Derby Safeguarding Children Board

Annual Report 2014 - 2015

Preface

The Children Act 2004 (Section 14a) requires Local Safeguarding Children Boards (LSCBs) to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report is the annual review of the work of the Derby Safeguarding Children Board for the financial year 1st April 2014 to 31st March 2015.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period. (Working Together 2015, Chapter 3, paragraph 17)

The report should demonstrate the extent to which the functions of the LSCB as set out in Working Together 2015 are being effectively discharged.
The statutory functions of the LSCB are to:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of Working Together to Safeguard Children 2015;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

This is a public report that will be formally presented to the City Leadership Board and to the Children, Families and Learners Board, the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.

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Contact details:	The Derby Safeguarding Children Board can be contacted on Telephone: 01332 717811 or Email: dscb@derby.gov.uk

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1.1 Welcome to Derby Safeguarding Children Board's annual report for 2014-15. This is a public report which sets out the work of the Board and its understanding of the effectiveness of safeguarding arrangements across the city. It is intended to inform the decisions made by the leaders of services and those who fund and commission local services. This report also aims to give everyone who lives and works in Derby a sense of how well local services and people in the community are working together to keep children safe.

1.2 This report has two main sections. In the first we describe what we have done to co-ordinate safeguarding activity across partners; in the second we describe the Board's work in monitoring the effectiveness of safeguarding within and across agencies. Some of our work is undertaken jointly with Derbyshire Safeguarding Children Board, which I also chair. A number of our partner agencies cover both city and county areas and children of course cross the city county boundary daily for school or for leisure activities. It is therefore important that the two Boards work closely together and that we have the same policies and procedures for protecting children.

1.3 Our focus for the past year has been on early help for families, domestic violence and child sexual exploitation. We are able to report on good outcomes for children and families receiving early help, better understanding of the needs of families where there is domestic abuse offered and effective support for children at risk of sexual exploitation, but the Board would like to see further evidence of positive impact in these areas. These will therefore continue to be priorities in the coming year alongside monitoring the impact of budget reductions and ensuring that all agencies continue to give priority to safeguarding, including early help.

1.4 Derby Safeguarding Children Board is constantly looking for ways to increase its effectiveness in making children safer. I would like to acknowledge the commitment of staff across all agencies in supporting the work of the Board.

2 Introduction

2.1 The purpose of this Annual Report is to:

- provide an outline of the main activity and achievements of the Derby Safeguarding Children Board during 2014 – 2015;
- provide an assessment of the effectiveness of safeguarding activity in Derby;
- provide the general public, practitioners and main stakeholders with an overview of how well children in Derby are protected;
- identify gaps in service development and any challenges ahead;
- priorities for action 2015 – 2016

2.2 "Safeguarding and promoting the welfare of children" is terminology used throughout this report. Working Together 2015 defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

"Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone's responsibility. Everyone who comes into contact with children and families has a role to play."

2.4 References to reports used to write this report are included to show where the information was obtained. It is important that this report is transparent about the sources of information whilst acknowledging that the content of many of the reports is not available to the public.

Characteristics of Derby

2.5 Derby is a unitary authority with a population of 244,625, an increase of 12.2% since the last census in 2001[1] (in contrast to an East Midlands increase of 8.7% and England increase of 4%). There are 64100 children and young people under 19 living in Derby.

2.6 From 2001 – 2011 there was a population increase of 27,100 (12.2%), with the largest change contributed by the Asian / Asian British people with an increase of 12,600 (68.1%). There have been increases in complex families, especially larger family units and migrant families from Eastern Europe.

2.7 The Black and Minority Ethnic (BME population in Derby has increased from 15.7% in 2001 to 24.67% in 2011. Additionally, Derby has 3,300 more children under the age of 4 in 2011 than it did in 2001 and the city has experienced a higher than average population growth over the same period of time.

