Topic information	
Topic title	Safeguarding Children
Topic owner	Helen Blackman
Topic author(s)	Helene Denness, Sarah Quilty and Sophie Russell
Topic quality reviewed	August 2017
Topic endorsed by	NCSCB BMG
Topic approved by	NCSCB
Current version	June 2017
Replaces version	2013
Linked JSNA topics	FGM, Children in Care, Domestic Violence

Contents

Executive Summary 5

Introduction 5

Unmet needs and gaps 9

Recommendations 11

Full JSNA Report 13

1. Who is at risk and why? 13

1.1 What makes children and young people more vulnerable; parental characteristics 13

1.1.1 Parental alcohol/substance misuse 14

1.1.2 Parental Mental Health Problems 14

1.1.3 Domestic Violence 15

1.2 What makes children and young people more vulnerable? Characteristics of the child/young person 16

1.2.1 Children with Disabilities 16

1.2.2 Young people who have substance misuse problems 17

1.2.3 Children and young people involved in anti-social or criminal behaviour 18

1.2.4 Children who go missing from home or care 19

1.2.5 Children and Young People who return to their family following a period in local authority care 19

1.2.6 Children and young people who are carers 21

1.3 Children who are, or may be, experiencing abuse and/or neglect 21

1.3.1 Children and young people experiencing neglect 22

1.3.2 Children and young people experiencing other types of abuse 23

1.3.2 Online abuse 24

1.3.3 Trafficked Children 25

1.3.4 Child Sexual Exploitation 26

1.3.5 Female Genital Mutilation 26

1.3.6 Honour Based Violence 27

1.4 Children in Care 28

2. The size of the issue locally 29

2.1 What makes children and young people in Nottingham more vulnerable? Parental characteristics 29

2.1.1 Parental alcohol/substance misuse 29

2.1.2 Parental Mental Health Problems 30

2.1.3 Domestic Violence 33

2.2 What makes children and young people in Nottingham more vulnerable? Characteristics of the child/young person 35

2.2.1 Disabled children 35

2.2.2 Young people who misuse substances 36
2.2.3 Children and young people involved in anti-social and/or criminal behaviour 37
2.2.4 Children who go missing from home or care 38
2.2.5 Children and Young People who return to their family following a period in local authority care 39
2.3 Children who are, or may be, experiencing abuse 41
2.3.1 Referrals to Children's Social Care 41
2.3.2 Section 47 enquiries 42
2.3.3 Initial child protection conference 43
2.3.4 Children in Need 43
2.3.5 Children on a child protection plan 44
..... 45
2.3.6 Rate of Children in Care 45
2.3.7 Rate of re-referrals and child protection plans 46
2.3.8 Source of referrals 48
2.3.9 Child protection plans for physical, mental and sexual abuse or neglect 50
3.0 Targets and Performance 54
3.1 National targets 54
3.2 Local targets and performance 56
4.0 Current activity, service provision and assets 56
4.2 Universal Services 56
4.2.1 Midwifery Service 56
4.2.2 Health Visitors and Community Public Health Nursing (5-19 years) 56
4.2.3 General Practitioners (GPs) 57
4.2.4 Schools 57
4.3 Specialist Services for Safeguarding Children 58
4.3.1 Designated Nurse and Doctors for Safeguarding 58
4.3.2 Named Professionals for Safeguarding 58
4.3.3 Local Authority Designated Officer (LADO) 58
4.4 Nottingham City Council services 59
4.4.1 Children and Families Direct (C&FD) 60
4.4.2 The Domestic Abuse Referral Team (DART) 60
4.4.3 Duty and Screening Team 60
4.4.4 Children's Centres/Early Help 61
4.4.5 Priority Families 61
4.4.6 Targeted Family Support 62
4.5 Specialist services that support vulnerable children, young people and families 63

4.5.1 CAMHS 63
4.5.2 Multi-systemic Therapy (MST) 64
4.5.3 Multi-systemic Therapy for Child Abuse and Neglect (MST CAN) 64
4.5.4 Services to support children and young people affected by parental substance use 64
Explore Families (Lifeline) 64
4.5.5 Stronger Families 65
4.5.6 Action for Young Carers 65
4.5.7 Youth Offending Service 65
4.5.8 Family Intervention Project (FIP) 66
4.5.8 Safe Families for Children project 66
5. Evidence of What Works 67
6. What is on the horizon? 72
7. Local Views 73
8. Unmet needs and service gaps 76
9. Knowledge gaps 78
10. Recommendations for commissioners 79
Appendix 1: Policy, guidance and reports 81

Executive Summary

Introduction

Safeguarding is everyone's responsibility. All partners have a duty to safeguard children and young people who are at risk of abuse, neglect and/or exploitation. Abuse can be physical, sexual and/or emotional. Neglect is the ongoing failure to meet a child's basic needs. Exploitation includes child sexual exploitation (CSE), trafficking and/or modern slavery.

There are two key principles which underpin the safeguarding of children:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- A child-centred approach; for services to be effective they should be based on a clear understanding of the needs, experiences and views of children and young people.

National and local policy, guidance and reports are summarised in appendix 1.

No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

In order that organisations and their staff collaborate effectively, it is vital that every individual working with children and families is aware of the role that they have to play and the role of other professionals. In addition, effective safeguarding requires clear local arrangements for this collaboration.
In Nottingham, any professional, member of the public or employee with concerns about a child's welfare should make a referral to local authority Children's and Families Direct. Professionals should take responsibility to escalate their concerns through their line manager where they remain concerned about a child's welfare.

Nottingham's Family Support Strategy (2016-2017) has three principles:

1. Ensure the right children get the right help at the right time
2. Talking and listening to children, families and professionals
3. Help families to help themselves

For more information see Nottingham City Council's Family Support Strategy and Pathway

Nottingham City offers a wide range of support services enabling the needs of most children and young people to be met within universal services which can be accessed by all children and young people (i.e. there is no threshold). Where it is evident that a child's needs cannot be met within universal provision an early help and/or family assessment can be completed to decide what support is needed and to ensure that additional support is co-ordinated to meet the needs of the child or young person. Early help services and advice and guidance are available to all professionals and citizens through Children's Centres and Children & Families Direct Hub.

The Children and Families Direct Hub encourages contact for all concerns/support requirements for children, young people and families with additional needs to ensure that early help can be provided in a timely manner.

There is a clearly defined process and set of responsibilities to support and guide practitioners when children's needs move between different levels of support and the Social Care threshold for support as a Child in Need or as a child in need of protection. This is referred to as the Integrated Working and Case Transfer Procedure, see appendix 1, which ensures that workers are confident to work together as the support needs of the child/young person and family as their needs change. Figure 1 identifies levels of support in Nottingham City

<table>
<tr><td>Universal</td><td>Self help</td><td>Children and families are doing well and there are no significant concerns about health, development or achievement that cannot be met within universal services.</td><td>Routine Health and Educational Assessments</td></tr>
<tr><td>Additional</td><td>Early Help</td><td>Children and families are experiencing problems requiring universal services to work together with other support services to prevent problems increasing.</td><td>Child or Family Early Help Assessment</td></tr>
<tr><td>Extensive</td><td>Targeted Help</td><td>Children and families are experiencing a range of increasing problems that require extensive multi-agency support to meet the needs of the whole family and crisis is likely to be prevented.</td><td>Child or Family Early Help Assessment or Statutory Assessment may be required</td></tr>
<tr><td>Child in Need</td><td rowspan="2">Specialist Help</td><td>Children are 'in need' if they are disabled or unlikely to achieve a reasonable standard of health or development unless services are provided (Children Act 1989).</td><td rowspan="2">Statutory Assessment</td></tr>
<tr><td>Protection</td><td>Children who are suffering or likely to suffer significant harm.</td></tr>
</table>

Figure 1: Levels of support in Nottingham City

Nottingham's model for prevention, early intervention and specialist services, see figure 2, highlights the fact that children and young people may need differing levels of support at

different times. We aim to work with families so that their needs can ultimately be met in local universal services wherever possible.

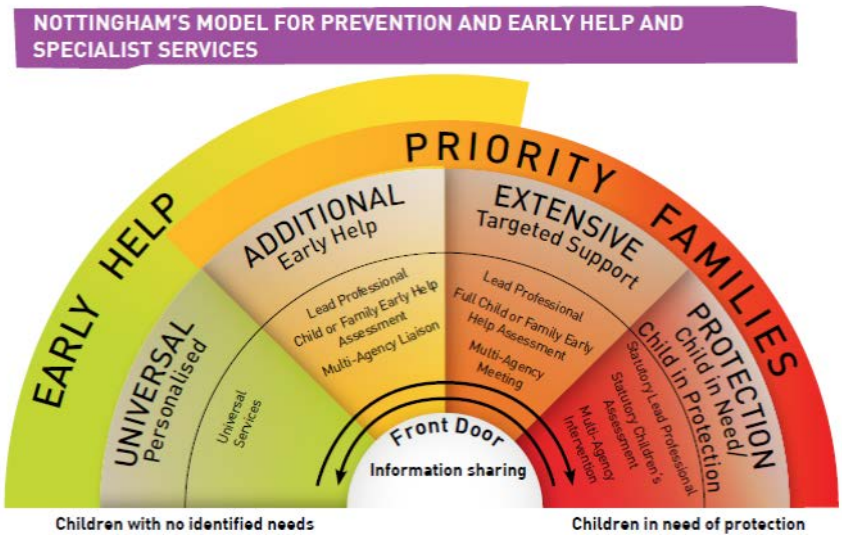


Figure 2: Nottingham's Model for Prevention and Early Help and Specialist Services

The Priority Families Approach prioritises families with multiple problems though the appointment of a key worker/lead worker for each family who manages the family and their problems and supports them to work towards agreed goals which are shared and jointly owned across local partners.

Nottingham City Council utilises **Signs of Safety** as its practice framework across all of its Children and Family Services. It is a strengths-based, safety-oriented approach designed to help all the key stakeholders involved with a child, the parents, extended family, community, and agencies to keep a clear focus on assessing and enhancing a child's needs and safety at all points in Family Support Pathway. The Signs of Safety framework is organised around a rigorous and balanced assessment and planning process that is developed in partnership with children, their families and their communities. This assessment process provides the focus for families, professionals and support networks to work together to develop and implement detailed plans that describe the day-to-day actions everyone will take to ensure and enhance children's safety, belonging and wellbeing.

Signs of Safety situates the child at the heart of practice and has many tools to aid engagement with children and their families. All of these tools are designed to deepen practice; to make it more collaborative and participatory; to ensure that practice is robust and rigorous; to create action steps and plans that allow children, young people and families to thrive; and to ultimately work more effectively together in seeking to strengthen families and to secure enduring child safety, belonging and wellbeing.

Local Population and Need

The rate of referrals to Children's Social Care in Nottingham, in 2016, was 882 per 10,000 children and young people, higher than the statistical neighbour average of 701 per 10,000. The rate of referrals has reduced by 90.1 per 10,000 children and young people lower than the statistical neighbour average 99.7 per 10,000.

In Nottingham, in 2016, the rate of children on a child protection plan was 83 per 10,000 children and young people; higher than the statistical neighbour rate of 57 per 10,000. The Nottingham rate of children on a child protection plan need increased by 2 per 10,000 in 2016; in contrast, statistical neighbours saw a decrease of 4 per 10,000 in the same time period.

There were 4,016 referrals to children's social care in Nottingham in 2016[1]; a reduction of 311 referrals from 2015. In 2016, schools and colleges were the agency responsible for the greatest number of referrals to children's social care making 20% (823/4016) of all referrals; an increase of 2% from 2015. This is unsurprising given the close contact schools have with children, young people and families and the skills staff have in identifying safeguarding concerns.

In 2016, the police were responsible for 20% (799/4016) of referrals; a slight reduction from 21% (912/4327) of referrals in 2015. This reduction follows the ongoing decline in the proportion of referrals from the police established in 2011.

Conversely, learning disability and mental health staff are among the staff group with the lowest referrals to social care making <1% (23/4016) of referrals in 2016, broadly similar to the rate of referral since 2011. The mechanism underpinning this is unclear, particularly as safeguarding procedures and associated training are well embedded in local specialist services. Local intelligence suggests that staff who have limited contact with children, young people and families are less likely to refer and/or are supporting citizens already receiving support from children's social care.

Where children and young people may be at risk of harm or may require services a social worker will complete a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential. It is important to note that many children/young people have risks identified in more than one category and

[1] The 4016 referrals noted is up to November 18th so conclusions re year on year comparison are made with caution

thus the number of risks is greater than the number of children/young people having an assessment.

Risks can be recorded in more than one category. Children/young people who were assessed as having risks identified related to parental mental health problems, domestic violence etc. may have other risks identified such as domestic violence.

51% (1988/3885) of the assessments in Nottingham in 2015/16 identified risks related to domestic violence; lower than the statistical neighbour average of 55%. Domestic violence was the most commonly identified risk in Nottingham in 2015/16 as it was in England in the same time period.

40% (1544/3885) of the assessments in Nottingham in 2015/16 identified risks related to parental mental health problems; higher than the statistical neighbour average of 36%. Mental health problems were the second most commonly identified risk in Nottingham in 2015/16 as it was in England in the same time period. As some mental health problems are very common, whereas others have very low prevalence, recording of mental health problems as a risk does not indicate the severity of the illness.

35% (1367/3885) of the assessments in Nottingham in 2015/16 identified risks related to parental substance use. 19% (735/3885) of risks identified related to drug misuse, matching the England average of 19% but lower than the statistical neighbour average of 21%. 16% (632/3885) of risks related to alcohol misuse, lower than the England average of 18% and the statistical neighbour average of 19%.

The percentage of re-referrals in Nottingham, in 2016, was 23%; similar to the statistical neighbour rate of 20% with the rate of re-referral decreasing by 3%. The percentage of re-referrals in Nottingham continues to decrease, suggesting that whilst more children and young people in Nottingham are supported through formal safeguarding procedures than in other local authorities, fewer children are re-referred because children, young people and families receive the right support at the right time.

Unmet needs and gaps

- The number of public health nurses (5-19) (formally known as school nurses) have been steadily in decline which has decreased the extent to which they can be involved in packages of care around safeguarding. It is currently unclear whether the integrated

commissioning model will enable public health nurses to provide additional support to safeguarding packages of care for children and young people aged 5-19 years.

- The Nottingham City Council Early Help Service is working with families and children who have additional needs as well as delivering open access provision. This presents a challenge in providing sufficient capacity for open access services across the city and creates a tension between moving resources towards early intervention whilst still needing to provide more targeted support to stop needs escalating.

- The cost of specialist placements for children and young people is high, including those out of the city. In addition, specialist care sometimes means that children/young people are placed some distance away from their family and social networks.

- The number of children in care in Nottingham places a significant financial pressure on the local authority. Reducing the number of children in care could release savings for investment in other areas such as 'edge of care' and/or early help services.

- Local intelligence suggests that worklessness and/or poverty is increasing family stress which decreases the capacity to parent effectively. It is currently unclear whether this will lead to more children/young people requiring safeguarding.

- The number of CAFs has decreased as more priority family assessments are undertaken; local intelligence suggests all partners are not clear which assessment is needed when.

- More assessments of children/young people in Nottingham identify risks related to parental mental health problems than the statistical neighbour average but Learning Disability and Mental Health staff are less likely to refer to social care than other professionals.

- New and emerging communities in Nottingham City, including refugee and asylum seeking families with children and unaccompanied asylum seeking children, are less well understood than our settled communities. More insight is needed into their safeguarding needs.

- Whilst local intelligence suggests children and young people with SEND are over-represented in the population that need safeguarding, current data does not enable an accurate assessment of whether these children and young people are over represented in safeguarding in line with the national picture.

- The rate of children/young people who become subject to a child protection processes, e.g. becoming subject to a Child Protection Plan are higher than the statistical neighbour average. This is an issue which has been subject external scrutiny through inspection and peer review which found evidence of good practice locally. That said the mechanism underpinning these discrepancies merits further exploration

Recommendations

1. Commissioners should ensure through integrated commissioning of 0-19 services, that there are ssufficient health visitors and public health nurses 5-19s (formally school nurses) to support universal provision for children and young people in Nottingham City in order to identify early safeguarding concerns and participate in packages of care.

2. The Nottingham City Council Early Help Service is working with families and children who have additional needs as well as delivering open access provision. This presents a challenge in providing sufficient capacity for open access services across the city. Integration of universal and early help services across the 0-5 pathway should be commissioned in a way that enables early support whilst also providing more targeted support to stop needs escalating.

3. The cost of specialist placements for children and young people is high and can mean that children/young people are placed some distance away from home. Work should be undertaken to explore whether more local, specialist placements can be developed to ensure children/young people receive they need closer to home and to release cost-savings.

4. The number of Children in Care in Nottingham is financially challenging for the local authority. Whilst the edge of care interventions appear to be stabilising the numbers of children/young people coming into care these interventions need to be embedded and sustained in order to release funding to continue to invest in early intervention activities.

5. Local intelligence suggests that worklessness and/or poverty is increasing family stress which decreases the capacity to parent effectively and may lead to more children/young people requiring safeguarding. Investment in early intervention and support services, alongside services to reduce financial vulnerability, may mitigate some of this stress.

6. The number of CAFs has decreased as more priority family assessments are undertaken. Local intelligence suggests all partners are not clear which assessment is needed when thus more training/communication may be needed specifically around clarity in the family support pathway.

7. More assessments of children/young people in Nottingham identify risks related to parental mental health problems than the statistical neighbour average but Learning Disability and Mental Health staff are less likely to refer to social care than other professionals. The mechanism underpinning this is unclear thus further exploration is warranted.

8. New and emerging communities in Nottingham City including refugee and asylum seeking families with children and unaccompanied asylum seeking children are less well understood than our settled communities; further insight is required into their safeguarding needs.

9. Current data does not enable an accurate assessment of whether children and young people with special educational needs and disabilities (SEND) are over represented in safeguarding in line with the national picture. Further exploration of this group, e.g. through a case note review, will contribute to a better understanding of the safeguarding needs of children/young people with SEND.

10. The rate of children/young people who become subject to a child protection processes, e.g. becoming subject to a Child Protection Plan are higher than the statistical neighbour average. This is an issue which has been subject external scrutiny through inspection and peer review which found evidence of good practice locally. That said, the mechanism underpinning these discrepancies merits further exploration e.g. through a peer review and/or quality assurance audit process.

1. Who is at risk and why?

The life chances of children are determined, to some extent, before a child is born. Poor nutrition, smoking, substance misuse and mental health problems during pregnancy can have a major impact on birth weight and the health of the child. Parents who do not make use of antenatal care services are less likely to have problems identified and addressed and the welfare of the child may suffer.

Working Together to Safeguard Children (1) highlights specific cohorts of children/young people who are more vulnerable and thus more likely to need safeguarding. These include children:

- Living in family circumstances which presents challenges for the child such as substance misuse, adult mental health problems and/or domestic violence
- With special educational needs and disabilities
- Who are engaging in anti-social or criminal behaviour including substance misuse
- Who go missing
- Returned to their family from care

1.1 What makes children and young people more vulnerable; parental characteristics

There are a trilogy of risk factors, sometimes referred to as the toxic trio, which are often present where there are concerns about the safety or wellbeing of a child or young person. These are domestic violence, parental substance use and parental mental health problems. The presence of these factors creates an increased likelihood that children will be harmed in households where these factors are present.

Parental alcohol/substance misuse is strongly correlated with family conflict, and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences, which is magnified where both issues co-exist.

In a study of 338 social work files from six English local authorities, domestic violence featured in 60% of the referrals, parental substance misuse in just over half (52%) of cases, and both issues were present in a fifth (20%) of cases (2).

Evidence of parental substance misuse was noted in 57% of serious case reviews (3) and parental alcohol misuse noted in 22% of serious case reviews (4).

1.1.1 Parental alcohol/substance misuse

Substance misuse is often, but not always, associated with poor or inadequate parenting. In the majority of cases, substance misuse is associated with deprivation, poor physical and mental health, poor housing, domestic abuse, debt, offending and unemployment. Any or all of these factors are likely to have an impact on the family.

