Annual Report 2023 – 2024

Foreword from the NSCP Strategic Leadership Group Chair

I am pleased to introduce the NSCP annual report for 2023 – 2024 which outlines the continued progress we have made this year across the safeguarding partnership.

The NSCP Learning and Workforce Development Group's commitment allows us to have an expert local training pool, supported by knowledgeable practitioners from across the partnership which allows us to have extensive training offer (pg. 14). One of many training opportunities included "When we are scared: An Introduction to Trauma", supporting staff to keep the experiences of the children as central to what we do.

I also highlight the work of the Child Safeguarding Practice Review Group (pg.11), which has worked to complete rapid reviews where required, where the National Panel consistently agree with the recommendations for further review. The group continues to progress on its commitment to ensure the learning from reviews is shared widely across the partnership.

I have reflected on the comments by the Independent Scrutineer within this report which outlines his view that safeguarding in Nottinghamshire remains strong, dynamic and focused on the best possible outcomes for our children. This is a view I share, and I am pleased to outline the progress made on the NSCP business plan and the outline of how we as a partnership continue to meet the commitments we have made to Nottinghamshire children and families.

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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 2023'. In the period covered by this report the statutory guidance Working Together to Safeguard Children 2018 was in place until its update to the current guidance in December 2023. 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.

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 2023 - 2017 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

The partnership business plan has been updated to cover the 2023- 2024 period. For each action to meet the commitment, an initial 12-month period of work has been identified. Work on the commitments below began in December 2023, and so the priorities identified below are in progress with a view to completion of these by December 2024. Therefore it is important to note that the updates only cover the 202324 reporting period.

Commitment 1: We will work together to keep young people safe in their homes and communities	
Over the next 12 months	What we have done over the first 6 months
Children at risk of or experiencing exploitation will be supported through a joined-up response from the partnership. Children and young people will feel supported, safer and heard and parents and carers will be valued partners in our work to keep children safe from exploitation	The Police CARE (children at risk of exploitation) team has been implemented since November 2023 embedding the focus on wider child exploitation including both sexual and criminal exploitation of children. The implementation of a safeguarding and disruption team within the CARE model has aided in improved communication with partners. The reinvigoration of Operation Striver/ concerns network meetings has also been commenced and currently an intelligence officer post is being advertised within the CARE team to improve the intelligence and analytical capability. A TCE (Tackling Child Exploitation) Cross Authority subgroup has been created with representation from police, health, social care as well as the voluntary sector. Through this forum a joint exploitation strategy has been created and signed off by SLG and an agreement for an annual Nottinghamshire Child Exploitation conference hosted at Police HQ (Confirmed for 17th March 2025).A child exploitation annual review has been completed by children's social care, a first child exploitation problem profile is due in November 2024 and work is ongoing to seek a peer review from the College of Policing of the CARE team within its first 12 months.
Children with emotional or mental health difficulties will receive joined up support. Children with special educational needs and disabilities and their families will receive earlier intervention about identified safeguarding risks. Children showing their distress through severe self-harm will receive a more	The Tackling Emerging Threats to Children have provided multi-agency training which reference the different types of online risks/harms and specifically reference children with Special Educational Needs and Disabilities as well as recommending specific resources designed to be used with these children, carers and family. The Nott Alone website now has pages about Social Media and Online Safety. Schools are supported to increase online safety information for parents in their communications, and the TECT team have offered consultation to school about individual children many of whom have diagnosed, or believed to have additional needs. Training continues to be offered around areas such as Radicalisation, and harms outside the home to maintain a high level of understanding across the partnership of understanding in relation to these risks.