[1] 2011 Census Summary, Derby City Council (20/01/14)

2.8 Derby has higher than national averages of children living in the most deprived wards and living in poverty. Derby has a higher rate of unemployment including long term and youth unemployment than the East Midlands and England. Derby children and young people are more likely to have poorer health outcomes that have a direct impact on the welfare of children and young people. The extent of these challenges is illustrated on the children and young people's health benchmarking tool from Public Health England[2].

[2] http://fingertips.phe.org.uk/profile/cyphof/data#page/0

3 Executive Summary

3.1 The Derby Safeguarding Children Board has worked with partner agencies over the year to drive forward good standards of practice that keep children and young people safe. This has been achieved by understanding how effective are local services at identifying and responding to the needs of children and young people and where improvements are needed.

3.2 The work that the Derby Safeguarding Children Board does to understand how well children and young people are kept safe is shared with the organisations and partnerships that decide what the priorities are for the development of services in Derby.

3.3 The full report sets out the detail of how the Derby Safeguarding Children Board has gathered information from looking at records from individual children or young people or groups of similar cases to find out what difference is being made by the work that is being done (called case file audits). The Derby Safeguarding Children Board also gathers information from reports that have been produced by different agencies that describe in detail how a particular service has helped keep children and young people safe.

3.4 The Derby Safeguarding Children Board has a business plan to make sure it carries out the tasks that have been identified from the previous year to improve how children and young people are kept safe. Last year there were three main areas for development.

3.5 Early Help is provided to families to make sure that the support they need at an early stage helps them and prevents their circumstances from getting worse. An in depth report showed how Early Help is supporting families in Derby. The report tells us how families are able to say for themselves how services have helped them or not.

3.6 Overall the report shows how Early Help services from a range of different agencies are improving the circumstances of families. The report also says where there are areas for improvement and is commented upon in detail in section 14. There has been an improvement in the information that has been used to demonstrate the quality the services received by children and their families. This provides assurance to the Derby Safeguarding Children Board about the quality of services and the effective management oversight that is occurring.

3.7 Domestic Violence and Abuse affects the lives of many children and families and the Derby Safeguarding Children Board wanted to make sure that the local services are helping in the right way at the right time. During the year Derby City Council carried out a review of domestic violence services and arrangements across the council. The police requested an independent review of how well the multi-agency meetings are working that look at very serious cases of domestic abuse (these are called multi-agency risk assessment conferences - MARAC).

3.8 The reports show that there has been an improvement in how well people understand what needs to be done to support victims of domestic violence and abuse. Some further improvements could be made to understand what difference is made and what people think of the support they receive. There are plans for a multi-agency team to be set up in Derby to respond to concerns about domestic violence and abuse in the coming year and the Derby Safeguarding Children Board wants to make sure the new arrangements are helpful and keep families safe. Further comment is set out in section 16.

3.9 The Derby Safeguarding Children Board continues to closely examine the work being carried out to prevent and protect young people from Child Sexual Exploitation. Staff who work with young people and teachers were asked about how they respond when young people go missing to find out if they think about risks of sexual exploitation. Staff told us that they do consider these risks and described how they are working different ways to make sure young people are safe. When serious concerns have been raised about individual young people, they have been involved in the meetings to look at what support they need.

3.10 The Derby Safeguarding Children Board receives reports about how the support is reducing the risk to young people. It is extremely positive that multi-agency services have been able to show that they continue to work together to reduce the risk towards young people who are vulnerable to sexual exploitation. Further comment is set out in section 19.

3.11 In addition to the main themes, here is a summary of the other work carried out as part of the business plan during this year:

- Sections of the safeguarding children procedures were updated to help staff take action to keep children safe
- Young people worked with us to design posters in schools to help explain what good relationships are and where to get help if you are concerned. These posters have been sent to all secondary schools.
- Senior members of staff from the Derby Safeguarding Children Board provided information to explain how changes in their organisations affected the work people do to keep families safe.
- A Training Validation Scheme was put in place to make sure that the quality of safeguarding training was good enough and three organisations had their training approved.
- All agencies were asked to set out exactly which safeguarding training key staff needed to complete. Some agencies worked well and have clear plans in place. The remaining agencies will be challenged to complete this work in the coming year.
- Work was completed with the Safeguarding Adults Board to put in place a joint on line booking system for all staff in any setting to book onto courses to help them keep children or adults safe.
- The way in which the different sub groups of the Derby Safeguarding Children Board work together has been improved. This has led to a better understanding of local difficulties in the way people work, why they have occurred and what works best. This is called Learning and Improvement

Framework and it has helped identify how we can help all staff develop their local skills and knowledge to keep children and young people safe.

