020 but due to the impact of Covid-19 the work was postponed until July. The audit sample was taken from those children and young people where the incident that led to involvement from services was in the first half of 2019. The reason the audit sample was taken from this period was so that the interventions with the children and young people were likely to have ended at the time of the audit, and the success of outcomes rather than just compliance with the process could be assessed. Unfortunately, whilst the outcome data was useful, the unavoidable delays due to Covid-19 meant that some of the practice in the cases was not reflective of current practice as refinements as a result of new evidence had continued to be made in the intervening period.

6. In response a further sample audit of 20 children and young people was undertaken by the Local Authority in December 2020 representing more contemporary practice. This focused on the findings of the multi-agency audit referred to in **paragraph 4**. Work undertaken with children, young people and their families around their experiences of the process was undertaken at the same time and the results of this are presented in **Appendix 1**.

7. The multi-agency arrangements for assessment and intervention continue to be overseen by the Nottinghamshire Safeguarding Children Partnership (NSCP). The HSB steering group with senior representatives from the involved organisations continues to provide the direct oversight of the HSB panel, procedures, tools and training. The panel ensures that there are sufficient trained staff to complete both specialist assessments and interventions as well as commissioned services where required. Progress is regularly monitored by reporting to the NSCP Safeguarding, Assurance and Improvement Group (SAIG).

8. A specialist Child and Adolescent Mental Health Service (CAMHS) provision continues to be commissioned for intervention in cases where there are higher levels of concern or complexity. In addition, a regionally based 'Forensic CAMHS' continues to be in place. This is primarily consultative but provides an additional layer of expertise to local practitioners in understanding risk and planning interventions in the most concerning cases.

NSCP Multi-Agency Audit

9. Overall, the findings from this audit evidenced consistent progress with good practice and sometimes outstanding practice identified. As hoped areas were also identified where improvements could be made to ensure consistent excellence in our approach.

10. There was notable evidence of improved practice and progression from the findings of the previous audit in 2018 as follows:

- the identification of HSB was good with a range of professionals from different backgrounds identifying and referring cases promptly
- in some cases, outstanding relationships were established with the young person and these had a positive effect on the outcome
- examples of good multi-agency working
- assessments were of good quality
- where there was evidence of specialist assessments and intervention from the CAMHS service Head 2 Head, commissioned by the local authority to work specifically with children and young people who have harmful sexual behaviour and also have mental

health difficulties and/or a learning disability; this intervention contributed to good outcomes for the young person and these cases were graded outstanding
- evidence that the HSB Panel is making a positive contribution towards the management of risk and improving outcomes for young people.

11. The recommended actions included the following, all of which have now been completed:

- a further dip sample audit of 20 children and young people, focusing on the Local Authority's practice in: developing the use of specialist Child Protection Coordinator (CPC) consultation; the use of the appropriate pathway and specialist assessment; the timeliness of panel attendance and accountability for panel actions
- a bespoke piece of work to be undertaken by the lead Social Work Practice Consultants with children and young people and their parents and carers to gain their views of their experience of the HSB process (to be completed by 30th November 2020).

The Local Authority Dip Sample Audit

12. Although in the majority of the cases the HSB pathway was followed and specialist assessments undertaken, audits confirmed the findings of the original multi-agency audit and identified opportunities to increase the use of the specialist Child Protection Coordinator consultation; commissioning specialist assessments in more complex cases and adjustments to the point in the process at which the HSB panel provides oversight and direction.

Feedback from Children, Young People and Families

13. In February 2021 feedback was collected from four young people and seven parents and carers, as detailed in **Appendix 1**. This reflected the outcomes of the multi-agency and Local Authority dip sample audit. The young people and families who were spoken to generally reported the process as a positive experience but for some it had taken a long time for their child to be heard by the panel. They did not appear to have a good understanding of the panel's purpose or outcomes although most felt the intervention had been positive for the child and the family. Their views will be considered within the review referred to in the action plan outlined below.

The Organisational Audit

14. The organisational audit using the NSPCC Harmful Sexual Behaviour Audit Tool was undertaken in February 2021. This audit focuses on the Local Authority and its partner agencies in respect of their response, prevention, assessment, intervention and workforce development for HSB. The audit evidenced good improvement in understanding and practice but also highlighted areas that require further development and reassurance which have been taken into account within the action plan detailed below.