timely response in the right setting for their needs.	Work has been ongoing to develop an integrated care system (ICS) pathway for: • Children and young people presenting to an emergency department with mental and emotional health needs • Children and young people admitted to an acute medical trust with complex emotional/mental health needs where discharge to a more appropriate setting is delayed Unfortunately, there are difficulties in creating ICS pathways across trusts as there is currently nowhere to store the pathways and there are difficulties with governance arrangements. We therefore asked trusts to adopt the proposed ICS pathway as a trust pathway and manage under their own governance arrangements. This also allowed trusts to make links in the pathway to their own relevant guidelines (e.g. admission policies, restraint and rapid tranquilisation etc).These pathways have had multidisciplinary input and outline the roles and responsibilities of all agencies throughout the pathways, including the medical team, Trust safeguarding teams, child and adolescent mental health services (CAMHS), social care, look after children teams and the police. The pathways also reference the ICS escalation meeting, which is facilitated by the Integrated Care Board (ICB) and has also been instrumental in helping to resolve barriers and support in finding children and young people the right support in the right place, in a more timely manner. The pathways reflect the ethos that the mental health, safeguarding and emotional wellbeing of children and young people are everyone’s business. It also guides and reminds all partners that children and young people’s needs are central to the process and cooperative multi-agency working is often required in these cases which frequently combine a complex pattern of social, emotional and health factors. Service boundaries should not get in the way of appropriate care and vigilant safeguarding. It aims to ensure that children and young people’s acute needs are met in the best way possible whilst the system comes together to find the most appropriate setting to manage the needs longer term. The pathways are currently going through multiple governance groups at Nottinghamshire University Hospitals and are due to be ratified shortly (at the time of writing this has been completed - ratified as of July 2024). Sherwood Forrest Hospitals have not agreed to the pathway and we are

	awaiting a meeting to discuss this further and understand what alternative assurance/pathway they will be able to offer. Bassetlaw does not have inpatient facilities and so the pathway would need to be adopted across 2 ICS' which makes things more difficult. CAMHS would offer the same parallel assessment and Bassetlaw will need to liaise with Doncaster regarding in patient admission.
Schools, colleges and alternative education providers will become an integral part of the partnership. This will enable exploration of how the partnership can better work to meet the safeguarding needs of children in their education space.	Working Together 2023 provided some additional guidance to partnerships about the voice of education as follows: *create an environment which enables all schools (including independent schools and academy trusts), colleges, early years, and other education and childcare providers in the local area to be fully engaged, involved and included in local safeguarding arrangements. This means making sure that the views and contributions of education and childcare providers are articulated at the highest level of decision-making.* Over the 2023/24 period engagement work is planned with education sector leaders to hear from them how this can best be achieved, and whether a sub-group as signposted in the business plan is the best way to achieve what Working Together guidance suggests. As part of the updating of the partnership's safeguarding arrangements by December 2024 this work will be underway so that the arrangements can outline the agreed plan.
We will review our neglect strategy and toolkit to make sure it helps professionals and families understand when things are going wrong and see what the data tells us about whether it is working.	The toolkit has been reviewed and amended to reflect the use of strengths-based language. The shortened version for health professionals is still in progress. A partnership audit took place which unfortunately did not identify effective use of the toolkit across the system. Sadly, there have also been CSPR's where neglect has been a significant factor. This is also the case in Nottingham City. These concerns have been discussed with both Independent Scrutineers and at the joint SLG and there is a cross partnership meeting planned in August to consider how to support the consistent and effective use of the toolkit so that it helps professionals and families understand when things are going wrong and to reassure ourselves through our data that it is working.

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	
Over the next 12 months	What we have done over the first 6 months
We will stop talking about 'thresholds' and instead talk about what children and families need and how to provide it.	Staff across Social Care have been trained in strength based practice with more specific training in the MASH and Early Help Unit to reduce the focus on threshold and encourage a greater focus on the needs of the child and family. Sections of the *Pathway to Provision* have been redrafted using a strength based approach, updating the language and shifting the emphasis away from thresholds and towards needs. These sections are being piloted with a group of referrers as part of a wider test. Briefings on the proposed changes have been held within *Safeguarding Children Today* and changes to other aspects of the partnership training offer are being planned. Taken together these activities will help to embed cultural change across the partnership.
We will create a new front-door, with a greater focus on early help. Within this re-design, we will work together to think about how many referrals for children are made and whether some of these needs could be better met in the community or by early help	Extensive work has been undertaken over the past year to develop and implement a new model for the front door of children's services. Ofsted commented that, "The front door change programme has significantly transformed the multi-agency safeguarding hub, where practice is collaborative, focusing on earlier help for children and families through the multi-agency partnership. This is ensuring that children get the right help at the right time." An iterative approach is being taken, undertaking tests before implementing effective elements. This has resulted in a number of changes – increased focus on early help support; professionals from different disciplines working together in sub-teams; greater partnership involvement in decision making; improvements to the way Police Public Protection Notices are handled – all of which form a foundation for other changes as testing progresses. Referrers from across the partnership have been engaged throughout the programme to ensure that their needs will be met. Additional support for referrers is being piloted in two areas, with Early Help Advisers providing support in the community, aligned with Family Hubs, and Social Workers available via phone for coaching conversations as well as for receiving referrals. The change programme will continue, reducing referrals that result in no further action, embedding a reimagined front door and fostering a culture of support for professional referrers.