- We have carried out work with a young person and their family to help us understand their views of the support they received. This has helped us have a better understanding of how we can improve the support provided to families in similar circumstances.
- Young people have helped us make two films, one about forced marriage and one film about self-harm. Both films are used in our training and one film is on our website. Young people and staff are telling us that these films have helped them understand the issues better and helping them in their work.
- We have carried out research and have been able to give staff a better understanding across agencies of things that make young people vulnerable. This is particularly important when young people are unsafe for a number of reasons for example: sexual exploitation, homelessness and substance misuse.
- We have looked at whether the support for new parents and babies has improved as a result of the introduction of guidance for staff called the Pre-Birth Assessment and Intervention Protocol. We have found some improvement and identified whether further improvement is still needed.
- We have found out information to understand the risks to the health and safety of children and young people from new psychoactive substances (otherwise known as *legal highs*). We have been involved in working out the best way to tackle the problems and this will be work we carry on next year.
- We have improved our understanding of how children placed in Derby and in the care of other Local Authorities are kept safe. We know that they need support from local services and we are making sure that steps are taken so that they receive this support.
- We have received a report that tell us that young people who have committed crimes have been helped to stop offending and how the work of different organisations has helped keep them safe. We have also received a report about the work being carried out to help children and young people from new communities get into schools and be healthy and safe.
- We have produced information to make sure that all staff can keep children and young people at risk of Female Genital Mutilation safe.

3.12 The Derby Safeguarding Children Board judges that the way in which agencies and their staff have worked together has kept children and young people safe. The information gathered during the year shows how staff are alert to possible problems and have taken action to keep children safe. This information is set out in the full annual report.

3.13 Information included in the report also shows how the increase or decrease in the range of services that support families has been looked at and monitored by the Derby Safeguarding Children Board. Steps have been taken to keep up to date and understand proposed changes to different services and how children, young people, their families and staff might be affected.

3.14 The Derby Safeguarding Children Board recognises that progress has been made in many areas, but there is still much to do.

3.15 In this coming year we need to make sure we increase the ways in which children, young people and their families are able to tell us if they are safe and receiving the support that will keep them safe.

3.16 We need to obtain the views of staff on what they think about the support that is being provided by their own and other agencies. We need to know whether they are concerned about changes to the way organisations are providing services and whether this is making children and young people less safe.

3.18 We need to make sure all organisations are able to show us what support their staff provide to keep children and young people safe and how they can demonstrate that their services are making a difference.

4	Coordinating Local Work to Safeguard and Promote the Welfare of Children	

4.1 The Derby Safeguarding Children Board has two objectives, as detailed in the Children Act (2004) and Working Together to Safeguard Children (2015) and this report details the progress against each of these objectives, as follows:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and
- to ensure the effectiveness of what is done by each such person or body for that purpose.

4.2 The body of the report falls into two main sections to reflect these two objectives.

- The coordination function is described in sections 5 to 12
- Ensuring effectiveness is described in sections 13 to 38

5	Governance and Accountability	

5.1 The governance arrangements for the Derby Safeguarding Children Board were reviewed following publication of Working Together to Safeguard Children 2015 and will be ratified at the meeting of the Derby Safeguarding Children Board in September 2015. The governance arrangements now set out joint working arrangements with Derbyshire Safeguarding Children Board.