Substance misuse and withdrawal may affect a parent's ability to care for their child; specifically, a parent's ability to control their emotions. Severe mood swings and angry outbursts may confuse and frighten a child, hindering healthy development and control of their own emotions.

Nationally, parental substance misuse features prominently on the caseloads of social workers, although there is a need to understand why cases involving parental alcohol misuse seem to come to attention later, and often follow a different pathway, through social care (5).

In addition, children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse. Boys are less likely than girls to seek help and are more likely to come to the attention of services with regards to their presenting behaviour, for example through Youth Offending Services, than for the harm they are experiencing.

Nationally, it is estimated that 30% of children live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker (6). An estimated 79,291 babies under 1 year old in England live with a parent who is a problem drinker (7). Over three quarters (78%) of young offenders who also misused alcohol had a history of parental substance misuse (or domestic abuse) in their family (8)

Dual diagnosis describes the association between, substance misuse and mental illness. Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms. Conversely, psychological morbidity and psychiatric disorders can lead to substance use, harmful use and dependence. Children who have a parent with dual diagnosis are particularly likely to need safeguarding.

For more information please see
http://nottinghamshirescb.proceduresonline.com/p_ch_par_misuse_subs.html

1.1.2 Parental Mental Health Problems

Parental mental health problems may be life-long, episodic or specifically related to parenthood; around one in eight mothers experiencing postnatal depression. Failure to promote the secure relationships that underlie emotional health in infancy can have a direct result on emotional, social and physical health, both in childhood and in the longer term.

It is estimated that more than 4.2 million parents in the UK experience mental health problems. Approximately half of all adult mental health service users have children under the age of 18 years, and one in 10 will have a child under the age of 5 years (9). Whilst many

individuals with mental health problems function effectively with support from their family and community, some parents may need additional support to reduce the effect their mental health problem has on their capacity to parent.

The proportion of parents who experience serious mental illness (SMI) is not well defined. A recent systematic review has reported that at any one time in the UK, 9-10% of women and 5–6% of men with a mental health disorder are parents, less than 0.5% of whom will be experiencing a psychotic disorder (10). SMI is associated with increased risk of adverse outcomes in children. Short-term outcomes include poorer mental and physical health as well as increased risk of a range of behavioural, social and educational difficulties. Longer-term outcomes may extend into adulthood and include social or occupational dysfunction, lower self-esteem, increased psychiatric morbidity and alcohol or substance misuse (11).

Children of parents with mental health problems are more likely to enter the care system. Childcare social workers estimate that 50–90% of parents on their caseload have mental health problems, alcohol or substance misuse issues (12).

There are instances where a child may be at risk of significant harm as a result of parental mental illness, which can include children who feature within parental delusions as these children can become a target for parental aggression or rejection. The National Confidential Inquiry into Suicide or Homicide by people with Mental Illness (2016) identified that 11% of all homicides were by mental health patients. The data source does not enable an assessment of how many of these people were parents or how many victims were children. The majority of mental health patients convicted of homicide had a history of alcohol and drug misuse.[i]

Other potential risks relate to an unborn child of a pregnant woman with any previous major mental illness.

Where it is believed that a child of a parent with mental health problems may be at risk of significant harm the process is the same as for similar concerns about any child or young person in that a Strategy Discussion/Meeting should be held and consideration given to undertaking a Section 47 Enquiry.

For more information please see
http://nottinghamshirescb.proceduresonline.com/p_ch_par_mental_health.html]

1.1.3 Domestic Violence

Domestic violence and abuse (DVA) is defined by the Home Office (2013) as

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional."*

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office 2013).

Nationally, the majority of domestic violence and abuse is perpetrated by men against women but it is important to acknowledge that men are also affected by domestic and sexual violence. Research suggests that approximately 50% of male victims were also perpetrators of abuse. According to the British Crime Survey (BCS) at least 10% of women and 2.5% of men will suffer from domestic violence and abuse in a given year and 1 in 3 women will be subject to repeat incidents, compared to 1 in 10 male victims.

In almost a third of cases, DVA begins or escalates during pregnancy. DVA in pregnancy is associated with increased rates of miscarriage, premature birth, foetal injury and foetal death. The mother may be prevented from seeking or receiving anti-natal care and/or post-natal care.

Violence can pose a threat to an unborn child as assaults on pregnant women often involve punches or kicks to the abdomen, risking injury to the mother and baby. In addition if the mother is being abused this can affect her attachment to her child, more so if the pregnancy is a result of rape by her partner.

Children are considerably affected by DVA and witness about three-quarters of the abusive incidents within a household (Domestic Violence JSNA chapter). The abuser often uses his/her children in his/her controlling and coercive behaviour. Young people who live in households where there is DVA are more likely to experience DVA in their own relationships.

If a child lives in a home where there is DVA then they are likely to be at risk of abuse themselves including physical, sexual, or emotional abuse and/or neglect. 70% of children living in UK refuges have been abused by their father (14) Domestic abuse is a factor in more than 50% of serious case reviews[2] (15).

For more information please see Domestic Violence (2014) JSNA and

http://www.proceduresonline.com/nottinghamshire/scb/user_controlled_lcms_area/uploaded_files/sg_ch_dv_pract_guide.pdf

1.2 What makes children and young people more vulnerable? Characteristics of the child/young person

1.2.1 Children with Disabilities

Research suggests that children with disabilities are more vulnerable to abuse than non-disabled children. A large scale American study (16) that examined records of over 40,000 children found that disabled children were 3.4 times more likely to be abused or neglected than non-disabled children. Overall, the study concluded that 31% of disabled children had been abused, compared to a prevalence rate of 9% among the non-disabled

child population.[23] Research in the UK is limited; systematic review undertaken Stalker, K. and McArthur, K. (2010) identified few studies into the prevalence of abuse among disabled children.

A meta-analysis of data from research studies into prevalence and risk of violence against disabled children estimated that disabled children were 3.68 times more likely to experience violence than non-disabled children (17).

Kennedy reported that those working with disabled children were more likely to accept abusive practices, such as locking a child in a room, than they would be of their non-disabled peers. Marchant identified myths regarding the sexual abuse of disabled children including that disabled children are less likely to be sexual abused and more likely than other children to make false allegations of abuse.

Research suggests that the likelihood of abuse varies by type of disability. Sullivan and Knutson (2000) (18) found that children with behaviour disorders were approximately seven times more likely to experience neglect, physical and emotional abuse and 5.5 times more likely to experience sexual abuse. Children with speech and language difficulties were found to be nearly five times more at risk of neglect and physical abuse, almost three times more at risk of sexual abuse and almost seven times more at risk of emotional abuse.

Spencer *et al.* (2005) (19) found that children with conduct disorders were seven times more likely to be subject to a protection plan in any category, children with learning difficulties almost five times as likely, children with non-conduct psychological problems four times as likely and those with moderate/ severe speech and language disorders almost three times as likely. Studies in the US have also reported significant levels of abuse of children with Autism and Asperger's Syndrome (20).

As there are inconsistencies in the way disabled children are defined and counted, reported statistics are likely to be underestimates given that it may be difficult to prove neglect and the barriers disabled children and young people face in reporting.

Whilst the mechanism behind the increased risk of abuse disabled children face is not fully understood research by the NSPCC highlighted that children with special educational needs and disabilities were more likely to report lower knowledge, understanding and self-efficacy to keep safe in relation to bullying, domestic abuse, and appropriate and inappropriate touch when compared to their peers (21).

There is very limited data regarding the characteristics of children who have been the subject of serious case reviews (SCR) so it is not possible to assess whether they are over/under represented at SCR.

1.2.2 Young people who have substance misuse problems

The likelihood of using illicit drugs increases with the vulnerability of children and young people. The Home Office (22) identified five vulnerable groups of young people, namely those having that have been in care, have been homeless, truants and those excluded from school and 'serious' or frequent offenders. The report estimates that 24% of young people having one or more of these vulnerabilities will have used illicit drugs frequently during the last year compared to 5% of those without vulnerabilities.

Young people who misuse substances are more likely to need safeguarding. For example:

- If a parent/carer is not addressing a young person's drug misuse then they may not be adequately protecting them from harm.
- A young person may be misusing substances because he has or is suffering physical or mental harm as a result of neglect or abuse from their parents/carers or others such as in cases of CSE.
- Actual physical harm due to accidents is more likely in a young person misusing drugs or alcohol.

Substance misuse is nearly always likely to be linked to an underlying cause. Identifying and addressing the cause can help support the young person

1.2.3 Children and young people involved in anti-social or criminal behaviour

It is often the most vulnerable and victimised young people that become involved in persistent offending and require safeguarding.

There is a strong correlation between areas with high levels of crime and high levels of poverty. The work on identifying risk factors for offending is based on an understanding that offending is part of a larger pattern of anti-social activity which begins in childhood and often persists into adulthood. Only a limited understanding exists however, about the relationship between risk and protective factors and later offending and anti-social behaviour.

The existence of one or more risk factors in a child's life is not a good predictor of outcomes and children vary in terms of how they respond to risk. Risk factors are context-dependent and vary over time and with different circumstances. Where multiple risk factors exist, there is increased likelihood of poor outcomes for children. The best predictors of offending differ according by age group. For children aged between 6 and 11, committing an offence appears to be the best predictor of future delinquent behaviour; the strongest predictors for children aged 12 to 14 are a lack of social ties and association with anti-social peers (23).

Young people who offend are a risk to themselves and others. Siblings of young offenders are more likely to become offenders themselves.

Research suggests that young people who perpetrate group-based offending and violent behaviour will often have been the victims of abuse or neglect (24). For example, where violence is a common occurrence in the home or wider community, such behaviour becomes normalised and this will have an impact on the likelihood that young people will perpetrate this behaviour (25).

Young people who perpetrate crime and acquire weapons may also have been subject to other risk factors such as poverty, inconsistent parenting and reduced educational and life chances (26) (27) (28).

1.2.4 Children who go missing from home or care

Children who go missing from home any be fleeing problems such as abuse or neglect, to stay somewhere they'd rather be or because they have been coerced to run away by someone else. It is estimated that approximately 25 per cent of children and young people that go missing are at risk of serious harm (29). There are particular concerns about the links between children running away and the risk of sexual exploitation.

Missing children may be vulnerable to other forms of exploitation, violent crime and/or to drug and alcohol misuse; Children in Care missing from their placements are particularly vulnerable. In 2012, two national reports highlighted that many children missing from home were not being effectively safeguarded: the Joint All Party Parliamentary Group (APPG) Inquiry on Children Who Go Missing from Care (30) and the accelerated report of the Office of the Children's Commissioner's on-going inquiry into Child Sexual Exploitation in Gangs and Groups (31).

Children in residential care are at particular risk of going missing and vulnerable to sexual and other exploitation. Local Safeguarding Children Boards have an important role to play in monitoring and interrogating data on children who go missing.

It is difficult to establish the number of children who are missing from home or care but national estimates suggest the figure is in the region of 100,000 per year. One in six young runaways end up sleeping rough, one in eight resort to begging or stealing to survive and one in 12 are hurt or harmed as a direct result of running away (32)

Although Children in Care are particularly vulnerable when they go missing the majority of children who go missing are not looked after rather they go missing from their family home.

1.2.5 Children and Young People who return to their family following a period in local authority care

Nationally, 21% of children who entered care because their mother had a problem of addiction, left care an average 22 months after entry, if addiction was the only major difficulty. In contrast, where there were other serious problems in addition to addiction, only 12 per cent of children

returned home. Children who enter care because of domestic abuse are less likely to return home unless the known abuser has left the home (33). Parents with disabilities or physical health problems are more likely to have their children returned home to them than those with mental health problems (34).

Evidence suggests that the likelihood of children being returned to their parents within a fairly short space of time is lower for those who enter care as infants (especially for reasons of maltreatment) (35) (36) and for teenagers who enter care because of challenging behaviour. In the case of teenagers it may not be because they no longer need additional care and support but because at the age of 18 years they are no longer classified as Children in Care.

Children whose entry into care is precipitated by concerns about physical or sexual abuse are more likely to be returned home than those for whom neglect is the primary reason for entry into care (37) (38). This is usually as in cases of physical and sexual abuse the abuser has the left the family home including parents/carers who are in prison because of the abuse they committed. For children whose families have complex problems including drug and/or alcohol addiction, the proportion of children who are returned home after being in care is lower. Evidence suggests the longer the time children spend longer in care, the smaller the chance those children will return (36) (33).

Research carried out by Farmer and et al found that 82% of children went home to parents with a history of domestic violence, alcohol or drugs misuse or exposure to inappropriate sexual activity; whilst three-fifths (60%) went to a parent with mental health problems. Poor parenting was found to be the greatest predictor of child maltreatment after return (39). In addition, the study found that whilst almost half (46%) of the mothers and a fifth (17%) of the fathers to whom children returned were known to have alcohol or drug problems, only 5% received treatment to help them address their substance misuse (40).

Children and Young People who return to their family after being in care are particularly vulnerable and are three times more likely to return into care after 5 years (41), Nationally, 32% (3,180 of the 9,970) of the children who returned home in 2009-10 had re-entered care by 31 March 2013 (41). It is also important to recognise that a significant number of children oscillate between home and care. In a study by Farmer et al in 2011, a third of the children experienced two or more failed returns. This is strongly associated with poor outcomes for the child (42).

1.2.6 Children and young people who are carers

Children and young people who are carers will need additional support and may need safeguarding. Young carers carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility that would usually be associated with an adult (43). (Becker, 2000: 378). Being a carer at a young age can have a tremendous impact on a young person that can last into adulthood. If a child has to care for his parents or younger siblings it is very possible that his own needs are not being met.

Under The Children Act 1989, Local Authorities are required to provide services for children in need and young carers come under this responsibility. According to the Act if a local authority considers that young carers must have support needs they must also carry out an assessment. The Young Carers (Needs Assessment) Regulations 2015 require local authorities to look at the needs of the whole family when carrying out a young carers' needs assessment. Young carers' assessments can be combined with assessments of adults in the household, with the agreement of the young carer and adults concerned.

For more information see Carers JSNA

1.3 Children who are, or may be, experiencing abuse and/or neglect

Children and young people may enter the care of the local authority voluntarily, such as when parents are struggling to cope, or Children's Services may intervene because a child is at significant risk of harm. Children who are suspected of being subject to abuse and/or neglect are referred to children's social care services and may become subject to a child protection conference and a child protection plan.

In 2014 there were approximately 68,840 children in England and Wales under the care of Local Authorities (44) an estimated 46,155 (62%) of whom were looked after due to abuse or neglect.

Approximately 60 per cent of children enter care because of abuse or neglect (45). The vast majority of children live safely in foster care and residential care, but a minority of children across the UK experience harm each year from those responsible for their care. Biehal estimated there are 450–550 cases of abuse or neglect in foster care per year, and 250–300 cases of abuse or neglect in residential care per year (46).

1.3.1 Children and young people experiencing neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse and violence towards a carer, the needs of the child may be neglected.

Once a child is born, neglect may involve a parent failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers);
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs.

These definitions are used when determining significant harm and children can be affected by combinations of maltreatment and abuse, which can be impacted on by, for example, domestic violence and abuse in the household or a cluster of problems faced by the adults. Parental alcohol/substance misuse is strongly correlated with neglect.

Neglect has an impact on attachment as well as brain development for children less than 3 years of age. If a baby is neglected and/or malnourished neural cells can become weak or damaged which lowers brain function. If a child has a poor relationship, attachment or little interaction with a parent then it can change how their brain develops emotional and verbal pathways. Neglect can severely alter the way a child's brain works. Changes to the brain caused by neglect have been linked to panic disorder, post-traumatic stress disorder (PTSD) and attention deficit and hyperactivity disorder (ADHD) (47).

Some children who have been neglected may experience short and long term effects that last throughout their life. Whilst the consequences of neglect are varied they often include:

- Difficulties in maintaining healthy relationships later in life, including with their own children.

- Experiencing mental health problems including depression, dissociative disorders, memory impairments and post-traumatic stress disorder.

- Taking risks, such as running away from home, breaking the law, abusing drugs or alcohol, or getting involved in ‘dangerous which can led to sexual exploitation.

1.3.2 Children and young people experiencing other types of abuse

Child abuse is any action by another person, adult or child, that causes significant harm to a child. Abuse can be physical, sexual or emotional with many children experiencing more than one type of abuse, often alongside neglect. Working Together to Safeguard Children identifies four categories of abuse, Physical, Sexual, emotional and neglect. In order to fully understand the nature of child abuse it can be helpful to look at a wider set of types of abuse.

Physical abuse is deliberately, not accidentally, hurting a child by hitting, kicking, burning and/or poisoning. Injuries due to physical abuse can include bruises, broken bones, burns and cuts. Shaking or hitting babies can cause non-accidental head injuries (NAHI) which are associated with brain damage and death.

Some parents or carers will make up or cause the symptoms of illness in their child to gain medical attention. For example, by giving the child medicine they don’t need to make them unwell. This is known as fabricated or induced illness.

Adults who physically abuse children may have:

- Experienced child abuse themselves.
- Emotional or behavioural problems such as difficulty controlling their anger.
- Parenting difficulties including unrealistic expectations of children and/or not knowing how to respond to a child.
- Family or relationship problems.
- Health issues which impacts their capabilities to parent (48)

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images,

watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Sexual abuse can be further defined as contact abuse and non-contact sexual abuse. Contact abuse is where an abuser makes physical contact with a child, which may include penetration. Non-contact abuse includes non-touching activities such as persuading children to perform sexual acts over the internet.

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or child trafficking. Whilst many children and young people are groomed online, grooming also takes place face-to-face, by strangers or someone the child/young person know.

Groomers can be male or female and of any age. Many children and young people don't understand that they have been groomed or that what is happing is abuse

Emotional abuse is the ongoing emotional maltreatment or emotional neglect of a child. It is seriously damaging to a child's emotional health and development. Emotional abuse can involve deliberately trying to scare or humiliate a child and/or isolating or ignoring them. Many children who are emotionally abused are also suffering other types of abuse or neglect; however, this isn't always the case.

As features of emotional abuse are present in all other types of child abuse and neglect, it can be challenging to spot the signs of emotional abuse and separate emotional abuse from other types of abuse. The NSPCC state that emotional abuse is the second most common reason for children needing protection from abuse (49)

1.3.2 Online abuse

Online abuse is any type of abuse that via the internet including through social networks, online games and mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse through being online. Children can experience online abuse from people they know, as well as from strangers.

Some children/young people will experience online abuse as part of abuse that is taking place in the 'real world' such as bullying or grooming. For others, abuse only happens online for example abusers persuading children to take part in sexual activity online.

Children can feel like there is no escape from online abuse because abusers can contact them at any time of the day or night. The abuse enters safe places like their bedrooms with images and videos that can be stored and shared with other people.

1.3.3 Trafficked Children

Child trafficking was defined by the Council of Europe UK government in 2008 as:

> *"The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered 'trafficking in human beings."*

Child trafficking is a form of child abuse in which children are recruited, moved or transported and then exploited, forced to work or sold. Children are trafficked for:

- Child sexual exploitation
- Benefit fraud
- Forced marriage
- Domestic servitude such as cleaning, childcare, cooking
- Forced labour including to work in factories or agriculture
- Criminal activity including pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs and bag theft.

Whilst many children are trafficked into the UK from abroad, children are also trafficked within the UK.

Trafficked children experience multiple forms of abuse and neglect and can experience physical, sexual and emotional violence; this abuse is often used to control victims of trafficking**.**

Nationally it is estimated that 1 in 4 victims of trafficking are children. These figures don't include prosecutions for crime related to trafficking such as assisting unlawful immigration, false imprisonment, and causing, inciting or controlling prostitution for gain. Children were most commonly trafficked from Vietnam, Nigeria, Slovakia, Romania and from within the UK. The most common reasons for children to be trafficked are sexual exploitation and criminal exploitation. Since 2007 the NSPCC have been involved with 1,100 cases of child trafficking.