Too many children in Nottinghamshire have child protection plans. We will rethink how we work together and with families to avoid so many situations reaching a child protection plan.	Over the year April 2023 – March 2024, the numbers of children subject to a Child Protection Plan steadily reduced from 669 to 513. This is a significant reduction of just under 15%. Children's social care have been requesting fewer Initial Child Protection Conferences over the year – 123 in Q4 of 2022/23, compared to 73 in Q4 of 2023. We know that a lot of work has been undertaken in relation to ensuring that decisions are needs led, rather than solely threshold based, to dispel the view amongst professionals that children cannot be supported to a high level under a Child in Need Plan where a family are agreeing to work with us, and strengths based practice has continued to be further embedded into the way we work with families. All of these areas are likely to account for the reducing Child Protection plan numbers. Practice reviews and ongoing audit work has demonstrated that Child Protection Coordinators continue to make appropriate decisions when making children subject to Child Protection plans or ending those plans. The numbers of children becoming subject to a Child Protection Plan for a second or subsequent time fluctuated throughout the year, and overall sat at 24.1%, with 10.4% of those having had their prior plan ended in the last 2 years. These figures suggest that the Local Authority and our partners still have work to do in ensuring that moving on plans following the end of a child protection planning period are suitably robust to ensure that families are better supported to sustain positive changes they have made and that risks continue to be minimised.
We will improve the quality, attendance and timeliness of strategy discussions and make sure that the needs of all of the children relevant to the discussion are considered	The cross authority established safeguarding children partnership audit group have completed four audits as requested by the joint Senior Leadership Group of the partnerships. The audit themes focussed key areas identified through local issues but replicate many national drivers too, one of which was around strategy discussions and Section 47 enquiries. The Section 47 Strategy discussion audit day is now complete with an initial draft report in progress. From the audit day recommendations were considered and noted there is some further work required to enhance the strategy discussion process to continue to work to safeguard children and young people who require support across the partnership area. The findings identified some further learning to progress into recommendations and action plan which will remain under review.

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.	
Over the next 12 months	What we have done over the first 6 months
In developing these commitments, we asked some of Nottinghamshire's children and parents/carers what they thought. We will build on so that we can keep listening to as many voices as possible.	Links are being made across the partnership including with groups representing young people, parents and carers and participation groups via the ICB. The aim is the share the updated safeguarding arrangements with them in 2023 – 24 to ensure their views remain heard, however the partnership does have an awareness that there is still work to do to integrate the views of children, parents and carers more widely into the partnership/
We will focus on making the recommendations from our statutory reviews as clear and SMART as possible and address any themes reviews reveal. We will make sure what is learned in reviews is available to everyone working with children in Nottinghamshire.	The Child Safeguarding Practice Review group, who are responsible for statutory reviews are continuing to review their recommendations and actions to improve how effective they are. This is considered quarterly and is facilitated by an updated action tracker which has been developed to identify themes and areas of emerging risk. There has been progress in this area evidenced by there now not being any review actions over six months in age before completion which is an aim of the group and was not being achieved previously. Learning briefings are now developed for rapid reviews so that learning can be shared via partners but is also accessible on the Nottinghamshire Safeguarding Children Partnership Website to anyone who would find this learning useful. There is a commitment to continue to review how learning is shared for each review, and based on feedback from a survey of the partnership we will hold a workshop with the independent author of the current Local Child Safeguarding Practice review to share the learning and allow for practitioners to ask questions and deepen the impact of the learning.
We will develop an NSCP understanding of what trauma informed practice means and develop a plan to integrate this into practice	Ten events around Trauma "When we are Scared: An Introduction to Trauma" were offered during this reporting year with 286 employees attending, with a view to improving knowledge and focus on this area across the partnership. Feedback from these events found the attendees could identify how this could directly improve their practice with children and families. This is an area where further work is required in the 12-month period, to develop a plan to integrate this into practice in broader way across the partnership.

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.