5.2 The Independent Derby Safeguarding Children Board Chair has held twice yearly meetings with the Chief Executives and officers of all partner agencies in Derby (and Derbyshire) to monitor the priorities of the Derby Safeguarding Children Board. Partner agencies are demonstrating their commitment at the highest level to prioritise safeguarding and promote dialogue at an early stage and at a time of ongoing significant pressures on services.

5.3 The local authority Chief Executive, in partnership with the Lead Member and Director of Children's Services, scrutinised the work completed the Independent Derby Safeguarding Children Board Chair to ensure the effectiveness of the Derby Safeguarding Children Board. The progress and plans of the Derby Safeguarding Children Board were judged to be appropriate.

5.4 The Derby Safeguarding Children Board has put in place a risk register to formally record concerns about multi agency safeguarding arrangements and action taken to resolve them. The concerns recorded include issues affecting how organisations work together. Concerns about individual cases are not generally recorded here but continue to be addressed at an operational level by the practitioners and managers involved in the cases. Concerns about the impact of multi-agency working on individual cases along with concerns about serious child care incidents are considered by the Serious Case Review Panel.

5.5 The Business Plan is scrutinised at each quarterly Derby Safeguarding Children Board meeting and progress on the actions being taken by each sub group is illustrated to enable effective monitoring and challenge. This approach has enabled particular barriers to the completion of two tasks to be identified. For example action was successfully taken to obtain assurance to demonstrate that arrangements to safeguard children who self-harm were being monitored and audited appropriately.

5.6 During the year the Derby Safeguarding Children Board amended governance arrangements to embed the work of the Education Hub as a formal Sub Group to strengthen and support work with the education sector partners. The Workforce Group terms of reference were updated to improve the reporting arrangements so that workforce capacity, staff training and development, and allegations against staff functions can be more clearly monitored and reported upon.

6	**Relationship to the Derby City and Neighbourhood Partnerships Boards and Local Justice Boards**	

6.1 The responsibilities of the Derby Safeguarding Children Board are complementary to those of the Derby City and Neighbourhood Partnerships Boards with responsibilities for children and families to promote co-operation to improve the wellbeing of children in Derby. (These include the Leadership Board; Health and Wellbeing Board; Children Families and Learners Board and Derby Safeguarding Adults Board)

6.2 The Derby Safeguarding Children Board ensures that its priorities are shared with the other partnership boards. The Annual Report and Business Plan were formally presented to the City Leadership Board and to the Children, Families and Learners Board, the Chief Executive, Leader of the Council, the local police and crime commissioner and the Health and Wellbeing Board. In addition to the priorities set out in the annual report, additional priorities that emerged during the year have been raised, such as concerns around arrangements to safeguard children from new psychoactive substances leading to establishing a multi-agency strategy and action plan led by Public Health.

6.3 Over the last year the Independent Derby Safeguarding Children Board Chair has continued to be an active participant at the Children Families and Learners Board and the Derby City Partnership Leadership Board.

6.4 The Derby Safeguarding Children Board meeting arrangements include specific standing agenda items in respect of the Health and Wellbeing Board, Children Families and Learners Board and Derby Safeguarding Adults Board.

6.5 The Derby Safeguarding Children Board reports directly to the partnership Leadership Board and to the Children, Families and Learners Board, but is not an operational sub-committee of either.

6.6 The Derby Safeguarding Children Board role is to ensure the effectiveness of the arrangements made by wider partnership and individual agencies to safeguard

and promote the welfare of children. Individual partner agencies are requested to report on the impact of changes to their arrangements at quarterly meetings and are challenged by other members to provide additional reports on critical areas and the impact on safeguarding such as the development of the Multi Agency Safeguarding Hub.

6.7 As part of its role to monitor local partnership strategies, the Derby Safeguarding Children Board has provided feedback and challenge has been made to make sure sufficient focus is given to safeguarding children. For example the Health and Wellbeing Strategy has been challenged to include arrangements that safeguard children and challenge was made to obtain an up to date Joint Strategic Needs Assessment. The completion of the Joint Strategic Needs Assessment is awaited and will be monitored on an ongoing basis so that the Derby Safeguarding Children Board can be confident that local safeguarding needs are comprehensive and kept up to date.