1.3.4 Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status. The new (2015), nationally agreed definition of CSE is:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Sexual exploitation of children and young people under 18 years of age involves exploitative situations, contexts and relationships where young people, or a third person/s, receive 'something', including food, accommodation, drugs, alcohol, cigarettes, affection, gifts and/or money as a result of them performing, and/or others performing on them, sexual activities.

Child sexual exploitation (CSE) can occur through the use of technology without the child immediately recognizing their being exploited; for example, when a child is persuaded to post sexual images on the internet without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.

Violence, coercion and intimidation are common in CSE through exploitative relationships that take advantage of the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Children or young people may be tricked into believing they're in a loving, consensual relationship.

The Casey Report (2015) sets out some key issues for local authorities and police forces when dealing with child sexual exploitation. A brief summary can be found in appendix 1.

1.3.5 Female Genital Mutilation

FGM is a form of child abuse and is illegal in the UK. Female Genital Mutilation (FGM) is described by the World Health Organisation as:

> *'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'.* (51)

FGM is sometimes referred to as 'female genital cutting' or female circumcision'. However, it is preferred not to associate FGM with circumcision due to the severity of the procedure in comparison to male circumcision. FGM has no health benefits for women and girls, can cause severe short and long term health problems and is recognised internationally as being a violation of the human rights of women and girls.

FGM is a worldwide issue with an estimated 200 million women living with FGM in the world (52). However, women and girls from some communities are at increased risk. In some African countries, such as Somalia, the estimated prevalence of FGM is as high as 98%.

There are health implications for all women and girls undergo FGM. Health impacts caused by FGM can include, in the short term, severe pain, haemorrhage, shock and death. In the longer term women who have undergone FGM can experience psychological problems including post-traumatic stress disorder, anxiety and mood disorders and low self-esteem and problems with childbirth which can put both mother and baby at risk including difficult deliveries.

In Britain, FGM is seen in ethnic groups that have migrated from Egypt, Mali, Northern Sudan and Somalia. Dispersal of asylum seekers across the UK means increasing numbers of professionals will come into contact with women who have undergone FGM and girls who might be at greater risk[3].

FGM is usually carried out sometime between infancy and adolescence; however, FGM can happen at any age. In the UK girls are at most risk of FGM between the ages of 7 and 10 years of age. Risk factors for FGM include:

- A history of FGM in the family; especially if the mother has undergone FGM
- Being a woman/girl are from a community or ethnic group where FGM is highly prevalent and a part of the culture of that community (although this does not always mean FGM will take place).

Girls are also at higher risk of FGM in the run up to and during the school summer holidays, as they are able to have a longer time off to recover from FGM before returning to school.

For more information please see FGM JSNA chapter.

1.3.6 Honour Based Violence

Honour-based violence (HBV) is the term used to refer to a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups in order to protect supposed cultural and religious beliefs, values and social norms in the name of 'honour'. HBV crimes include forced marriage (FM), female genital mutilation (FGM), assault, rape and murder. The term HBV encompasses the full range of incidents and crimes which perpetrators carry out under the guise of maintaining or protecting perceived 'honour'.

HBV occurs in communities where the concepts of honour and shame are fundamentally bound up with the expected behaviour of families and individuals, particularly that of women and girls. There have been a number of high-profile 'honour killings', the most extreme form of so-called "honour"-based violence, in the UK in recent years. In other circumstances, the

[3] From School Summer Letter 2016

victim can be subjected to long term physical abuse and bullying as ‘punishment’ for ‘bringing dishonour on the family.

1.4 Children in Care

2. In UK law, Children in the care of a local authority are referred to as ‘Children in Care’. Children in Care can be accommodated as a result of a court order or with the voluntary agreement of their parents (S20). Legally, this could be when they are:

- The subject of an interim or full care order
- The subject of an emergency legal order to remove them from immediate danger
- Living in a secure children’s home, secure training centre or young offender institution or
- Unaccompanied asylum seeking children.

Accommodation provided by the local authority includes foster parent placements and residential children's homes.

2. The size of the issue locally

2.1 What makes children and young people in Nottingham more vulnerable? Parental characteristics

2.1.1 Parental alcohol/substance misuse

In 2015-16, 24% (276/1169) of Nottingham adults accessing structured drug and or alcohol treatment lived with their own or other children. The proportion of clients living with children was similar for alcohol only clients and other drug clients (21% and 25% respectively). These children are more likely to need safeguarding than children living in households where there is no alcohol/substance misuse.

The actual number of children in Nottingham who are living with parental alcohol misuse is likely to be much higher as local intelligence suggests many parents don't recognise they are drinking at harmful levels and don't appreciate the risk this may pose to their children.

Where children and young people may be at risk of harm or may require services a social worker will complete a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential. It is important to note that many children/young people have risks identified in more than one category and thus the number of risks is greater than the number of children/young people having an assessment.

As figure 3 shows, 35% (1367/3885) of the assessments in Nottingham in 2015/16 identified risks related to parental substance use. 19% (735/3885) of risks identified related to drug misuse, matching the England average of 19% but lower than the statistical neighbour average of 21%. 16% (632/3885) of risks related to alcohol misuse, lower than the England average of 18% and the statistical neighbour average of 19%.

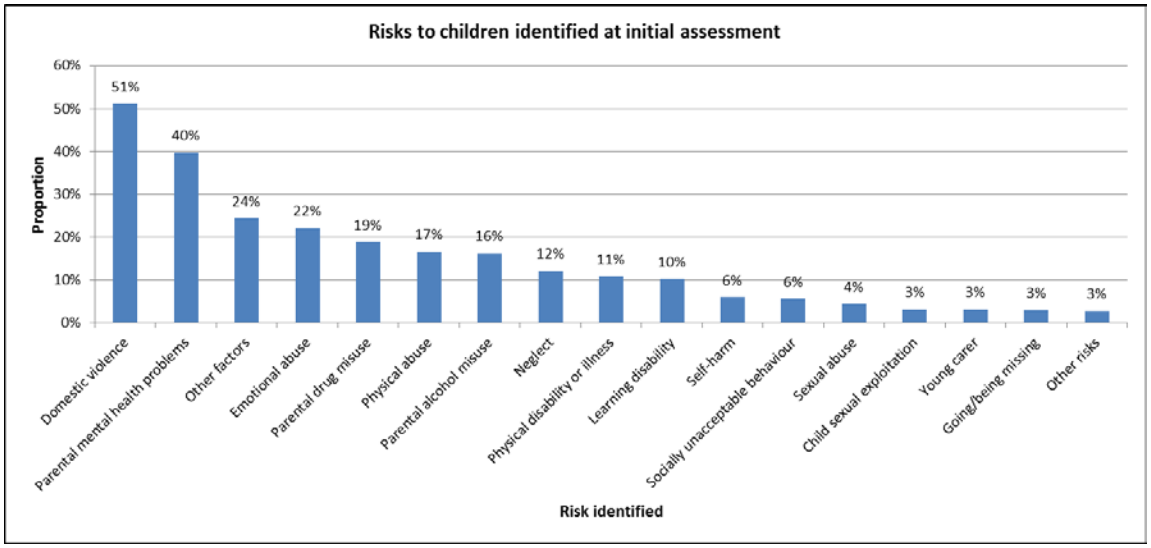


Figure 3: Risks to children identified at initial assessment 2015-16[4]
Source: Statistics child in need and child protection 2016-16 SFR 52/2016

Current data collection does not enable an assessment of whether the proportion of Children's Assessments in Nottingham identifying risks related to parental substance use is an increasing or decreasing trend.

Whilst national evidence suggests that parental substance use often co-exists with domestic violence, parental mental health problems and leads to child abuse current data collection does not enable an understanding of what proportion of children in Nottingham are affected by this triad of risk.

National reviews of serious case reviews suggest that parental substance use is associated with significant child abuse including fatalities due to child abuse, however, local numbers are too small to assess whether Nottingham reflects the national picture.

2.1.2 Parental Mental Health Problems

The Adult Psychiatric Morbidity Survey (2014) provides a methodology to estimate the prevalence of common mental health disorders and/or psychosis in people living in households with children (53). Using this methodology there are an estimated 10,000 adults in Nottingham with a current mental health problem who live in a household with dependent children. Most of these adults have common mental health problems (such as depression or anxiety); an estimated 338 have a psychosis.

[4] Other factors includes when the risks were not clearly identified at the end of the assessment and may include where this information is not known or not available. Other risks is for categories where the value was <1% of risks identified.

It is not possible, using this method, to identify how many children, rather than households, this equates to as both parents in a family could have a mental health problem. In addition, there is evidence to suggest that mothers in large families have higher rates of mental health problems.

This estimate is based on Nottingham's population size and household make up, but does not take into account other relevant factors including Nottingham's high levels of deprivation, lower age of motherhood, high rates of unemployment, higher ethnic diversity and population turnover.

It should be noted that this is a point estimate (an indication of level of need at a fixed point in time) and as such is an under-estimate of the proportion of people in Nottingham with mental health problems. More people would be affected by mental health problems over a time period such as a year.

Office for National Statistics (ONS) mid-year estimates suggests there are 64,978 aged 0-17 years in Nottingham in 2014.

Nationally, in 2015, households with dependent children had an average of 1.74 children (ONS). In 2011 there were 34,502 households with dependent children in Nottingham (ibid). This would equate to 1.88 children, aged 0-17 years, per household in Nottingham.

Based on whether they were one or two adults in households this would equate to an estimate of 55,478 adults living in households with dependent children in Nottingham. The 2011 census states that 90.73% of lone parents in Nottingham were female.
Using the above method it is estimated that there are 22,230 males and 33,247 females living with dependent children in Nottingham. As figure 4 illustrates, of these, 12.7% males and 20.2% of females would be likely to have a common mental health disorder.

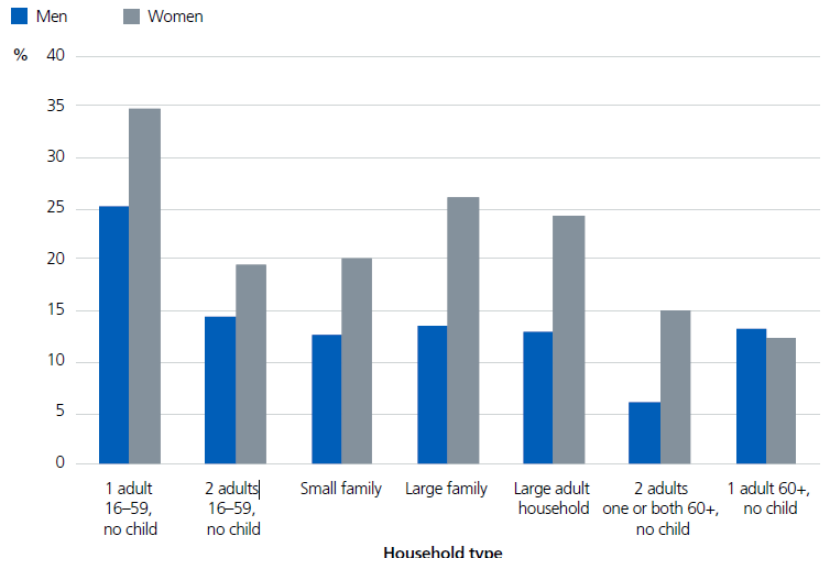


Figure 4: Prevalence of common mental disorder (CMD) by household type and sex
Source: APMS 2014. NHS Digital

Less than 1% of males and females living with dependent children (0.6% and 0.7% respectively, shown in figure 5) would be expected to have a psychosis.

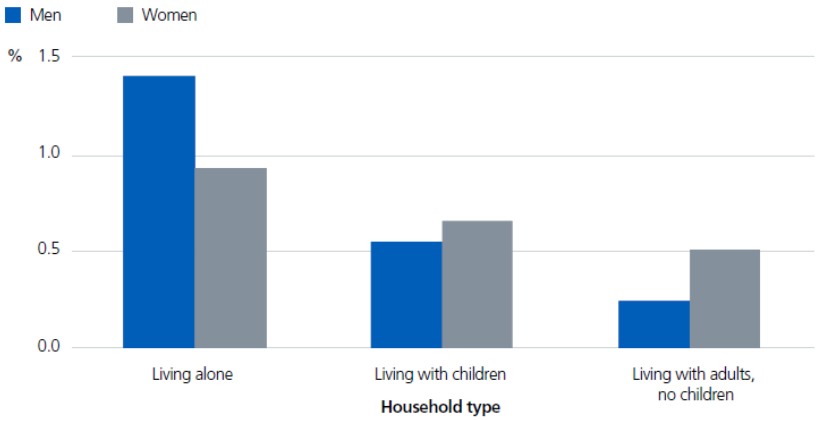


Figure 5: Psychotic disorder in the past year (2007 and 2014 combined) by household type and sex
Source: APMS 2014. NHS Digital

As stated previously, where children and young people may be at risk of harm or may require services a social worker will complete have a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential.

40% (1544/3885) of the assessments in Nottingham in 2015/16 identified risks related to parental mental health problems; higher than the England average of 37% and the statistical neighbour average of 36%. Mental health problems were the second most commonly identified

risk in Nottingham in 2015/16 as it was in England in the same time period. As some mental health problems are very common, whereas others have very low prevalence, recording of mental health problems as a risk does not indicate the severity of the illness.

Risks can be recorded in more than one category. Children/young people who were assessed as having risks identified related to parental mental health problems may have other risks identified such as domestic violence.

Current data collection does not enable an assessment of whether the proportion of Children's Assessments in Nottingham identifying risks related to parental mental health problems use is an increasing or decreasing trend.

2.1.3 Domestic Violence

Based on the British Crime Survey it is estimated that in Nottingham in any given 12 month period there are:

- 12,900 female survivors (4,300 of who will be suffering repeat victimisation).
- 3,200 male survivors (300 of who will be suffering repeat victimisation).

Various organisations collect information that provide a picture of the extent of domestic abuse in Nottingham, however Police data is the source most consistently collected at a City level. Nottingham Police receive, on average, 12,000 domestic violence and abuse (DVA) related calls annually of which 2,500 are recorded as crimes. 39% of all recorded violence in the city is DVA. 84% of victims of incidents recorded as crimes are women, 16% are men (DSV JSNA chapter).

Nottingham's Domestic Abuse Referral Team (DART) estimates that 3 children in every classroom of 30 have experience of domestic violence. Since DART inception, June 2012 to date, there have been 12,181 High/Medium risk incidents[5] recorded accounting for 20,652 individuals (survivors, perpetrators and children).

As stated previously, where children and young people may be at risk of harm or may require services a social worker will complete have a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential.

[5] As identified by the DASH-RIC assessment tool

51% (1988/3885) of the assessments in Nottingham in 2015/16 identified risks related to domestic violence; higher than the England average of 50% but lower than the statistical neighbour average of 55%. Domestic violence was the most commonly identified risk in Nottingham in 2015/16 as it was in England in the same time period.

Current data collection does not enable an assessment of whether the proportion of Children's Assessments in Nottingham identifying risks related to domestic violence is an increasing or decreasing trend.

Risks can be recorded in more than one category. Children/young people who were assessed as having risks identified related to domestic violence may have other risks identified such as parental substance misuse or parental mental health problems.

Whilst national evidence suggests that domestic violence is associated with significant child abuse, including fatalities due to child abuse, local numbers are too small to draw conclusions.

2.2 What makes children and young people in Nottingham more vulnerable? Characteristics of the child/young person

2.2.1 Disabled children

Local estimates of the numbers of children with SEN and disability are based on various routine data sources such as the Statistical First Returns to the Department for Education, Disability Living Allowance statistics and local figures of numbers accessing a range of children's services. These sources suggest that in 2015 there were approximately 3,500 – 4,000 children and young people, aged under 25 years, in Nottingham with disabilities[6].

Of these, approximately a 1000 children/young people have severe, complex and/or lifelong disabilities. This figure is based on a data collection from 2009 which hasn't been repeated. Local intelligence suggests this may be an underestimation of the actual number thus conclusions should be treated with caution. In the same time period 7,500 children were identified as having special educational needs, of which a proportion also had a disability.

For more information see Children and Young People with Special Educational Needs and Disabilities JSNA chapter http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA/Children-and-young-people/Children-and-Young-People-Special-Educational-Need.aspx

As stated previously, where children and young people may be at risk of harm or may require services a social worker will complete have a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential (SFR 2015-16).

21% (819/3885) of the assessments in Nottingham in 2015/16 identified risks related to disability. 10% (398/3885) relating to learning disability, lower than the England average of 12% and 11% (421/3885) relating to physical disability or illness. Due to the data collection method it is unclear whether the identified risks relate to disability or illness of the parent/carer or child/young person.

Current data collection does not enable an assessment of whether the proportion of Children's Assessments in Nottingham identifying risks related to disability or illness an increasing or decreasing trend.

[6] Whilst this estimate appears reliable it should be noted that this estimate is lower than local professionals believe to be the case.

In January 2017 17% (80/472) of children/young people subject to a child protection plan were identified as having a disability. Disability, in this context, is a broad category including children/young people with special educational needs as well as those with more complex disabilities thus conclusions should be drawn with caution.

Nottingham's Disabled Children's team undertakes assessments of children with permanent and substantial disabilities who are in need of aids and adaptations, short breaks and support services, protection or whom are looked after. In January 2017 9% (33/373) of children/young people were identified as Children in Care and <1% (3/373) were subject to a child protection plan.

2.2.2 Young people who misuse substances

It is challenging to establish the prevalence and patterns of young people's drug use and alcohol consumption in Nottingham. Estimating the number of young people who use substances using data from specialist services will underrepresent those who use substances.

Extrapolating from national survey data suggests that there has been a reduction in the number of young people who use drugs. These surveys suggest that there has been a reduction in the number of young people who use drugs; the proportion of 11-15 year olds who took drugs in the last month reduced from 8% in 2009 to 6% in 2013 and the proportion of 16-24 year olds who are frequent drug users reduced from 8% in 2009 to 5% in 2013 (JSNA).

Young person specific data on hospital admissions due to alcohol (Public Health England, 2016) suggests that there has been a reduction in the rate of alcohol specific admissions in young people aged under 18, both nationally and locally. In Nottingham in 2006/7-2008/9 the rate of admissions in this age group was 80 per 100,000 compared with 65 per 100,000 in the period 2011/12 -2013/14 (Public Health England, 2016).

For more information on the numbers of young people using substances in Nottingham see the Children and Young People Substance Misuse (2016) JSNA chapter.

As stated previously, where children and young people may be at risk of harm or may require services a social worker will complete have a Children's Assessment which identifies risks. In 2015/16 in Nottingham 3,885 assessments took place which identified 9,728 risks, actual and potential.

Local data collection suggests that <1% (402/7697) of risks identified in Nottingham in 2015/16 related to alcohol or substance misuse by the child/young person. National data collection does not enable comparison with the England, or the statistical neighbour, average.

2.2.3 Children and young people involved in anti-social and/or criminal behaviour

The number of young people in Nottingham aged 10-17[1] offending is decreasing; between 2006 and 2015 there has been a 79% reduction in the number of offences committed by young people. The majority of young people who offend are aged 15-17 years. Males make up the majority of the youth offending cohort, committing between 77% and 81% of crimes in the 5 year period.

In Nottingham, between 2009/10 - 2015/16, 363[2] young people subject to a child protection plan were involved in criminal behaviour representing an average of 108 young people a year. There is no significant trend (increase or decrease) during this time period.

In Nottingham, between 2009/10 - 2015/16, 291[2] children in need (CIN) were involved in criminal behaviour representing an average of 82 young people a year. Again, there is no significant trend (increase or decrease) during this time period.

In Nottingham, in the last 5 years (2009/10 - 2015/16) 80[7] young people became looked after (CHILDREN IN CARE/LAC) after being remanded into secure accommodation. This represents an average of 23 young people per year. There is a weak downward trend[8] in the number of young people in secure CHILDREN IN CARE/LAC.