There have been four rapid reviews completed in the 23-23 period, two of which met the timescales and two which did not. Where reviews have been out of timescale, this has been due to panel member availability and leave. The decision of the panel has been that consistency and knowledge around the reviews and learning has been important in order to maintain the standard of work. On those occasions an initial meeting has been held where immediate safeguarding actions could be considered. Timeliness remains an area for improvement and the CSRPG members have now ensured they have deputies identified where possible, to improve contingency in the group.

Rapid Reviews

A rapid review has been completed following the death of a five-month-old baby, where she had been co-sleeping with her mother and two older siblings. Although safer sleep messages had been delivered, work around ensuring more vulnerable families heard the safer sleep messages was identified. In late 2023, the safeguarding children partnership approved a refreshed safer sleep risk assessment toolkit developed by the safer sleep steering group. The toolkit contains information for practitioners about increased risk factors for SIDS, as well as tools for families such as a hazardous co-sleeping checklist and links to Lullaby Trust resources. This has been included in the child health and development record 'red book' used by health practitioners. Work has taken place to raise awareness of the risk assessment toolkit with services working with families where the risk of SIDS is greater and to embed safer sleep as 'everyone's business'.

The National Panel agreed with the decision of the review not to initiate an LSCPR.

A rapid review was completed in relation to a six-week-old baby after parents called an ambulance after she was reportedly choking. Due to the account not being felt to the consistent with the injury a child protection medical was undertaken and further evidence emerged of sustained and frequent abuse of the baby. The rapid review identified good practice from agencies, where professional curiosity and critical thinking following the ambulance being called safeguarded this child from likely future serious harm. Good multi-agency working was noted. An LCSPR was not recommended.

The National Panel responded, "We thought your rapid review was good and identified relevant learning".

A rapid review was completed in relation to a 5-month-old baby girl. She was born prematurely, at 27 weeks and complex health needs, and remained in hospital until she was 4 months of age, when she was discharged to her mother's care. She was open to social care on a Child in Need plan following a referral which highlighted some concerns about the suitability of mothers housing, support needed for her to meet her child's needs, and some concerns about mothers' presentation at the hospital including her interactions with staff. Mother required an interpreter to be used at times as English was not her first language. The baby was presented to hospital with a number of non-accidental injuries after a short period at home, which mother admitted causing.

The review found that the safeguarding response from partners followed procedure and showed some good practice. An LCSPR was not recommended, the National Panel agreed with this outcome. A specific action was identified, to explore the work completed with families of preterm infants with complex health needs prior to discharge and this is now underway.

The National Panel agreed with this outcome.

The fourth rapid review completed was following the death of a young person by suicide which she was in an inpatient setting out of area. Following her death, it was also identified that there was concerning content being shared by her peer group. The recommendation from this review was that an LCSPR should be commissioned. In addition to the specific experiences of the child, the focus will also be on broader thematic learning around some of the specific points identified in the rapid review, to include information sharing and linking 'known' children in shared communities and primary to secondary school transition support for vulnerable children and those previously known to children and family social care services.

The National Panel responded, "We thought this was a clearly written review that identified and distinguished between immediate actions the safeguarding partnership would take forward, and areas you can further learn from".

Other reviews

The partnership has also contributed to two out of area reviews, where the concerns related to the mental health of young people. In addition, the partnership are contributing to a Safeguarding Adults Review (SAR) for a young person, who died by suicide at 19 years of age, as part of the progress to recognise the journey for this young person and support services having started when they were a child. The NSCP has also been asked to contribute to the National Review into Child Sexual Abuse within the Family environment, by facilitating a practitioner event following a previous rapid review undertaken by Nottinghamshire in 2022.

In this reporting period, of note is the partnership progress in looking at alternative forms of learning which may not meet the criteria for statutory review. We have held a practitioner event to look at the experiences of a Looked After young person where there had been increasing concerns about exploitation from the professional group, and understanding alongside those practitioners what learning could be gained in other similar situations. A learning review has been undertaken for a young person whose parent died by suicide, as although partners felt it was appropriate to examine their experiences and gain any learning. The group are building on this willingness to look at the need for a review or learning to be gained, rather than the threshold for the statutory review alone to be the deciding factor in whether a learning event takes place.