The Brook Traffic Light Tool

15. In December 2019 the Local Authority reported that the 'Brook Traffic Light Tool', identified by the National Institute for Clinical Excellence as best practice, had been adopted by the NSCP for use by all partners to help make judgements about presenting sexualised behaviours and appropriate actions to be taken including whether a safeguarding referral

to the Multi-Agency Safeguarding Hub (MASH) should be made. This tool guides practitioners in deciding whether behaviours are normal for a child at a certain stage of development, raise some concerns that need further investigation or are an immediate cause for concern. Due to a change in the licensing arrangements for use of this tool alternatives utilising the same principles are currently being considered and relevant training for all professionals will be facilitated alongside this.

Summary

16. A summary of the outcomes of the audit work is as follows:

- the audit work has identified that there have been substantial improvements in consistency of practice and outcomes for children and young people. Practitioners' confidence has increased, and Harmful Sexual Behaviour is being identified and specialist assessments are being undertaken
- the use of specialist Social Work Practice Consultants in all social work teams is continuing to build on social work skills, knowledge and experience
- partner agencies have been using the Brook Traffic Light Tool effectively to identify and refer concerns around Harmful Sexual Behaviour to the MASH
- the multi-agency panel is an effective forum to offer consultation on specialist assessments and use of assessment tools and to identify barriers to working with the child and young person but in some cases this happens too late in the process to contribute to reducing delay
- the outcomes for most of the children and young people that were audited were good and some were outstanding but there were identified areas for improvement in terms of the process and the timeliness of some assessments and interventions
- there is a particularly vulnerable group of children and young people who have disorders of conduct and emotion, neurodevelopmental issues, mental health problems and/or learning difficulties and who could potentially be engaged in high risk behaviours. This is an area of practice that requires continued focus to ensure specialist assessment and intervention is undertaken at the earliest opportunity.

Action Plan

17. This plan will be overseen by the HSB Multi Agency Steering Group, which is chaired by the Group Manager for Safeguarding, Quality and Improvement:

- a review of the panel process and specialist Child Protection Coordinator consultation in respect of specialist assessments, interventions and consultations to improve timeliness and decision making. This will include a focus on children and young people who have disorders of conduct and emotion, neurodevelopmental issues, mental health problems and/or learning difficulties and who are engaged in dangerous, high risk behaviours. This will be completed by the end of June 2021 and will be led by the Group Manager for Safeguarding, Quality and Improvement, together with members of the Steering Group which includes practitioners from Children's Social Care and Health.
- implementation of up to date training of 16 social work practice consultants in specialist assessment and intervention for children and young people with HSB by the end of May 2021

- decision and implementation in respect of replacement tool for the Brook Traffic Light Tool and a review of the current cross partnership procedures with Nottingham City by the end of July 2021.
- review of the NSCP training programme and content to reflect the outcomes of the Action Plan by the end of July 2021
- continued work with the NSCP to ensure a consistent and robust approach across the partnership.

Other Options Considered

18. No other options have been considered at this time.

Reason/s for Recommendation/s

19. Harmful Sexual Behaviour by children is a significant concern to the public and Elected Members and has been considered by IICSA. The recommendation is made to ensure that the Committee has an opportunity to be informed about current practice and direct further work in any areas of ongoing concern.

Statutory and Policy Implications

20. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That Committee agrees to receive an annual report of Nottinghamshire's response to Harmful Sexual Behaviour by children and that this be included in the work programme.

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Constitutional Comments (AK 24/03/21)

21. This report falls within the remit of Children and Young People Committee by virtue of its terms of reference

Financial Comments (SAS 18/03/21)

22. There are no financial implications arising directly from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

https://legacy.brook.org.uk/our-work/the-sexual-behaviours-traffic-light-tool

Independent Inquiry into Child Sexual Abuse – initial response: report to Policy Committee on 18th September 2019

Independent Inquiry into Child Sexual Abuse – action plan: report to Children and Young People's Committee on 16th December 2019

Electoral Division(s) and Member(s) Affected

All.

C1456