During the same time period 124 young people received a custodial sentence. This represents an average of 28 young people a year. There is a strong downward trend[9] in the number of young people in Nottingham receiving custodial sentences.

[1] Some young people who committed offences aged 17 were dealt with after their 18th birthday.
[2] Note: young people may be counted in more than one financial year
[2] Note: young people may be counted in more than one financial year
[7] Note, young people can be counted in more than one Financial Year
[8] 0.1<r-squared<0.3
[9] 0.7<r-squared<0.9

2.2.4 Children who go missing from home or care

Table 1 shows the number of episodes a child or young people in Nottingham went missing from home or care between 2012 and 2015. It is important to note that this is the number of episodes, not the number of children/young people who have been reported missing or absent from home or care. A child/young person may have multiple episodes with each episode recorded by the local authority.

	2012-2013	2013-2014	2014-2015	2015/16
Number of missing and absent children (episodes) (2012-2014)	724	1548	1655	1970
Average episodes per month	60	129	138	164

Table 1: Number of children who go missing from Nottingham City per year and average number of children missing who are notified to Nottingham City Council by Nottinghamshire Police per month.
Source: Internal information from Nottingham City Council's Missing Children Team,

The distinction between 'missing' and 'absent' children was introduced in national guidance in January 2014 and implemented by Nottinghamshire Police in November 2015. Thus, whilst the data appears to indicate a sharp increase in the number of episodes a child/young person went missing or absent from home or care it is not possible to establish whether this relates to a real increase or a change in classification of missing and absent.

In addition, data now includes those missing for less than 24 hours which, coupled with an improvement in recording, may be responsible for the increase in children/young people reported as missing. The distinction between missing' and 'absent' children was in response to concerns raised by the Association of Chief Police Officers regarding the amount of police resources used for 'missing children' investigations where it was unlikely any crime had been, or would be, committed. Work is underway to update local guidance these categories as the absent category has been replaced in national guidance with a graduated definition of missing Within this system Nottinghamshire Police control room staff decide if a child/young person will be recorded as 'missing', 'absent' or as a 'concern for safety'. This decision is reached after completing a question schedule. If a child/young person is classified as 'missing' police resources are allocated to making enquiries whereas if a child/young/person is classified as 'absent', the matter is held under review and no resources are allocated immediately. In Nottingham City all children that are reported missing on two or more occasions or assessed

as being vulnerable (whether classed as absent or missing by the police) are offered a return interview.

Local intelligence suggests that the high national profile of 'missing children', including in the media, is another factor contributing to the observed increase; parents/carers are now more aware of what they need to do should their child go missing.

From 1st April – 31st October 2016 there were 1,339 episodes relating to 511 'unique' children. 50% (672/1339) were absent notifications, 48% (644/1339) missing notifications and <1%[10] (21/1339) were away from placement without authorisation notifications. Of these 1,339[11] episodes:

- 55% (734/1339) were missing or absent for less than 1 day
- 31% (420/1339) were missing for 1 day
- 10% (134/1339) were for 2-3 days
- <1% (35/1339) were for 4-8 days
- <1% (2/1339) were between 9-14 days
- <1% (3/1339) episodes between 15-28 days
- <1% (7/1339) episodes over 28 days

37% (487/1,335) of episodes were from Children in Care, 17% (226/1335) of whom were missing from residential care e.g. children's homes. Current projections suggest that there will be more than 2200 episodes in 2016-17.

2.2.5 Children and Young People who return to their family following a period in local authority care

Children who leave care may:

- Return home to live with parents, relatives, or other person with parental responsibility as part of the care planning process (not under a special guardianship order or residence order or (from 22 April 2014) a child arrangements order).
- Return home to live with parents, relatives, or other person with parental responsibility which was not part of the current care planning process (not under a special guardianship order.
- Leave care to live with parents, relatives, or other person with no parental responsibility.

[10] Due to rounding these proportions don't add up to 100%
[11] Length of absence does not add up to 1,335 as in the duration of absence was not recorded.

As figure 6 illustrates, in Nottingham, in 2014-2015, the percentage of children returning home after a period of being looked after/child in care was 27% which is lower than the statistical neighbour average of 36% and England average of 34%. This is a decrease of 9% from 2013-14 which is higher than the statistical neighbour reduction of <1%. The England percentage remains unchanged.

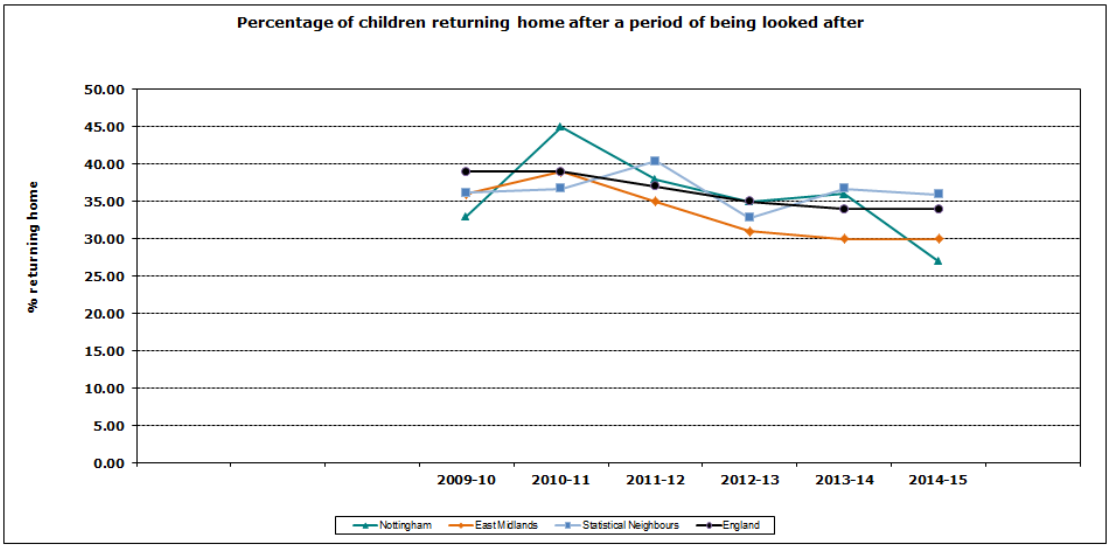


Figure 6: Percentage of children returning home after a period of being looked after
Source: DfE Statistical First Release, SFR 52/2016

Local intelligence suggests that the reduction in the proportion of children and young people returning home after a period of care is due to a number of interconnecting factors including appropriate interventions taking place prior to care and stabilisation of 'edge of care' interventions

In addition, Nottingham is participating in the NSPCC reunification practice framework which supports social workers and their managers to apply structured professional judgement to decisions about whether, when and how a child should return home from care. It supports families to understand what needs to change, to set goals with the support of workers, access support and services and review progress. (54)

2.3 Children who are, or may be, experiencing abuse

2.3.1 Referrals to Children's Social Care

As figure 7 illustrates, the rate of referrals to Children's Social care in Nottingham is 882 per 10,000 children and young people, higher than the England average of 532 per 10,000 and the statistical neighbour average of 701 per 10,000.

The rate of referrals has reduced by 90.1 per 10,000 children and young people significantly higher than the England reduction of 16.1 per 10,000 but lower than the statistical neighbour average 99.7 per 10,000.

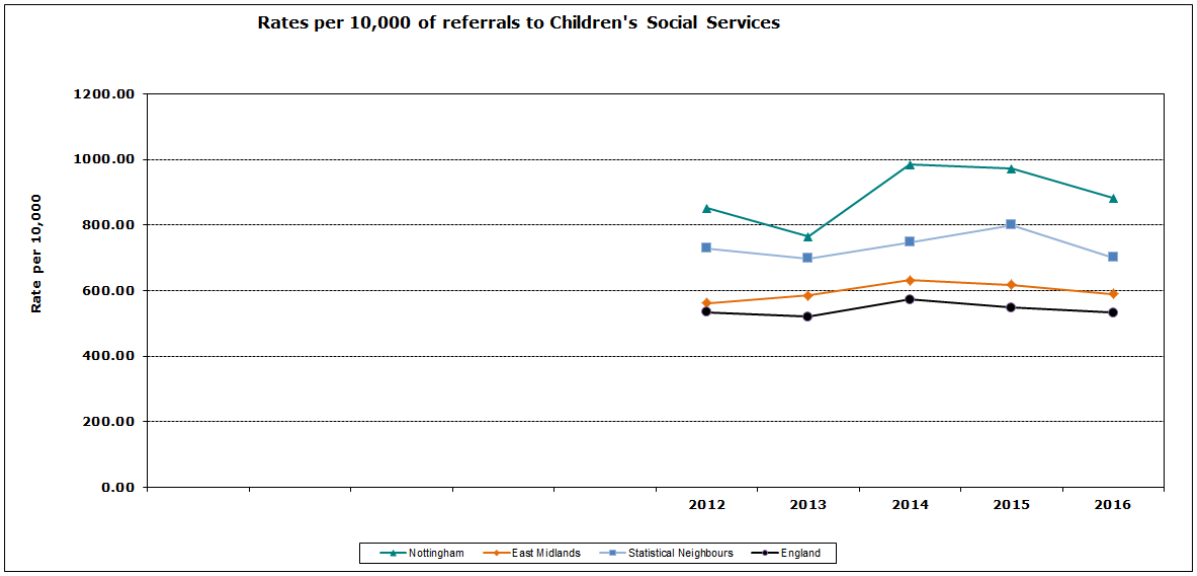


Figure 7: Referrals to Children's Services, rate per 10,000
Source: DfE Statistical First Release, SFR 52/2016

Local intelligence suggests that the high rate of referrals in Nottingham is because the city has an informed and proactive workforce in universal, and universal plus, services that appropriately identify safeguarding concerns and make timely referral to children's social care. The rate of referrals is decreasing as staff in universal services become more confident in what constitutes appropriate referrals.

2.3.2 Section 47 enquiries

Section 47 of the Children act 1989 places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. As figure 8 illustrates, in Nottingham, in 2016, the rate of Section 47 enquiries was 280 per 10,000 children and young people; nearly double the England rate of 148 per 10,000 and higher than the statistical neighbour rate of 224 per 10,000.

The Nottingham rate of section 47 enquiries increased by 72 per 10,000 in 2016, seven times the England increase of 9 per 10,000. Whilst the statistical neighbour rate also increased, the increase was less marked at 11 per 10,000.

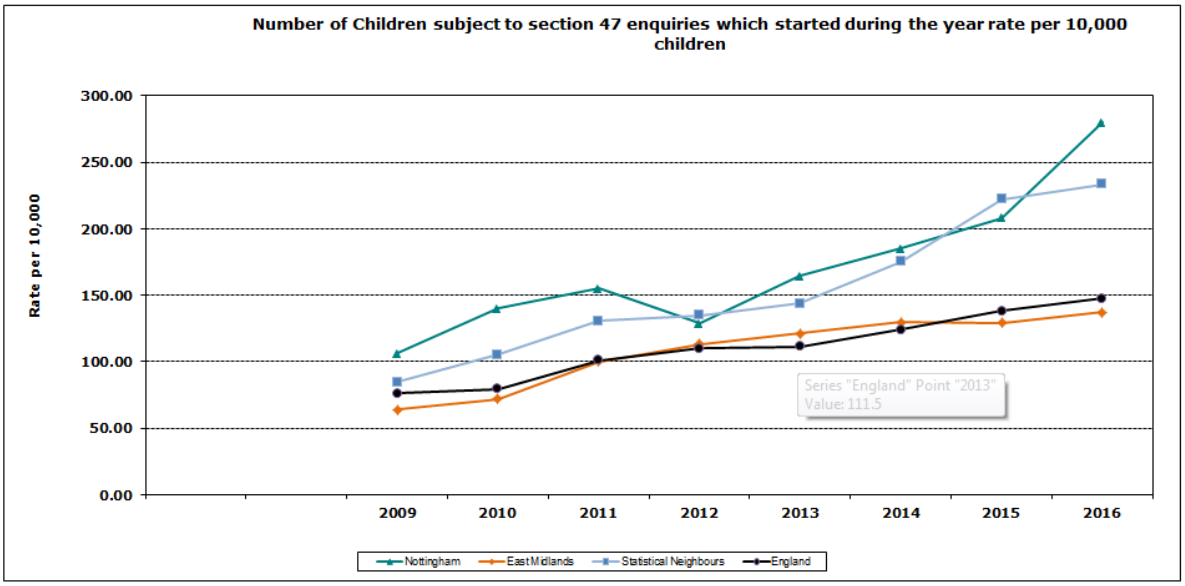


Figure 8: Number of children subject to a section 47 enquiry, rate per 10,000
Source: DfE Statistical First Release, SFR 52/2016

The mechanism underpinning the high, and increasing, rate of section 47 enquiries in Nottingham is unclear and warrants further exploration. Nonetheless, local intelligence suggests that whilst more children and young people in Nottingham are supported through formal safeguarding procedures than in other local authorities, fewer children are re-referred because children, young people and families receive the right support at the right time.

2.3.3 Initial child protection conference

As figure 9 illustrates, in Nottingham, in 2016, the rate of initial child protection conferences (ICPC) was 155 per 10,000 children and young people; more than double the England rate of 63 per 10,000 and higher than the statistical neighbour rate of 85 per 10,000.

In 2016, the Nottingham rate of ICPCs increased by 21 per 10,000; 21 times the England increase of 1 per 10,000. In contrast statistical neighbours saw a decrease of 1 per 10,000 in the same time period.

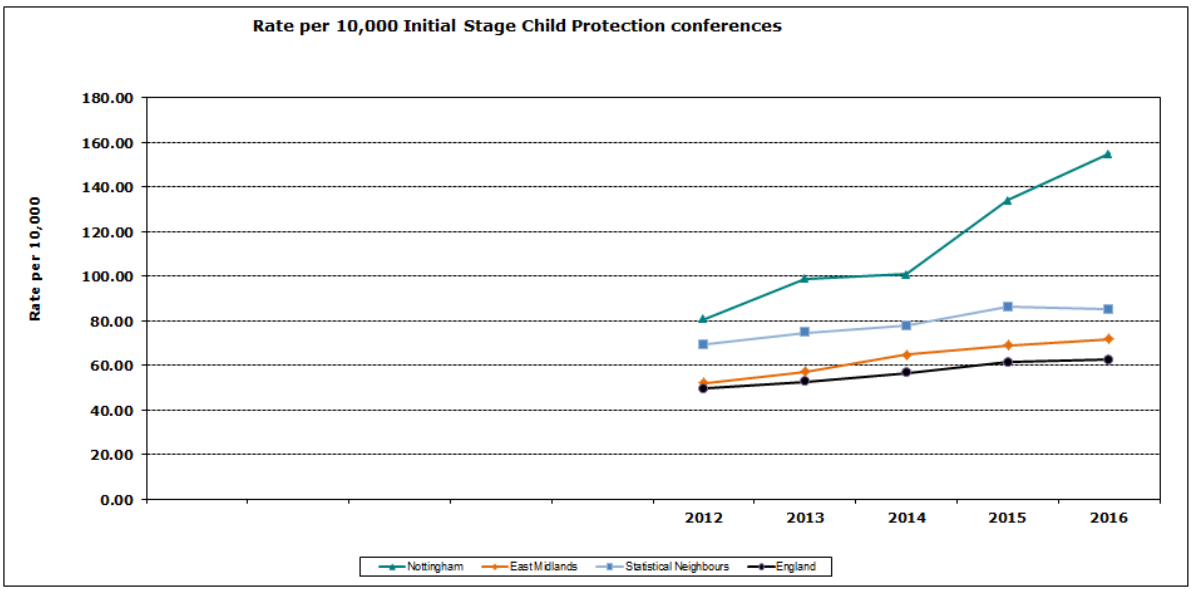


Figure 9: Initial child protection conferences, rate per 10,000, 2012-16
Source: DfE Statistical First Release, SFR 52/2016

As stated in relation to section 47 enquiries, the mechanism underpinning the high, and increasing, rate of ICPCs in Nottingham is unclear and warrants further exploration. Nonetheless, local intelligence suggests that whilst more children and young people in Nottingham are supported through formal safeguarding procedures than in other local authorities, fewer children are re-referred because children, young people and families receive the right support at the right time.

2.3.4 Children in Need

As figure 10 illustrates, in Nottingham, in 2016, the rate of children in need was 547 per 10,000 children and young people; higher than the England rate of 338 per 10,000 and the statistical neighbour rate of 441 per 10,000.

In 2016, the Nottingham rate of children in need increased by 25 per 10,000; higher than the England increase of <1 per 10,000 but lower than the statistical neighbours increase of 31 per 10,000. Whilst the rate increased in 2016, the steep increases observed from 2011-2014 appear to be levelling off.

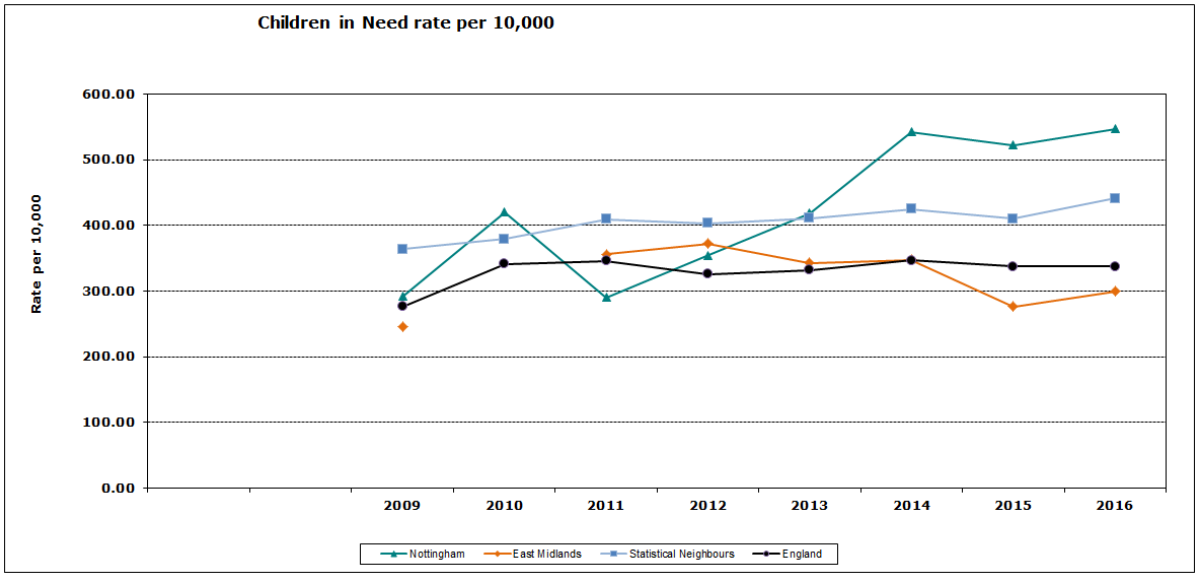


Figure 10: Children in Need rate per 10,000, 2009-16
Source: DfE Statistical First Release, SFR 52/2016

The mechanism underpinning the high rate of children in need in Nottingham is unclear and warrants further exploration. However, it is important to note that there are subtle differences as to how local authorities define a 'child in need', the DfE definition is open to some interpretation, and thus comparisons between Nottingham and other areas should be made with caution.

2.3.5 Children on a child protection plan

As figure 11 illustrates, in Nottingham, in 2016, the rate of children on a child protection plan was 83 per 10,000 children and young people; nearly double the England rate of 43 per 10,000 and higher than the statistical neighbour rate of 57 per 10,000.
In 2016, the Nottingham rate of children on a child protection plan need increased by 2 per 10,000; higher than the England increase of <1 per 10,000. In contrast, statistical neighbours saw a decrease of 4 per 10,000 in the same time period.