Multi-agency training, guidance and procedures

During 2023-24, 7,100 eLearning courses have been completed, in addition to 3,032 practitioners attending our face to face/virtual training events which means a total of 10,132 workforce training opportunities have been accessed during the year across the Partnership. This has decreased slightly by 1,497 compared to the previous year and is due to the E Learning statistics.

We have offered 60 events which is slightly higher than previous year (54 events). Five face to face events have been offered. Overall attendance at our training events has remained approximately the same. We offered 5 Safeguarding Children Today seminars over the last year which provide an essential update for managers and staff whose roles and responsibilities involve safeguarding children. This event is often used as an opportunity to meet the requirement of refreshing inter-agency training. Its aims to increase understanding of the national and local context for the safeguarding agenda, refresh and up-date knowledge on safeguarding issues and themes currently affecting practice in Nottinghamshire and specifically to share learning identified from Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPR).

Professional curiosity was identified as a theme which was a key area of improvement in both practice and partnership work in last year's annual report. As such we have shared this learning in a variety of ways; within our Safeguarding Children Today seminars, an article in our NSCP Newsletter on Professional Curiosity and included more content around this within our face-to-face course on Decision making and Disguised Compliance.

A new e-learning course has been authored. The new course offered was Child Protection Conferences and Looked After Children Reviews. This module is suitable for staff in a variety of roles who work with children, young people, and their families and who may at some point be invited to a Child Protection Meeting or Looked After Children review which is convened by Childrens Social Care. It includes the newly updated report templates and gives examples of completed report templates and guidance for practitioners to use. This course went live on 2nd October 2023 and since then we have had 128 course completions so far.

Individual organisation attendance varies across the partnership. In relation to the three safeguarding children partners statistics, there has been a slight decrease in attendance from Nottinghamshire County Council staff from 1,868 to 1,680. In comparison we have seen a significant rise in attendance from Police colleagues from 32 in the previous year to 111 attendees this reporting year. In relation to Health attendance, we have also seen a significant increase from 209 to 372, but this is more representative of what we would usually expect each year in comparison to 2022-23 when numbers were low due to the

knock-on effect of Covid and capacity issues. Attendance from other relevant partner agencies including foster carers and schools/colleges has remained approximately the same, which again is positive.

The delivery of this offer is greatly assisted by outstanding support from across the partnership. Over the last year we have had 50 partners support us with delivering our annual training programme. We have also commissioned 6 external training providers with specialist knowledge to enhance our training offer.

Feedback from participants is valued and continues to inform continuous development of the offer. All feedback is considered and areas for improvement or to make the training more accessible for practitioners is used to improve the provision. Views are sought three months post training, to build an understanding of the impact of the training on practice. When attendees were asked *Has the training changed or improved your practice?* 95.5% of respondents said it had. The responses provided by practitioners gives some insight into the direct impact on children and families.

Training feedback

Safeguarding Children Today

"The Local Child Safeguarding Practice Reviews were of particular interest to me, and I have begun to read them since the seminar."

"Extremely well put together presentation, some of the content and local statistics were very thought provoking and will impact on my future practice and how I see things."

Working Together to Safeguard Children

"I have a clearer understanding of procedures, know who can help and in what situations, clearer viewpoint of my role and responsibilities."

Professional curiosity

"Professional curiosity will be at the heart of all the work I do. Additionally, I will use my managerial role to support staff to look for the information that disproved what they are thinking first."

When we are scared: An Introduction to trauma.

"All the children I currently have allocated have experience some trauma and so now I am more aware of this and how to provide better support to these children now I have a better understanding of trauma."

"During my job, I refer to trauma and it has now made me consider hope and resilience with young people more and how we can build this with our work."

Reflections, next steps and priorities

This year has seen continued progress for the partnership, with a more needs led approach for the Child Safeguarding Practice Review group in relation to learning events and with an expanded training offer which continues to receive good feedback from attendees. Areas for development have been identified in the report which will be a focus for the coming year alongside the implementation of the requirements of the new statutory guidance Working Together 2023, which will be outlined in the updated safeguarding arrangements. The business plan priorities are still ongoing until December 2024, however the updates reflect that for the majority of the actions significant progress has already been made. Continued progress on these actions will be made, with a view to ensuring the partnership commitments are met.

Priorities for 2023- 2024

The Nottinghamshire Safeguarding Children Partnership priorities for next year will be to continue to work towards the commitments identified in the business plan.

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.