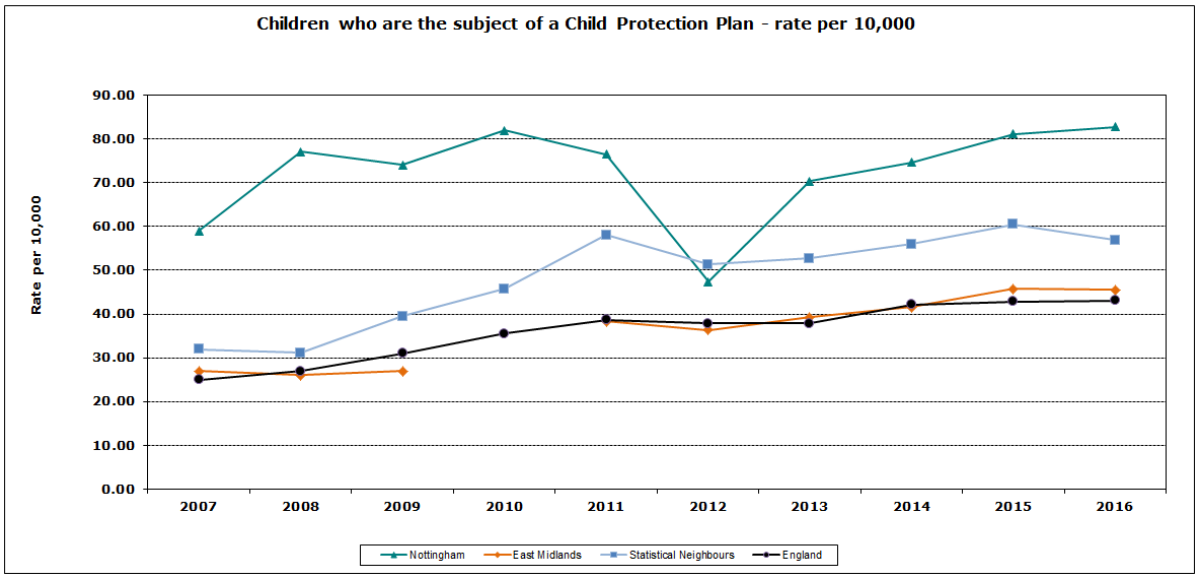


Figure 11: Children who are the subject of a child protection plan, rate per 10,000
Source: DfE Statistical First Release, SFR 52/2016

As stated in relation to section 47 enquiries and ICPCs, the mechanism underpinning the high, and increasing, rate of children subject to a child protection plan, in Nottingham is unclear and warrants further exploration. Nonetheless, local intelligence suggests that whilst more children and young people in Nottingham are supported through formal safeguarding procedures than in other local authorities, fewer children are re-referred because children, young people and families receive the right support at the right time.

2.3.6 Rate of Children in Care

As figure 12 illustrates, in Nottingham, in 2016, the rate of children in care/looked after was 90 per 10,000 children and young people; similar to the statistical neighbour rate of 91 per 10,000 but higher than the England rate of 60 per 10,000.

In 2016, in Nottingham the rate of children in care/looked after increased by 1 per 10,000. The England rate remained unchanged and statistical neighbours saw a decrease of <1 per 10,000 in the same time period.

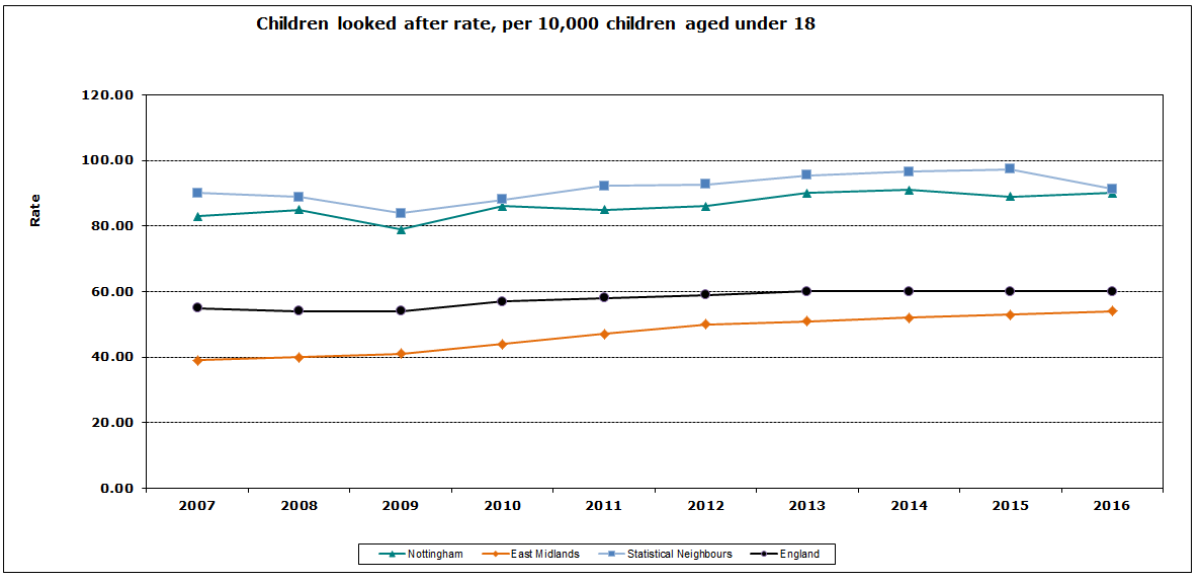


Figure 12: Children Looked After rate per 10,000 children 2007-16
Source: DfE Statistical First Release, SFR 52/2016

For further exploration of data related to children in care/looked after children please see the Children in Care JSNA chapter.

2.3.7 Rate of re-referrals and child protection plans

As figure 13 illustrates, in Nottingham, in 2016, the percentage of re-referrals was 23%; similar to the England rate of 22% and the statistical neighbour rate of 20%. In 2016, the Nottingham rate of children in care decreased by 3%; the statistical neighbour rate also saw a decrease of 3% whilst the England rate decreased by 2%.

The percentage of re-referrals in Nottingham continues to decrease, suggesting that whilst more children and young people in Nottingham are supported through formal safeguarding procedures than in other local authorities, fewer children are re-referred because children, young people and families receive the right support at the right time.

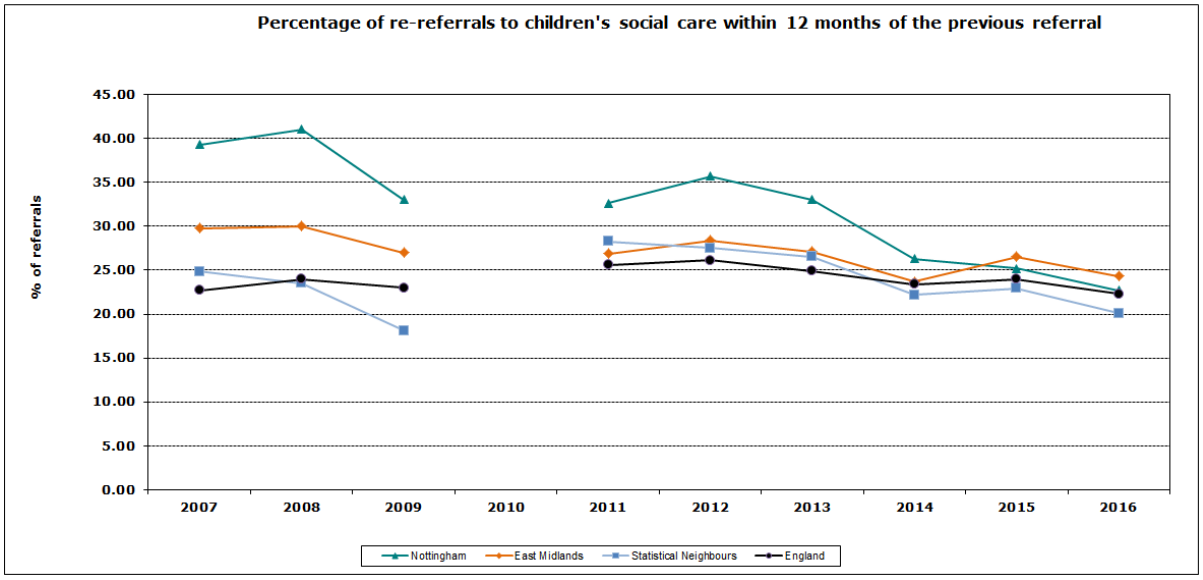


Figure 13: Percentage of re-referrals to children's social care within 12 months of previous referral Source: DfE Statistical First Release, SFR 52/2016

As figure 14 illustrates, in Nottingham, in 2016, the percentage of children becoming subject to a child protection plan (CPP) for a second or subsequent time was 17%; similar to the England rate of 18% and the statistical neighbour rate of 19%.

In 2016, in Nottingham the percentage of children becoming subject to a CPP for a second or subsequent time increased by 1%; the England rate also increased by 1%. In contrast, the statistical neighbour rate also saw an increase of 5% in the same time period.

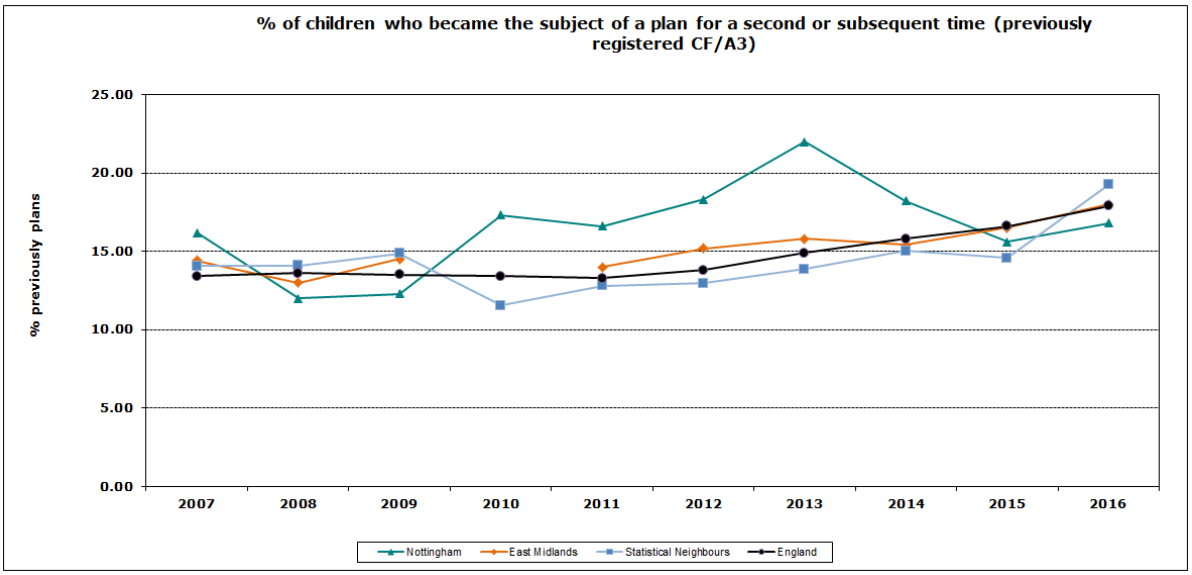


Figure 14: Percentage of children who became the subject of a child protection plan for a second or subsequent time 2007-16
Source: DfE Statistical First Release, SFR 52/2016

2.3.8 Source of referrals

There were 4,016 referrals to children's social care in Nottingham in 2016[12]; a reduction of 311 referrals from 2015.

Figure 15, shows the ten agencies that made the most referrals to children's social care in Nottingham 2008-2016. 'Other' is a broad category that includes referrals from professionals working in the hospital and community and self-referrals. This group of individuals were responsible for 27% (1066/4016) of referrals in 2016.

In Nottingham, in 2016, schools and colleges were the agency responsible for the greatest number of referrals to children's social care making 20% (823/4016) of all referrals; an increase of 2% from 2015. This is unsurprising given the close contact schools have with children, young people and families and the skills staff have in identifying safeguarding concerns.

In 2016, the police were responsible for 20% (799/4016) of referrals; a slight reduction from 21% (912/4327) of referrals in 2015. This reduction follows the ongoing decline in the proportion of referrals from the police established in 2011.

Conversely, learning disability and mental health staff are among the staff group with the lowest referrals to social care making <1% (23/4016) of referrals in 2016, broadly similar to the rate of referral since 2011. The mechanism underpinning this is unclear, particularly as safeguarding procedures and associated training are well embedded in local specialist services. Local intelligence suggests that staff who have limited contact with children, young people and families are less likely to refer and/or are supporting citizens already receiving support from children's social care.

[12] The 4016 referrals noted is up to November 18th so conclusions re year on year comparison are made with caution

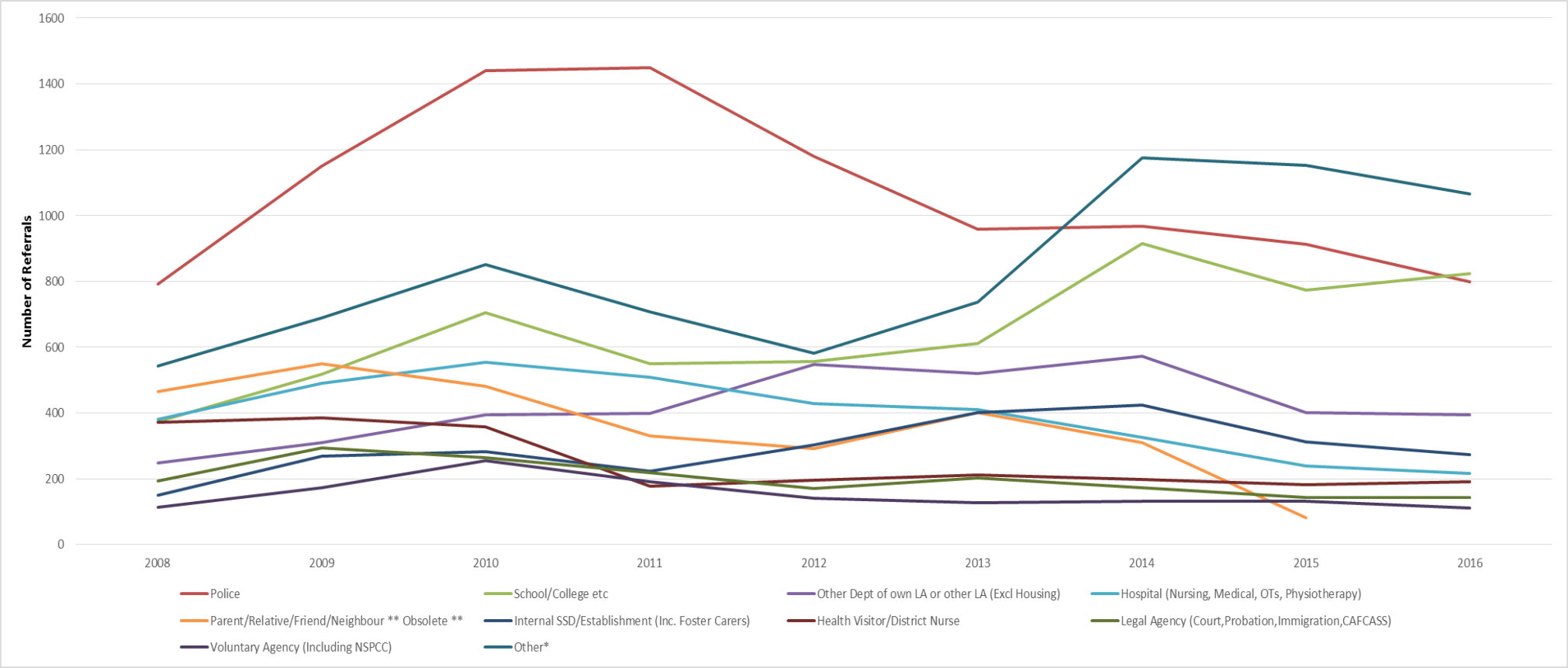


Figure 15 Sources of referral to social care 2008-2016
Source: NCC internal records, January 2017

2.3.9 Child protection plans for physical, mental and sexual abuse or neglect

In Nottingham, in 2015-2016, 826 children/young people became subject of a child protection plan for physical mental and sexual abuse or neglect; 96 children more than the previous year, see figure 16. Statistical neighbours saw a decrease of 51 children/young people in the same time period although; as this is an absolute number rather than a rate conclusions should be drawn with caution.

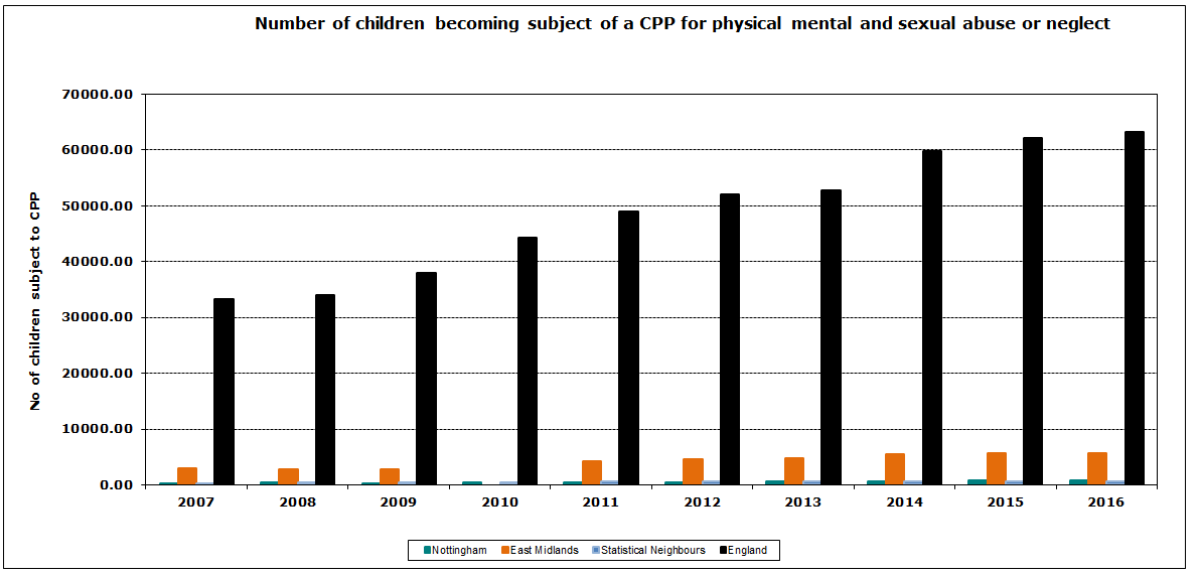


Figure 16: Number of children becoming the subject of a child protection plan for physical, mental and sexual abuse or neglect 2007-16
Source: DfE Statistical First Release, SFR 52/2016

Physical abuse

As figure 17 illustrates, in Nottingham, in 2016, the rate of children who became subject of a child protection plan (CPP) for physical abuse was 16 per 10,000 children and young people. The rate in Nottingham is more than double the statistical neighbour average of 7 per 10,000 and nearly three times higher than the England average of 5 per 10,000.

This is a decrease of 2 per 10,000 in the rate of children who became subject of a CPP for physical abuse from 2015, which is higher than the England average reduction of 0.1 per 10,000 and lower than the statistical neighbour reduction of 9 per 10,000.

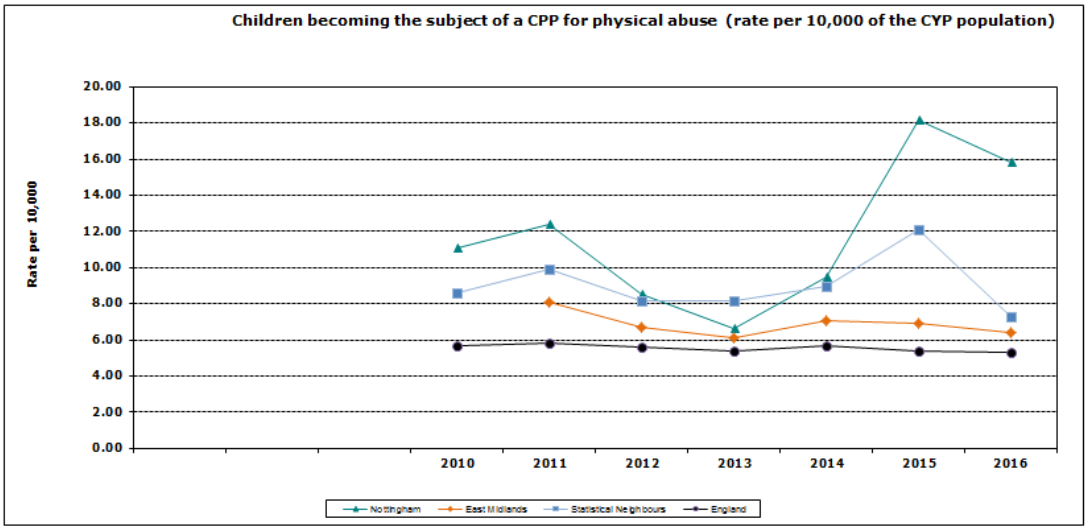


Figure 17: Children becoming the subject of a child protection plan for physical abuse, 2010-16
Source: DfE Statistical First Release, SFR 52/2016

As this reduction follows a sharp increase in 2015 any conclusions regarding a trend in the rate of children becoming subject to a CPP for physical abuse should be drawn with caution. Nonetheless, maintaining the level of investment in local services has ensured that children/young people experiencing physical abuse are identified early and receive appropriate support; where necessary through formal safeguarding procedures.

Emotional abuse

As figure 18 illustrates, in Nottingham, in 2016, the rate of children who became subject of a child protection plan (CPP) for emotional abuse was 65 per 10,000 children/young people. The rate in Nottingham is more than double the statistical neighbour average of 31 per 10,000 and more than three times higher than the England average of 19 per 10,000.

This is an increase of 12 per 10,000 in the rate of children who became subject of a CPP for emotional abuse from 2015 which follows the trend in increase observed from 2012 onwards. The rate of increase in Nottingham is much higher than the England average increase of 1 per 10,000. In contrast statistical neighbours saw a reduction of 1 per 10,000.

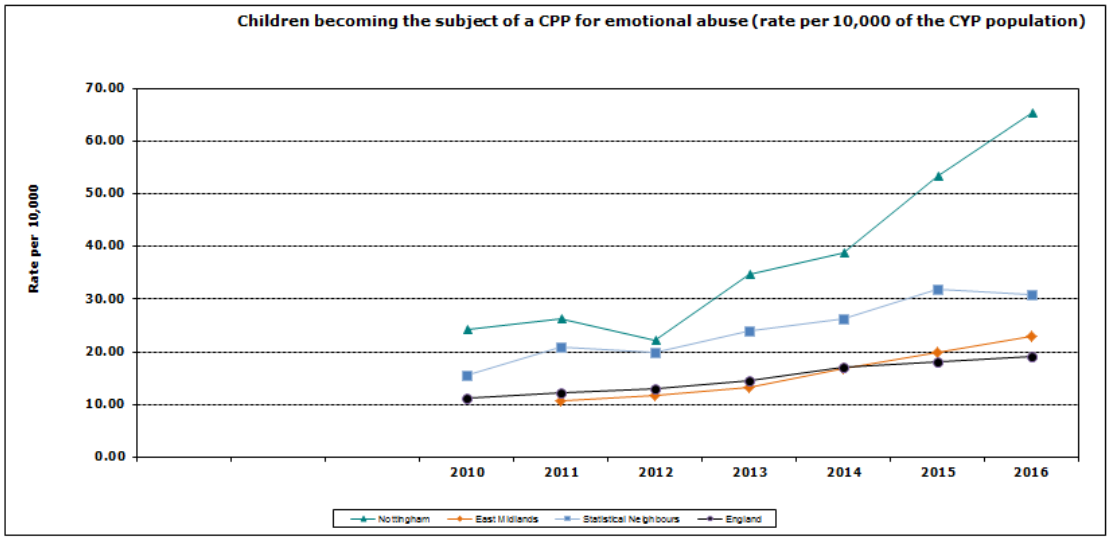


Figure 18: Children becoming the subject of a child protection plan for emotional abuse 2010-16
Source: DfE Statistical First Release, SFR 52/2016

It is unsurprising that the rate of children becoming subject of a CPP for emotional abuse is higher than the statistical neighbour average, and rising, as promoting emotional health and wellbeing is a priority across the city and as such has increased staff awareness of emotional abuse. In addition, in part due to a serious case review, Nottingham's integrated children's integrated services delivery plan has 'healthy minds' as one of three priorities and as such has been discussed at learning events and team meetings.

Local data collection doesn't currently enable an assessment of whether emotional abuse is identified on its own or alongside physical or sexual abuse. Further exploration is warranted.

Sexual abuse

As figure 19 illustrates, in Nottingham, in 2016, the rate of children became subject of a child protection plan (CPP) for sexual abuse was 3.2 per 10,000 children/young people. The rate in Nottingham is similar to the statistical neighbour average of 3.4 per 10,000 and higher than the England average of 2.5 per 10,000.

This is a reduction of 1.4 per 10,000 in the rate of children became subject of a CPP for sexual abuse from 2015 which is higher than the statistical neighbour decrease of 1.2 per 10,000. There was no change in the rate in England in the same time period.

Local intelligence suggests that an increase in referrals to children's social care for sexual abuse, and thus the increase in CPPs related to this abuse, was associated with intense media coverage of historical child sexual abuse which increased the number of children/young people who felt able to disclose abuse.

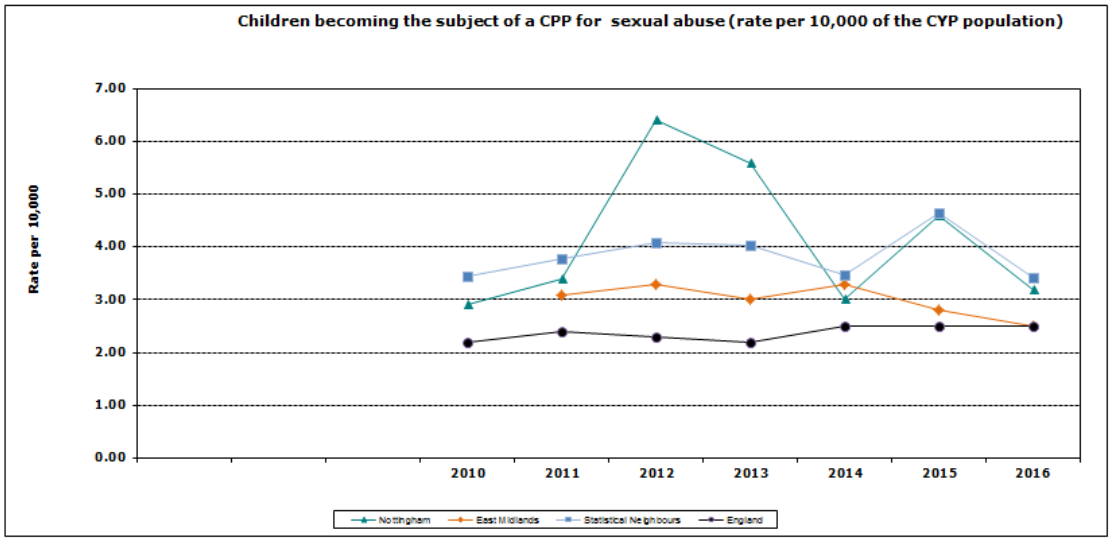


Figure 19: Children becoming the subject of a child protection plan for sexual abuse 2010-16
Source: DfE Statistical First Release, SFR 52/2016

Neglect

As figure 20 illustrates, in Nottingham, in 2016, the rate of children became subject of a child protection plan (CPP) for neglect was 41 per 10,000 children/young people. The rate in Nottingham is higher than the statistical neighbour average of 27 per 10,000 and the England average of 24 per 10,000.

This is an increase of 4.9 per 10,000 in the rate of children became subject of a CPP for neglect from 2015; more than 4 times higher than the England increase of 1.1 per 10,000 and 7 times higher the statistical neighbour increase of 0.65 per 10,000.

Whilst the mechanism underpinning this is unclear, local intelligence suggests that there is an increased awareness in universal, and universal plus services, of the serious consequences of neglect and thus more referrals are made under this category. Once such a referral has been received by children's social care, social worker assessments have identified often serious, neglect issues which lead to children, young people and families receive appropriate support; where necessary through formal safeguarding procedures.

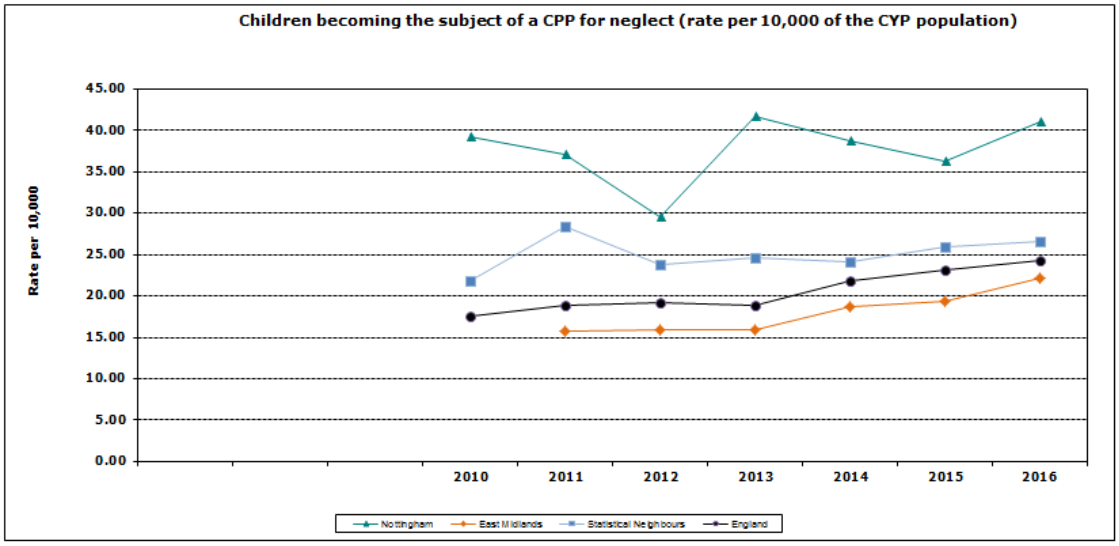


Figure 20: Children becoming the subject of a child protection plan for neglect 2010-16
Source: DfE Statistical First Release, SFR 52/2016

3.0 Targets and Performance

3.1 National targets

The Children's Safeguarding Performance Information Framework[13] describes the key nationally collected data that can enable those involved in child protection, at the local and national levels, to understand the 'health' of the child protection system.

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395653/_2015-01-12__The_Childrens_Safeguarding_Performance_Information_Framework.pdf

The framework is broken down into five themes each of which has national performance indicators and suggestions for how this can usefully be supplemented with local information. The themes are:

• Outcomes for children and young people and their families

• Child protection activity (including early help)

• The quality and timeliness of decision making

• The quality of child protection plans

• Workforce

The Public Health Outcomes Framework and associated 'Fingertips' tools identify a range of outcome measures related to children. Some of these indicators relate specifically to Children in Care, may be indicators of harm or neglect and/or identify factors that may make children more vulnerable. These include:

- Children in Care Immunisations, the proportion of Children in Care who are fully immunised
- Average difficulties score for all Children in Care aged 5-16 who have been in care for at least 12 months
- Children in poverty, under 16s, percentage of children living in low income families
- Infant mortality, rate per 1000 live births
- Proportion of adults in contact with secondary mental health services
- Domestic Abuse, rate of domestic abuse incidents reported by the police per 1000 population
- Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years) , rate per 10,000 resident population

Indicators related to safeguarding children in the **NHS Outcomes Framework** include:

- Preventing people from dying prematurely domain:
    - Infant mortality
    - Neonatal mortality and stillbirths

- Ensuring that people have a positive experience of care domain:
    - Improving children and young people's experience of healthcare

3.2 Local targets and performance

Nottingham Children's and Young People's Plan (CYPP) (2015/16) has two priorities related to safeguarding children.

- Safeguarding and supporting children, young people and families will benefit from early and effective support and protection to empower them to overcome difficulties and provide.
- Empowering families to be strong and achieve economic wellbeing. More families will be empowered and able to deal with family issues and child poverty will be significantly reduced.

For more detail on the plan please see Nottingham City Council : The Children And Young People's Plan (CYPP)

4.0 Current activity, service provision and assets

4.2 Universal Services

4.2.1 Midwifery Service

Maternity services in Nottingham are provided by Nottingham University Hospitals (NUH) and provide community midwifery services, obstetric care, and manage the whole midwifery service.

Within NUH there are specialist midwives who work with vulnerable women specifically for teenage pregnancy, FGM, substance/alcohol misuse, homelessness, DV and perinatal mental health.

4.2.2 Health Visitors and Community Public Health Nursing (5-19 years)

Health Visitors have a statutory responsibility to identify and protect children. The professional remit for all health professionals in the NHS, private sector and other

agencies is enormous. The Nursing and Midwifery Council's Code of Professional Conduct (2002) states: 'Where there is an issue of child protection, you must act at all times in accordance with national and local policies' (Section 5.4). It continues to emphasise that nurses have a responsibility to 'identify and minimise the risk to patients and clients'. These statements, in conjunction with the Children Act (1989) demonstrate that the health professional's role is broad and can be interpreted at several levels.

4.2.3 General Practitioners (GPs)

A GP is a family doctor and is the main point of contact for general healthcare for NHS patients. All UK residents are entitled to the services of an NHS GP. There are 61 GP practices within Nottingham City.

The majority of children and their families in the UK are registered with a GP and general practice remains the first point of contact for most health problems.
GPs and their practice teams have a key role not only in providing high-quality services for all children but also in detecting families at risk, supporting victims of maltreatment and providing on-going care and assessment while contributing to case conferences and care plans.

4.2.4 Schools

There are 75 Primary schools, 17 of Secondary schools, 5 Special Schools and 3 Pupil Referral Units in Nottingham City.

Schools play an essential role in protecting children from abuse. Staff have close, regular contact with children and young people. They're in a strong position to:

- identify child protection concerns early
- provide help and support
- help children understand how to stay safe from abuse
- refer a child to relevant agencies

Schools have a statutory duty to protect children in their care. They must have:

- a child protection policy
- child protection procedures
- a designated lead for child protection - both on the board of trustees and in the senior management team
- safe recruitment processes

The school environment must be a safe place for children and must ensure that adults who work in the school, including volunteers, don't pose a risk to children. Staff should receive training in how to identify and respond to child protection concerns.

4.3 Specialist Services for Safeguarding Children

4.3.1 Designated Nurse and Doctors for Safeguarding

The Designated professionals are clinical experts and strategic leaders for safeguarding. They are a vital source of advice to the CCG, NHS England, the local authority, the LSCB and the Health and Wellbeing Board, and provide advice and support to other health professionals including the Named Professionals for Safeguarding in the provider organisations, quality surveillance groups (QSG), regulators.

4.3.2 Named Professionals for Safeguarding

The Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the LSCB.

4.3.3 Local Authority Designated Officer (LADO)

Working Together 2015 describes the LADO as providing:

> *"…advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure they are dealt with as quickly as possible consistent with a fair process."*

The LADO manages cases where it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Where the above criteria are met, the LADO is responsible for chairing a strategy meeting to consider whether there should be:

- a police investigation of a possible criminal offence
- enquiries and assessment by children's social care about whether a child is in need of protection or in need of services, and
- consideration by an employer of disciplinary action in respect of an individual.

In Nottingham, the LADO is based in the Safeguarding and Quality Assurance Service area in Nottingham City Council. The allegations management team oversees referrals and investigations and is responsible for contributing to the preparation of reports to the Operational Management Group of the Nottingham City Safeguarding Children Board.

Local intelligence suggested that the observed increase in the number of referrals to the LADO reflects both historical abuse and a more rigorous approach to recording the data.

4.4 Nottingham City Council services

Nottingham City Council works in partnership with statutory and voluntary agencies across Nottingham to provide open access services that support families and try to give every child the best start in life. This includes identifying vulnerable families, children and young people who may need safeguarding and promoting the health and well-being of children in need and children in care.

The Children and Families Directorate plan leads thematic work across 'Early Help' to tying together three main areas of focus:

- Learning City/ Healthy minds

- Relationships/ Resilient children
- Families and Communities.

This thematic drive supports the targeted and specialist work with vulnerable families. By early identification of the most vulnerable and through Signs of Safety assessment appropriate support can be offered either through targeted group work or one to one support based around the above themes.

4.4.1 Children and Families Direct (C&FD)

This team forms the front door access to services and includes administration officers, social workers, family support workers, an early support specialist, family support specialist, a senior practitioner and a team manager. It is their role to ensure that referrals and enquiries are dealt with as effectively as possible so that the caller/referrer is not passed on multiple times and the child/family is referred to the service most appropriate to their needs which could be Children's Centres, Targeted Family Support or other agency for example. The team works closely with the duty team and ensures any immediate child protection issues are passed straight through to this team.

4.4.2 The Domestic Abuse Referral Team (DART)

This team is co-located with C&FD and will be made up of family support workers, health colleagues, administration officers and a senior practitioner. The team works closely with C&FD and the duty team to ensure families receive support from the most appropriate service.

4.4.3 Duty and Screening Team

The duty and screening teams of social workers and managers and includes an emergency duty team who works out of hours. The team assesses the referrals that require immediate investigation, working closely with C&FD and social care fieldwork teams.

4.4.4 Children's Centres/Early Help

There are 18 centres consisting of 6 main hubs and 12 reach sites across the city. The 60 family support workers support families with children under 5 providing universal services and additional support around three main areas of focus:

- Learning City/ Healthy minds and relationships
- Resilient children
- Families and communities

The Centres' offer includes 1:1 work with parents/carers, universal groups such as stay and play which support parenting and child development. The Targeted Intervention Plan provides evidence based programmes which address specific issues such as domestic abuse, parenting and attachment and behaviour.

'Play and Youth' are universal services for Children and Young People between the ages of 5-19 (up to 25 years for disabled young people). Delivery takes place from 10 purpose built centres, community venues and parks and open spaces. Targeted work takes place within the sessions to address issues such as healthy eating, being active, staying safe (raising awareness of domestic abuse, sexual health, substance misuse etc.). In 2015/16 Early Help Services reached 7,557 children who attended a total of 104,555 times.

4.4.5 Priority Families

Priority families is part of a government commitment to whole family working, especially, in supporting the families that need help the most. In Nottingham, frontline staff are supported to focus on the whole family, rather than just individuals with 'isolated' issues, sharing the expertise of our huge range of talented staff.

Spending extra time with the whole family supports a focus on the bigger picture at an earlier stage which is better for the family and could reduce the need for costly interventions further down the line. The five key essentials are:

1. Prioritise the families with multiple problems who are of most concern and highest reactive costs
2. Appoint a key worker/lead worker for each family who manages the family and their problems
3. Work towards agreed goals for every family for each of the headline problems which are shared and jointly owned across local partners
4. Be transparent about outcomes, benefits and costs
5. Engage in ongoing service reform according to evidence of effectiveness and savings

The eligibility criteria for priority families are:

- Parents and children involved in crime/anti-social behaviour
- School attendance and exclusions
- Children who need help – children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness
- Families affected by domestic violence/abuse
- Parents and children with a range of health problems

4.4.6 Targeted Family Support

These teams consist of Family Support Workers, a Team Manager and a Family Support Practice Specialist. They work closely alongside Children's Social Care and Early Help Services providing support to children and their families who require extensive support in dealing with a multiple issues. As most of the families in need of this service meet the Priority Family criteria they are subject to a Family Assessment for those that don't, or are not willing to consent, the CAF process is applied. 2119 children across 1039 households were allocated to TFST teams at some point during 2015/16.

Priority Family Accredited Practitioners also work with identified families and support Family Support Workers in applying the priority families approach.