Additionally, the annual report for 2024/25 will also include the Working Together 2023 defined information regarding partnership funding and data.

Independent Scrutineer Overview

This year has been a particularly important one in relation to the NSCP as the cycle of external inspection for Police, Health and latterly the OFSTED inspection of Children's Services has come to a conclusion.

At the inception of the present arrangements for safeguarding, following the review undertaken by Sir Alan Wood, in 2019. The pre-existing inspectoral arrangements for Police (HMICFRS) Health (CQC) and Children's Services (OFSTED) were left unchanged. With suggestions that the safeguarding function of the new statutory partnerships should be inspected across the piece, either by one of the existing inspectoral bodies, or by a new and specific organisation deemed (I would guess) either unnecessary or else overly complicated.

As the Independent Scrutineer for NSCP the resulting inspectoral arrangements have always been, in my opinion, something of a compromise with regard to safeguarding. As none of the inspectoral bodies has a remit to fully consider the effectiveness of our Partnership in the round. Rather by following the 'breadcrumbs' from each stand alone inspection it is to some extent possible to read across, and get some insight and evaluation as to how we are doing.

Many of you will have heard me say on numerous occasions that in orientation to my role as Scrutineer I have seen this as not being just another layer of inspection. My view has been that statutory partners are already inspected enough, and that in all likelihood the very last thing the Partnership needs is an Independent Scrutineer taking a 'finger wagging' stance, and focusing on errors and omissions, as opposed to opportunities to make advances that bring our considerable resources and energies together.

But this non-inspectoral orientation on my part does potentially leave the door open to not establishing a sufficiently high challenge/high support safeguarding environment if, as I suggest above, the three stand alone inspectoral bodies do not do this externally and routinely.

So how does this 'square' for NSCP, and how can I say with any evidence and authority that our Partnership remains strong, collegiate across the different agencies and open to both reflection and learning?

Well firstly I keep a very close eye on the process of making Serious Incident Notifications, whereby safeguarding incidents that meet specified criteria are referred to OFSTED and the Child Safeguarding Practice Review Panel.

Despite the criteria mentioned above for making Serious Incident Notifications, it is evident that considerable discrepancy remains nationally between Authorities, even where demographic and other comparative criteria are similar. Unsurprising perhaps given that however clearly criteria are set out, some degree of interpretation and discretion is required to come to a final view as to what is and what is not a circumstance requiring formal notification.

But my interest is not in how other Authorities approach this task, but rather how this works in Nottinghamshire and whether a fair and consistent approach is taken to notification.

Here I can confirm that whilst the statutory responsibility for Serious Incident Notifications rests in the Local Authority, delegated to the Director of Children's Services, I have found that the approach taken is indeed fair and consistent, even if this at the early stage of my time as Scrutineer meant that Nottinghamshire made very slightly more notifications than our statistical comparator Authorities.

Where Serious Incident Notifications are made this triggers a requirement to complete a Rapid Review within fifteen working days. With the subsequent report then sent to OFSTED the Child Safeguarding Practice Review Panel.

Secondly, I keep a very close eye on the process of writing Rapid Reviews, and the degree to which the agencies making up our Partnership contribute to and learn from the conclusions reached. As the completed Rapid Reviews go to the Child Safeguarding Practice Review Panel who comment on the quality of the work done, it is not just my opinion that the NSCP is strong in this area, but this is also the overwhelming view of the Panel.

But some degree of external inspection is still required and, despite my argument above that none of the existing bodies has oversight of the safeguarding function of the Partnership in the round, it is OFSTED inspection, through their responsibilities across Local Authorities, that perhaps comes closest to giving an overview and some evaluation of direction of travel and progress.

Nottinghamshire has recently been visitied by OFSTED and as you may have seen in the press, the outcome was very positive, especially with regard to those 'joined up' aspects of inspection relating to Partnership and Safeguarding.

This is a terrific achievement, and everyone involved has every reason to be proud of a job well done, with a clear and positive result for Nottinghamshire.

So overall an important year for safeguarding in Nottinghamshire, and one in which I feel empowered to draw together the evidence I have seen for myself, and also that ratified through inspection, to come to the view that safeguarding has been and remains strong, dynamic and focused on the best possible outcomes for our children.

Our safeguarding Partnership works as well as it does because of the energy, commitment and skills that you all bring to the table. I see that, and thank you all for it.