4.5 Specialist services that support vulnerable children, young people and families

4.5.1 CAMHS

Children and young people who need safeguarding or who are 'looked after' are more likely to develop mental health problems than their peers. The Behavioural, Emotional and Mental Health (BEMH) pathway supports professionals working with children or young adults, and their parents/carers, who have emotional health or wellbeing needs. The pathway can also be directly accessed by parents/carers and young adults. The pathway is for children and young adults registered with a Nottingham City GP aged from 0-19 years or to 24 years for young adults with a special education need (SEN) or a learning disability (LD).

Specifically, the BEMH pathway is for children and young people who present with concerns about their behaviour, emotional wellbeing or mental health and/or concerns about possible ASD or ADHD. The pathway aims to:

- Identify at the earliest opportunity where emotional wellbeing support is needed
- Ensure that the right early intervention and support strategies are put in place,
- Guide referrals to existing services provided by partner organisations across Nottingham City, this may include referrals to more specialist services
- Join-up current services and support for emotional wellbeing into a seamless pathway
- Enable timely multi-disciplinary assessment by the most appropriate professional
- Ensure there is ongoing person-centered support planning and that multi-agency support is implemented

In addition to assessment the BEMH team provide parenting programmes including specialised programmes for the parents/carers of children with a diagnosis of autism or ADHD.

For more information go to; Pathway for Children and Young People with Behavioural, Emotional or Mental Health Needs

The CAMHS LAC team works with children and young people up to 18 years old who are looked after and living away from their birth parents, in the care of Nottingham City Council .

These children and young people may be living with foster carers or living in residential care. The team will also offer specialist consultation and support to children and young people who have been adopted, and their families.

4.5.2 Multi-systemic Therapy (MST)

A programme of intensive therapy delivered to young people aged 11-17 most in need who are at risk of out of home placement either into care or custody due to either offending or severe behaviour issues. The team consists of 4 Therapists and a Supervisor providing round the clock support to young people.

4.5.3 Multi-systemic Therapy for Child Abuse and Neglect (MST CAN)

Newly introduced in December 2015 MST CAN provides intensive support to children 6-17 and their families who have involvement with child protection services in the category of Child Abuse and Neglect. The evidence based programme addresses the specific problems which led to the family into CP services. The main aim is to keep families together whilst ensuring that children are safe. The team consists of 3 therapists, 1 case manager, and 1 part-time psychiatrist and 1 supervisor.

4.5.4 Services to support children and young people affected by parental substance use

Explore Families (Lifeline) works with children and families affected by their own or others use substance misuse. The service works with individuals and whole families to reduce the impact of substance misuse, support recovery, and challenge the inequalities linked to drugs and alcohol in Nottingham City.

The **Integrated Adult Drug & Alcohol Treatment & Support Service** works with adult substance users providing a wide range of treatment and support which includes reducing harm to individuals, families, children and the community as a direct or indirect result of substance misuse.

The service identifies children affected by adults substance misuse, assesses the impact and risk, including identification of any safeguarding concerns, and responds accordingly through care planning, referral and joint work with other agencies. There are clear requirements for taking risks to children into account when providing pharmacological treatment including safe storage.

4.5.5 Stronger Families

Stronger Families is a support programme commissioned from Women's Aid integrated Services which supports families where domestic abuse has occurred. Children attend group sessions over 12 weeks, where a safe space is created to talk and learn alongside other children who have been through similar experiences.

4.5.6 Action for Young Carers

The Action for Young Carers service supports approximately 300 young carers a year. Between July 2015 and March 2016 the service supported 90 young carers of people with mental health conditions.

4.5.7 Youth Offending Service

Three locality teams deliver statutory specialist youth justice and crime prevention in relation to children and young people and their families. Working with partner agencies, the teams work to strengthen protective factors against further offending, and ensure that children and young people completing YOT interventions have access to the full range of universal services to maximise their life chances. Partners include Police, Probation, Futures and Health.

4.5.8 Family Intervention Project (FIP)

Working with young people and their families who are at risk of being made homeless due to anti-social behaviour, the team consists of 6 practitioners and a manager. All these cases fit the Priority Families criteria and are thus worked according to this approach.

4.5.8 Safe Families for Children project

Safe Families for Children (SFFC) is a volunteer organisation that gives support to families in crisis. It has proven highly effective in reducing family breakdown, preventing child neglect and abuse, and has brought about significant reductions to the numbers of children entering the care system. Nottingham has participated in Safe Families for Children (SFFC) since 2015. A rigorous, longitudinal evaluation of the work in the UK commenced in 2015.

Referrals are made from Childrens Social Care Fieldwork Teams and the Targeted Family Support Team. The referrals are children who are identified as Sbeing in need

but must not include those children with a Child Protection Plan. SFFC offers befriending to the family, hosting overnight stays, day outs and resources such as providing essential household items and practical help such as redecorating or garden clearance.

There is a small central staff team who screen referrals in and support the volunteer workforce. Volunteers are recruited and are subject to full background and home environment checks and provided with developmental opportunities alongside some mandatory training. The majority of volunteers are recruited through the Christian church, plans to widen to other faith and non-faith citizens is currently underway and will be completed by March 2017.

5. Evidence of What Works

NICE Guidance

Antenatal and postnatal mental health: clinical management and service guidance

http://www.nice.org.uk/guidance/cg192

This guideline covers recognising, assessing and treating mental health problems in women who are planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year. It covers a broad range of common and more serious mental health problems and promotes early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth.

This guidance is particularly relevant to safeguarding as children living with parents who have mental health problems are more likely to need safeguarding especially when there is also parental substance use and domestic violence.

Child maltreatment: when to suspect maltreatment in under 16s

http://www.nice.org.uk/guidance/cg89

This guidance provides a summary of clinical features associated with child maltreatment, described as alerting features that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated.

Domestic violence and abuse overview

http://pathways.nice.org.uk/pathways/domestic-violence-and-abuse

This pathway covers how to help identify, prevent and reduce domestic violence and abuse. Although it does not specifically reference 'child abuse', it does reference the importance of strategies to support for children who are affected by domestic violence and abuse.

Alcohol-use disorders overview

http://pathways.nice.org.uk/pathways/alcohol-use-disorders

This pathway covers prevention, diagnosis and management of alcohol-related disorders, including hazardous and harmful drinking, alcohol dependence and the physical complications of alcohol use in adults and children and young people aged under 18 years in educational institutions. This guidance is particularly relevant to safeguarding as children living with parents who misuse alcohol or other substances are more likely to need safeguarding especially when there is also parental mental health problems and domestic violence.

Looked-after children and young people

http://www.nice.org.uk/guidance/ph28

This guideline identifies the actions needed to improve the quality of life, including physical health, and social, educational and emotional wellbeing, of looked-after children and young people. The focus is on ensuring that organisations, professionals and carers work together to deliver high quality care, stable placements and nurturing relationships for looked-after children and young people.

Looked-after children and young people

http://www.nice.org.uk/guidance/qs31

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. This quality standard defines best practice for the health and wellbeing of looked-after children and young people.

Primary prevention initiatives support children, young people and families so they don't become at risk of abuse, neglect and/or exploitation. The evidence includes:

School-based Education Programmes: Walsh et al, 2015 found evidence that school-based sexual abuse prevention programmes were effective in increasing children's' skills in protective behaviours and knowledge of sexual abuse prevention concepts. Knowledge gains do not deteriorate overtime. In terms of harm, there was no evidence that programmes increased or decreased children's anxiety or fear. Children exposed to a child sexual abuse prevention programme had greater odds of disclosing their abuse. The long-term benefits of programmes to reduce incidence or prevalence of child sexual abuse in children, has not been adequately established.

Universal Campaigns: The evidence for universal campaigns designed to prevent child physical abuse remains inconclusive (Poole et al, 2014). Such campaigns have targeted risk factors such as lack of knowledge regarding positive parenting techniques,

parental impulsivity, stigma of asking for help, inadequate social support and inappropriate expectations for a child's development stage.

Early intervention initiatives successfully reduce the need for children and young people to enter formal safeguarding processes. The evidence includes **Home Visiting for Families Experiencing Domestic Abuse:** A systematic review by Prosman et al, 2015 found home visiting interventions to be effective in reducing domestic violence although long term effectiveness was unknown. Children who witness domestic violence are known to have poorer emotional health; there is also a high risk of physical abuse in families with domestic violence. The review showed that interventions focused on reducing domestic violence also reduce child abuse and prevented intergenerational transmission of domestic violence.

Home visiting is an intervention that ensures vulnerable women with children stay in contact with regular services as they are usually considered hard to reach. The support is thus beneficial for both abused mothers and their children.

Evidence also identifies strategies to **prevent further abuse and enable children and young people to return home following time in local authority care.**

Parenting Programmes on Child Maltreatment: According to a meta-analysis by Chen et al, 2016 parenting programmes successfully reduced substantiated and self-reported child maltreatment reports. The programmes also reduced risk factors and enhanced protective factors associated with child maltreatment. Parent behaviours such as child physical and psychological abuse and neglect are targeted. An effective public health approach applied as primary, secondary and tertiary child maltreatment intervention in all settings, for all groups.

Return home is more likely to succeed where it is planned and a thorough assessment has been undertaken [(50)]. Other factors identified as supporting stable return home include having a clear plan intended to secure a staged return; involvement of children and families in reunification planning , addressing the underlying problems that lead to

entry into care; the provision of family-focused interventions and the availability of services/support (Farmer and Wijedasa, 2012[14]; Thobunet et al, 2012[15]).

Taking Care: Practice Framework for Reunification: The pilot framework by NSPCC[16] intended to provide a robust and evidence-based system of assessment and decision making, reducing the risk of abuse and/or neglect recurring where children or young people are returned home, and to improve children's outcome. This was to be used by Local Authority social workers when deciding whether a child can be returned home. The framework also informed and supported work with children and families throughout the reunification process, including when a child has returned home. The framework fits with the wider Local Authority objectives of reducing the number of looked-after children by providing safe reunification and only bringing back into care where appropriate.

The evaluation of the framework (Hyde-Dryden et al, 2015) which was piloted across 9 Local Authorities between 2012 and Nov, 2014 reported the following:

- A total 325 children were supported
- Parents considered the practice framework for reunification assessment/process to be better. In their opinion it was in depth, there were engagement roles for both parents and their children.
- The use of an NSPCC social worker to complete direct work was considered as one of the key strengths for the assessment process. NSPCC independence from the LA was the most important factor.
- Professionals reported the framework provided a clear structure thus greater transparency concerning the objectivity of the assessment process. This view was corroborated by some parents.
- Helped produce clear evidence to identify which form of support were appropriate for children and parents in each case, including the use of multi-agency support.
- The framework was suitable for all eligible cases: all groups, ages and legal status

[14] Farmer, E. and Wijedesa, D. (2012) The Reunification of Children in care with their Parents: What Contributes to Stability? *British Journal of Social Work 44* (2). p.348-366

[15] Thoburn, J., Robinson, J. and Anderson, B. (2012) *Returning Children Home from Public Care.* Social Care Institute for Excellence (SCIE): Research Briefing 42

[16] NSPCC – National Society for the Prevention of Cruelty to Children

Key limitations and concern about the framework and its implementation:

- There was no systematic monitoring of the outcome for children returning home. We are therefore unable to ascertain the effectiveness of the intervention on reducing recurrence.
- Limited number of families and social workers involved in evaluation. Although the findings provide valuable insight cannot be generalised as the collective experience of social care staff and parents/carers.
- Concerns were expressed about the additional time and resource implications of aspects of the framework.

Interventions for Offenders: The evaluations of these interventions show mixed/inconclusive results. A recent systematic review of research on interventions for individuals at risk of abusing children found research in this area was inconclusive (Långström et al, 2013[17]), a finding also reached by a Cochrane Collaboration review (Dennis et al, 2012[18]). Other meta-analysis has, however, concluded that, overall, sex offenders who receive treatment, in both prison and community settings, have a somewhat lower sexual reconviction rate than those who do not receive treatment (Hanson et al, 2002).

Whilst some cognitive behavioural treatment (CBT) programmes have been found to be effective in reducing sexual and general reoffending, not all have. Other similar approaches (psychotherapy, counselling and non-behavioural treatment) have generally not been found to reduce reconviction. Pharmacological treatment (for example, hormonal drugs that reduce sexual drive) has been shown to reduce sexual reoffending (Schmuker et al, 2008[19]). Reviews have concluded that sexual offender programmes that follow the Risk, Need and Responsivity principles lead to the largest reductions in reconviction (Hanson et al, 2009[20]).

[17] Långström, N., Enebrink, P., Laurén, E. M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: systematic review of medical and psychological interventions. *BMJ: British Medical Journal*, *347*.

[18] Dennis et al (2012) *Psychological interventions for adults who have sexually offended or are at risk of offending (Review)*, The Cochrane Collaboration

[19] Schmuker & Lösel (2008) 'Does sexual offender treatment work? A systematic review of outcome evaluations', *Psicothema 2008,* 20 (1)

[20] Hanson, Bourgon, Helmus, & Hodgson (2009) The principles of effective correctional treatment also apply to sexual offenders: A Meta-analysis, *Criminal Justice and Behavior*, 36, 865–891

According to the Ministry of Justice summary of evidence on reducing reoffending, (Transforming Rehabilitation,2014) research suggests that medium and high-risk sexual offenders benefit most from treatment, while low-risk sexual offenders demonstrate negligible benefits, and intensive treatment could, in fact, be counterproductive.

6. What is on the horizon?

The number of children and young people aged 15 years and under is projected to increase by 2,700 by 2020 reflecting the recent increase in birth rate (ONS Mid 2012 population projections). This estimate does not include children arriving in Nottingham from Europe and further afield. If the proportion of children and young people requiring safeguarding increases in tandem there will be increased pressure on services.

Nottingham is an increasingly diverse city. New and emerging communities in Nottingham City including refugee and asylum seeking families with children are less well understood than our settled communities; further insight is required into their safeguarding needs.

Nottingham is seeing an increasing number of unaccompanied asylum seeking children (UASC) and young people including those resettled from the Calais camps and reunited with families. By their nature UASC are vulnerable and may have additional health and social care support needs. Thus it is challenging to anticipate the effect on local services.

The implementation of Liquid Logic and the integration of the data the system enables will enable increasing ability to target activity. It is unclear how this will translate into operational practice.

Austerity increases family stress and puts pressures on services. Nottingham City Council is mitigating these affects by protecting children's services wherever possible and investing in services to reduce financial vulnerability in families but it is unclear what long term impacts might be. In addition, the fragile and fixed term funding of

family support services leads to increase targeting of provision and less universal and open access services. It is unclear what the impact of this will be in the medium and longer term.

Whilst national and international evidence suggests that 'early help' has a long-term positive effect on the need for safeguarding it is unclear, in Nottingham, when this investment will lead to cost savings.

The Wood Review and social work reform, if adopted into government policy, will change the organisation and delivery of safeguarding processes. The direct impact on children, young people and families, if any, is not known.

Integration of services is a key tenant of current government policy and is being implemented locally in health and children's services. Long-term evaluation will be needed to see if this results in improved outcomes for children, young people and families.

7. Local Views

The 2016 Report on Children's Wellbeing in Nottingham was conducted by the Children's Society in Nottingham City Survey in summer 2015. It asked children about their feelings about their lives as a whole alongside their opinions on more specific issues and different aspects of their lives.

The survey findings found that:

- Children and young people in Nottingham City are relatively happy with their lives overall and have slightly higher subjective well-being than the U.K average. However, 11.5% of children in the survey had low levels of subjective well-being.
- Young people in secondary school are generally less happy about their lives compared to primary school children, with further gender differences: Secondary school girls are particularly less happy about their lives and school. The findings suggest that secondary school girls experience different kinds of pressures and constraints compared to secondary school boys.

- Compared to the UK average, children and young people in Nottingham City are more likely to have negative opinions about adults in their local area, as well as safety and freedom in their local area.
- Many of the children surveyed reported being worried about different types of crime. 38% of children in the survey said they had experienced some form of crime. This is equivalent to around 9,800 children aged 8 to 15 in Nottingham City experiencing crime. Unsurprisingly, experience of crime was related to lower levels of well-being.

In Nottingham City the **Child's Voice** is used to describe processes by which children's voices are heard to enable understanding of their experience and actively involve them in decisions about their lives and provide evidence on how their voice has influenced professional decision making. As a Signs of Safety (SOS) implementing Local Authority Nottingham City Council works in true partnership with children and their families.

Long-standing participation and engagement opportunities include through the Children in Care Council and annual *Have Your Say* survey. In addition, the planned roll out of *Mind of My Own (MOMO)* in March 2017 will further enhance opportunities for young people to share their views and experiences with key professionals.

The Children in Care ***Have Your Say*** survey has been conducted annually since 2011. The survey enables the local authority to capture the opinion of Children in Care and care leavers in relation to the commitments made to children through the Children in Care charter.

Children in Care's views are collected under broad headings. Findings from the 2016 survey found that:

- There has been an increase in the proportion of Children in Care who felt that their carer and social worker treated them with **respect** 'all or most of the time', and a decrease in those who felt they were 'never' treated with respect.

- 71% felt that social workers had enough **time** for them all/most of the time. Less children/young people felt that their social workers 'never' had enough time for them.

- Awareness and willingness to use the Children in Care **advocacy** service has increasing to 13% in 2016 from 7% in 2015. 87% knew where to go if they needed support or wanted to make a complaint.

- An increasing proportion of Children in Care feel **listened to** by their social workers, carers and teachers 'only sometimes'. 94% felt their carers and 86% felt their social workers listened all/most of the time.

- **Involving our Children in Care.** 83% of Children in Care felt that their opinions are heard and make a difference to their life all/some of the time.

- **Keeping our Children in Care safe and well.** Children in Care who felt where they lived was the right place for them has decreased to 79%.

- **Supporting our Children in Care to be healthy.** 93% of children stated they felt healthy all the time; however, 16% reported feeling worried all or most of the time.

- **Supporting our Children in Care to achieve at school and elsewhere.** 62% of Children in Care felt they were doing well at school. An increasing proportion of children, 62%, knew about their personal education plan and were involved in drawing up their plan.

- **Preventing unnecessary changes for Children in Care.** 27% of children experiencing no change in social worker, school, home or carer, continuing the downward trend since 2014.

- **Helping Children in Care achieve a successful journey into independent adulthood**. The proportion of children who are happy or very happy with the support they receive to plan for their future has increased to 91%.

- **Overall rating**. An increasing proportion of Children in Care, 82%, stated that they were happy/very happy with how NCC takes care of them; the second highest proportion since the survey started.

8. Unmet needs and service gaps

- The number of public health nurses (5-19) (formally known as school nurses) have been steadily in decline which has decreased the extent to which they can be involved in packages of care around safeguarding. It is currently unclear whether the integrated commissioning model will enable public health nurses to provide additional support to safeguarding packages of care for children and young people aged 5-19 years.

- The Nottingham City Council Early Help Service is working with families and children who have additional needs as well as delivering open access provision. This presents a challenge in providing sufficient capacity for open access services across the city and creates a tension between moving resources towards early intervention whilst still needing to provide more targeted support to stop needs escalating.

- The cost of specialist placements for children and young people is high, including those out of the city. In addition, specialist care sometimes means that children/young people are placed some distance away from their family and social networks.

- The number of children in care in Nottingham places a significant financial burden on the local authority. Reducing the number of children in care could release savings for investment in other areas such as ‘edge of care’ and/or early help services.

- Local intelligence suggests that worklessness and/or poverty is increasing family stress which decreases the capacity to parent effectively. It is currently unclear whether this will lead to more children/young people requiring safeguarding.
- The number of CAFs has decreased as more priority family assessments are undertaken; local intelligence suggests all partners are not clear which assessment is needed when.

- More assessments of children/young people in Nottingham identify risks related to parental mental health problems than the statistical neighbour average but

Learning Disability and Mental Health staff are less likely to refer to social care than other professionals.

- New and emerging communities in Nottingham City, including refugee and asylum seeking families with children and unaccompanied asylum seeking children, are less well understood than our settled communities. More insight is needed into their safeguarding needs.

- Whilst local intelligence suggests children and young people with SEND are over-represented in the population that need safeguarding, current data does not enable an accurate assessment of whether these children and young people are over represented in safeguarding in line with the national picture.

- The rate of children/young people who become subject to a child protection plan (CPP) for physical abuse, emotional abuse and/or neglect are all higher than the statistical neighbour average the mechanism underpinning this is not fully understood.

9. Knowledge gaps

- There is insufficient high-quality research on what interventions are successful in reducing offences against children, specifically, sexual re-offending.

- Further insight is needed into the safeguarding needs of new and emerging communities including refugee families and children and unaccompanied asylum seeking children.

- Current data from CareFirst does not enable an accurate assessment of whether children and young people with special educational needs and disabilities (SEND) are over represented in safeguarding in line with the national picture. It's unclear whether the implementation of Liquid Logic will inform a better understanding of the safeguarding needs of children/young people with SEND.

- Current data collection does not enable an assessment of what proportion of children/young people in Nottingham are affected by the triology of risk/toxic trio

- The rate of children/young people who become subject to a child protection processes, e.g. becoming subject to a Child Protection Plan are higher than the statistical neighbour average. This is an issue which has been subject external scrutiny through inspection and peer review which found evidence of good practice locally. That said, the mechanism underpinning these discrepancies merits further exploration.

The rate of children/young people who become subject to a child protection plan (CPP) for **physical abuse, emotional abuse and/or neglect are all higher than the statistical neighbour average. Whilst local intelligence suggests that this is because children/young people are identified early and receive appropriate support, where necessary through formal safeguarding procedures, further exploration is warranted.**

10. Recommendations for commissioners

1. Commissioners should ensure through integrated commissioning of 0-19 services, that there are ssufficient health visitors and public health nurses 5-19s (formally school nurses) to support universal provision for children and young people in Nottingham City in order to identify early safeguarding concerns and participate in packages of care.

2. The Nottingham City Council Early Help Service is working with families and children who have additional needs as well as delivering open access provision. This presents a challenge in providing sufficient capacity for open access services across the city. Integration of universal and early help services across the 0-5 pathway should be commissioned in a way that enables early support whilst also providing more targeted support to stop needs escalating.

3. The cost of specialist placements for children and young people is high and can mean that children/young people are placed some distance away from home. Work should be undertaken to explore whether more local, specialist placements can be developed to ensure children/young people receive they need closer to home and to release cost-savings.

4. The number of Children in Care in Nottingham is financially challenging for the local authority. Whilst the edge of care interventions appear to be stabilising the numbers of children/young people coming into care these interventions need to be embedded and sustained in order to release funding to continue to invest in early intervention activities.

5. Local intelligence suggests that worklessness and/or poverty is increasing family stress which decreases the capacity to parent effectively and may lead to more children/young people requiring safeguarding. Investment in early intervention and support services, alongside services to reduce financial vulnerability, may mitigate some of this stress.

6. The number of CAFs has decreased as more priority family assessments are undertaken. Local intelligence suggests all partners are not clear which assessment is needed when thus more training/communication may be needed specifically around clarity in the family support pathway.

7. More assessments of children/young people in Nottingham identify risks related to parental mental health problems than the statistical neighbour average but Learning Disability and Mental Health staff are less likely to refer to social care than other professionals. The mechanism underpinning this is unclear thus further exploration is warranted.

8. New and emerging communities in Nottingham City including refugee and asylum seeking families with children and unaccompanied asylum seeking children are less well understood than our settled communities; further insight is required into their safeguarding needs.

9. Current data does not enable an accurate assessment of whether children and young people with special educational needs and disabilities (SEND) are over represented in safeguarding in line with the national picture. Further exploration of this group, e.g. through a case note review, will contribute to a better understanding of the safeguarding needs of children/young people with SEND.

10. Current data collection does not enable an assessment of what proportion of children/young people in Nottingham are affected by the triology of risk/toxic trio. Further exploration is warranted in order to inform local action.

11. The rate of children/young people who become subject to a child protection processes, e.g. becoming subject to a Child Protection Plan are higher than the statistical neighbour average. This is an issue which has been subject external scrutiny through inspection and peer review which found evidence of good practice locally. That said, the mechanism underpinning these discrepancies merits further exploration e.g. through a peer review and/or quality assurance audit process.

Appendix 1: Policy, guidance and reports

Policy

The United Nations Convention on the Rights of the Child (UNCRC) is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so enshrined children's rights.

The **Children Act (1989)** requires local authorities to give due regard to a child's wishes when determining actions to be taken to protect them. These duties complement requirements relating to the wishes of children who are, or may be, looked after including those who are provided with accommodation and children taken into police protection.

The Act introduced the concept of significant harm as the threshold which justifies compulsory intervention in family life in the best interests of children with section 47 placing a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. 'Harm' being defined as ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill treatment of another. Ill-treatment included sexual abuse and other forms of ill treatment that are not physical.

The **Children Act (2004)** stated that Local Safeguarding Children Board (LSCB) must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

Regulation 5 of the Local Safeguarding Children Boards Regulations (2006) further defined the functions of the LSCB including developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority and communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.

The **Equality Act 2010** puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity including ensuring that no child or group of children is treated less favourably due to a protected characteristic such as ethnicity or disability.

The **Serious Crime Act (2014)** contains a number of wide-ranging provisions to pursue, disrupt and bring to justice, serious and organised criminals and gangs. The Act strengthens the law around female genital mutilation (FGM) by extending the extra-territorial jurisdiction of the offence; provides anonymity for victims; creating a new civil protection order; and a new offence of failing to protect a girl from FGM and placing a new duty on professionals, including teachers, to notify the police of such offences.

Guidance

Working Together to Safeguard Children (2015) identified two key principles:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

Children's social care reform: A vision for change (2016)[21] outlines the government's reform vision and acts as a precursor to the children's social care strategy.

The programme aims to radically to reform the children's social care system, ensuring practice excellence and achieving more for children is paramount. Reforms are structured around three areas:

- People and leadership, bringing the best people into the social care profession and giving them the right knowledge and skills including so they can develop as leaders equipped to nurture practice excellence.
- Practice and systems, creating the right environment for excellent practice and innovation to flourish.
- Governance and accountability, making sure that data is used to show strengths and weaknesses in the social care system and develop

[21] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491968/Childrens_social_care_reform_a_vision_for_change.pdf

innovative organisational models that have the potential to radically improve services.

Information on local policies can be found by following the hyperlinks below:

Children and Young People's Plan

Children in Care Sufficiency Strategy 2016 - 2018

Family Support Strategy and Pathway

[i] Appleby et al, 2016 The National Confidential Inquiry into Suicide or Homicide by people with Mental Illness, University of Manchester

Bibliography

1. **HM Government.** *Working together to safeguard children.* London : Crown Copyright, 2015.

2. **Cleaver H, Nicholson D, Tarr S & Cleaver D.** *Child Protection, Domestic Violence and Parental Substance Misuse.* London:Jessica Kingsley : Family Experiences and Effective Practice, 2007.

3. **Point, Turning.** *Turning Point (2011). Bottling it up: The next generation. The effects of parental alcohol misuse on children and families.* London : Turning Point, 2011.

4. **Brandon, M., Bailey, S., Belderson, P., Gardner R., Sidebotham, P., Dodsworth, J., Warren, C., Black, J. (2009).** *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07.* s.l. : DCSF Research report DCSF - RR129, 2009.

5. **Templeton, John Adamson and Lorna.** *Silent Voices- Supporting children and young people affecting parental alcohol misuse.* London : The Children's Commissioner, 2012.

6. **Manning V, Best D, Faulkner N & Titherington E.** New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health.* 9, 2009, Vol. 377.

7. **Cuthbert C, Rayns G & Stanley K.** *All Babies Count. Prevention and protection for vulnerable babies.* London : NCPCC, 2011.

8. **Delargy D, Shenker D, Manning J & Rickard A.** *Swept under the carpet: Children affected by parental alcohol misuse.* London : Alcohol Concern, 2010.

9. **Seeman MV, Gopfert M. . In Gopfert M, Webster J, Seeman MV.** *Parenthood and adult mental health Parental Psychiatric Disorder: Distressed Parents and their Families.* New York : Cambridge University Press, 2004.

10. **Parker G, Beresford B, Clarke S, Gridley K, Pitman R, Spiers G, et al.** *Research Reviews onPrevalence, Detection and Interventions in Parental Mental Health and Child Welfare: Summary Report.* York : Social Policy Research Unit, 2008.

11. **Penny Bee, Peter Bower, Sarah Byford, Rachel Churchill, Rachel Calam, Paul Stallard, Steven Pryjmachuk, Kathryn Berzins, Maria Cary, Ming Wan and Kathryn Abel.** The clinical effectiveness, cost-effectiveness and acceptability of community-based interventions aimed at improving or maintaining quality of life in children of parents with serious mental illness: a systematic review. *NICE .* 2014, Vol. 18, 8.

12. **Office of the Deputy Prime Minister.** *Mental health and social exclusion,.* London : ODPM, 2004.

13. **Gopfert M, Webster J, Seeman MV.** *Parental Psychiatric Disorder: Distressed Parents and Their Families.* Cambridge : Cambridge University Press, 1995.

14. **Bowker, L., Artbitell, M. and McFerron, J.** *Domestic violence factsheet: children.* Bristol : Women's Aid Federation of England, 1998.

15. **Peter Sidebotham, Marian Brandon, Sue Bailey, Pippa Belderson, Jane Dodsworth, Jo Garstang, Elizabeth Harrison, Ameeta Retzer and Penny Sorensen.** *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014.* London : Department for Education, 2016.

16. **Sullivan, P.M., & Knuton, J.F.** Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect.* 24, 2000, Vols. 10 1257-12173.

17. *Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies.* **Jones, L., et al.** 9845, s.l. : Lancet, 2012, Vol. 380.

18. **Sullivan P.M., and Knutson J.F.** Maltreatment and disabilities:a population based epidemiological study. *2000.* 24,, Child Abuse and Neglect, Vols. 10, 1257–1273.

19. **Spencer, N., Devereux, E., Wallace, A., Sundrum R., Shenoy, M., Bacchus, C. and Logan, S.** Disabling Conditions and Registration for Child Abuse and Neglect: A Population-Based Study. *Paediatrics.* 2005, Vols. 116, pp609-613.

20. **Mandell, D.S., Walrath, C.M., Manteuffel, B., Sgro, G. and Pinto-Martin, J.A.** The Prevalence and Correlates of Abuse among Children with Autism Service in Comprehensive Community-Based Mental Health Settings. *Child Abuse and Neglect,.* 2005, Vol. 29.

21. **McElearney, A., Scott, J., Stephenson, P., Tracey, A. and Corry,.** *The Views of Principals, Teachers and Other School Staff in Relation to Teaching "Keeping Safe" Messages in Primary Schools in Northern Ireland.* Belfast : NSPCC, 2011.

22. **The Home Office.** *Identifying and exploring young people's experience to risk, protective factors and resilliance to drug use.* London : The Home Office, 2007. ISSN 1477-3120.

23. **Peter McCarthy, Karen Laing and Janet Walker.** *Offenders of the Future? Assessing the Risk of Children and Young People being involved in criminal and anti social behaviour.* Norwich : Majesty's Stationery Office, 2004.

24. **Young, T, Fitzgerald, M and Hallsworth, S & Joseph,.** *Groups, gangs and weapons.* London : Youth Justice Board, 2007.

25. **Day, C and Hibbert, P and Cadman.** *(Unpublished) A literature review into children abused and/or neglected prior to entering custody.* s.l. : Commissioned by the Youth Justice Board.

26. **Duffy, M & Gillig, S eds.** *Teen gangs: A global view.* London : Greenwood Press., 2004.

27. *"The concentration of offenders in families, and family criminality in the prediction of boy's delinquency".* **Farrington, D, P.** 579-596, s.l. : Journal of Adolescence, 20001, Vol. 24.

28. **Margo, J.** *Make me a criminal: Preventing youth crime.* London : Institute for Public Policy Research., 2008.

29. **Department for Education.** *Children who run away from home or who go missing or care.* London : Department of Education, 2014.

30. **The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers.** *REPORT FROM THE JOINT INQUIRY INTO CHILDREN WHO GO MISSING FROM CARE.* London : The Children's Society, 2012.

31. **Commissioner, The Children's.** The Children's Commissioner. [Online] 18 August 2015. http://www.childrenscommissioner.gov.uk/inquiry-child-sexual-exploitation-gangs-and-groups.

32. **Society, The Children's.** *Still Running 3:Early findings from our third national survey of young runaways .* London : The Children's Society, 2011.

33. **Sinclair, I., Baker, C., Wilson, K. and Gibbs, I.** *Foster children: where they go and how they get on.* London : Jessica Kingsley Publishers, 2005.

34. **Fernandez, E. and Lee, J.S.** 'Returning children in care to their families: factors associated with the speed of reunification',. *Child Indicators Research.* 4, 2011, Vols. 4 pp 749–65.

35. **Thoburn, J.** *Reunification of children in out-of-home care to birth parents or relatives a synthesis of the evidence on processes,practice and outcomes,.* Munich : German Youth Institute, 2009.

36. **Sinclair, I., Baker, C., Lee, J. and Gibbs, I.** *The pursuit of permanence: a study of the English care system, Quality Matters in Children's Services series.* London : Jessica Kingsley Publishers, 2007.

37. **Lietz, C.A. and Strength, M.** Stories of successful reunification: a narrative study of family resilience in child welfare, Families in Society. *The Journal of Contemporary Social Services.* 2, 2011, Vols. 92 b pp 203–210.

38. **Delfabbro, P., Jeffreys, H., Rogers, N.,Wilson, R. and Borgas, M.** A Study into the placement history and social background of infants placed in South Australian out-of-home care 2000–2005 predictors of subsequent abuse notifications. *Children and Youth Services Review.* 2, 2009, Vols. vol 31, pp 219–226.

39. **Farmer, E. and Dance, C. with Beecham, J., Bonin, E. and Ouwejan, D.** *An Investigation of Family Finding and Matching in Adoption. Executive Summary.* London : Department for Education, 2010.

40. **Farmer, E. and Wijedasa, D.** The reunification of looked after children with their parents: What contributes to return stability? *British Journal of Social Work.* 10, 2012, Vols. 1-19.

41. **Department for education.** *Improving permenence for looked after children.* London : Crown Copyright, 2013.

42. **Farmer, E., Sturgess, W., O'Neill, T. and Wijedasa, D.** *Achieving Successful Returns from Care: What Makes Reunification Work?* London : British Association for Fostering and Adoption, 2011.

43. **Becker, S.** *'Young Carers', in M. Davies (ed.) The Blackwell Encyclopedia of Social Work.* Oxford : Blackwell, 2000.

44. **Department for Education.** *Children in need census.* London : Department for Education, 2014.

45. **Jütte, S. et al.** *How safe are our children? The most comprehensive overview of child protection in the UK.* London : NCPCC, 2015.

46. **Biehal, N. et al.** *Keeping children safe: allegations concerning the abuse or neglect of children in care: final report.* London : NSPCC, 2014.

47. **Department for Education.** *26. Department for Educarion. Conception to age 2- the age of opportunity. .* Croydon : Wave Trust, 2013.

48. **Miller-Perrin, C.L. and Perrin, R.D.** *Child maltreatment: an introduction.* London : SAGE, 2013.

49. Emotional abuse at a glance. *NSPCC.* [Online] 2016. https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/emotional-abuse/.

50. **Department for Children, Schools and Families.** *Safeguarding Children and Young Pdeople from Sexual Exploitation: Supplementary Guidance to Working Together to Safeguarding Children.* London : HMSO, 2009.

51. Female genital mutilation: Fact sheet. *World Health Organisation.* [Online] February 2016. http://www.who.int/mediacentre/factsheets/fs241/en/.

52. Prevalence of FGM. *World Health Organisation.* [Online] 2016. http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/.

53. **McManus S, Bebbington P, Jenkins R, Brugha T. (eds.).** *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* Leeds : NHS Digital, 2016.

54. Reunification: an evidence-informed framework for return home practice. *NSPCC.* [Online] 2015. https://www.nspcc.org.uk/services-and-resources/research-and-resources/2015/reunification-framework-return-home-practice/.

55. **Wade, J., Biehal, N., Farrelly, N. and Sinclair,.** *Maltreated Children in the Looked After System: A Comparison of Outcomes for Those Who go Home and Those Who do Not.* London : DfE Education Brief, 2010.

56. **Commissioner, The Children's.** *Iinquiry child-sexualexploitation gangs and groups.* London : The Children's Commissioner, 2015.

57. **Berelowitz, S. et al.** *I thought I was the only one. The only one in the world. The Office of the Children's Commissioner's inquiry in to child sexual exploitation in gangs and groups: interim report London.* London : Office of the Children's Commissioner., 2012.

58. **Department for Children, Schools and Family.** *Safeguarding Children and Young People from Sexual Exploitation.* London : Department for Children, Schools and Family, 2009.

59. **al., Beckett H et.** *Research into gang-associated sexual exploitation and sexual violence: interim report .* Luton : University of Bedfordshire, 2012.

60. **Department of Health.** *Health Workiing Group Report Child Sexual Exploitation.* London : Department of Health, 2014.

61. **Centre, Child Exploitation and Online Protection.** *Out of mind, out of sight: breaking down the barriers to child sexual exploitation: executive summary.* London : Child Expoitation and Online Protection Research Centre, 2011.

62. **Barnardo's.** *Cutting them free: how is the UK progressing in protecting its children from sexual exploitation .* London : Barnardo's, 2012.

63. *Census.* London : Office for National Statistics, 2011. http://www.ons.gov.uk/ons/rel/census/2011-census/detailed-characteristics-for-local-authorities-in-england-and-wales/index.html.

64. **Social Care Institute for Excellence [SCIE].** *Research briefing 11: The health and well-being of young carers .* London : s.n., 2005. http://www.scie.org.uk/publications/briefings/briefing11/index.asp#users.

65. **Aldridge, J. and Becker, S.** *Children Caring for Parents with Mental Illness:Perspectives of Young Carers, Parents and Professionals.* Bristol: : The Policy Press., 2003.

66. **Society, Carers Uk and The Children's.** *Dearden, C and Becker, S (2004) Young Carers in the UK: The 2004 Report.* London : s.n.

67. **Glover, V. Sutton, C.** Support from the Start: effective programmes in pregnancy. *Journal of Children's Services.* 2012, Vol. 7, 1 8-17.

68. **O'Connor, T. G. Heron, J. Golding, J.Beveridge, M. Glover, V.** 29 Maternal antenatal anxiety and children's behaviour/emotional problems at 4 years. *British Journal of Psychiatry,.* 2002, Vol. 180, 502-8.

69. **Talge, N.M. Neal, C. Glover, V.** Early stress, translational research and prevention science network: fetal and neonatal experience on child and adolescent mental health. . *Journal of Child Psychology and Psychiatry.* 2007, Vol. 48, 245-61.

70. **Ofsted.** *Learning Lessons from Serious Case Reviews: Year 2.* 2009. www.ofsted.gov.uk/resources/learning-lessons-serious-case-reviews-year-2.

71. **ONS.** *Alcohol related deaths.* London : ONS, 2012.

72. **NSPCC.** NSPCC. [Online] 8 August 2015. http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/what-is-neglect/.

73. **(UKHTC, Serious Organised Crime Agency (SOCA) and UK Human Trafficking Centre.** *A Strategic Assessment on the Nature and Scale of Human Trafficking in 2012.* London : s.n., 2013.

74. **Meltzer, H. et al.** *The mental health of young people looked after by local authorities in England .* London : The Stationary Office, 2003.

75. **M, Diggins.** *Think Child, Think Parent, Think Family: a Guide to Parental Mental Health and Child.* London : Social Care Institute for Excellence, 2011.

76. **Force, Social Inclusion Task.** *Reaching Out: Think Family .* s.l. : Cabinet Office,, 2007.

77. **NSPCC.** NSPCC. *NPSCC.* [Online] 2016. [Cited: 07 June 2016.] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/child-sexual-exploitation/.

78. *Survey of BACCH and BACD members and Child Development Team leads.*