6.8 The Derby Safeguarding Children Board regularly liaises with the officers and Chair of the Derby Safeguarding Adult Board. This enables the sharing of priorities and joint “Think Family” issues and has led to joint strategic development such as online booking arrangements for safeguarding training that has improved access for practitioners to training relevant to both areas of practice. Joint work has been carried out to ensure that the implications of the Care Act 2014 are understood and the impact addressed as the roles for both adult and children’s safeguarding arrangements have shared objectives.

6.9 The Director of Children’s Services is a member of the Derby Safeguarding Children Board and reports on Children, Families and Learners Board (CFLB) matters to all Derby Safeguarding Children Board meetings. The Derby Safeguarding Children Board seeks to provide challenge and scrutiny to the work of the CFLB ensuring that in the commissioning, planning and delivery of services, the safeguarding of children is paramount in the CFLB’s decision making.

6.10 The Children and Young People’s Overview and Scrutiny Board focusses on safeguarding and child protection arrangements across the local authority and regularly holds officers to account at performance surgeries. The Derby Safeguarding Children Board has both provided reports and received updates from the scrutiny board. The Review of Serious Case Reviews and Learning Reviews 2008-2014 was formally reported to the scrutiny board to provide independent evidence of the impact of changes arising from the reviews and the contribution of the local authority and partner agencies. Arrangements are in place for increased involvement in the work of the scrutiny board in the coming year, particularly in respect of scrutiny of the arrangements for children who are missing and children at risk of child sexual exploitation.

6.11 The Derby Children and Young People's Plan during 2013 – 2015 includes the priority issues raised by Derby Safeguarding Children Board and progress has continued to be reviewed by the Children, Families and Learners Board and Children and Young People Overview and Scrutiny Board of Derby City Council.

6.12 The Derby Safeguarding Children Board has liaised with both the Local Family Justice Board and Criminal Justice Board to identify where safeguarding arrangements can be improved. For example the Local Family Justice Board participated in the development of training materials to improve the skills of staff acting to promote the welfare of children in local courts.

6.13 The Derby Safeguarding Children Board will be formally reporting to the Strategic Governance Board of the Police and Crime Commissioner in May 2015 on the effectiveness of safeguarding arrangements delivered by the Police.

7 Participation of Children and Young People

7.1 The Derby Safeguarding Children Board continues to draw upon the work of the Derby City Council (DCC) and members of the Children and Young People's Network to help inform it about the views of children and young people and how these views contribute to the improvement of services and priorities.

7.2 The annual report on the Effectiveness of Early Help Arrangements[3] sets out the analysis and evaluation of local early help arrangements. The report sets out the responses of 303 children and their families on their evaluation of the service they experienced. The views of the children and their families were appropriately analysed and scrutinised. Both commentary about the effectiveness of arrangements and areas for development are identified in the report and there is clear commitment to ensure that their views inform the future improvement to early help services.

7.3 The Derby Safeguarding Children Board continues to enable young people to be key participants in their safety planning and central to the success of the CSE strategy during the past year. This informs effective practice in individual cases and systemic learning for the service (The monitoring and audit section illustrates this in more detail).

7.4 Young people have been involved in a learning review completed during 2014. Changes in guidance to staff were informed by the views of a young person alongside the introduction of a specific course arising from learning from the review. Three different practice guidance leaflets have been published on the website and are helping staff understand how they can use feedback from young people as part of their everyday practice. These are: Working with babies and pre-school children; Working with school age children and Young People, and Working with New and Emerging Communities.

7.5 The posters developed with young people from Voices in Action Youth Council to improve safety in personal relationships were completed and circulated for display in all secondary schools and colleges.

7.6 Young people from nine secondary schools including the Royal School for the Deaf worked with the Derby Safeguarding Children Board and the City and

[3] Report to the Derby Safeguarding Children's Board on the Effectiveness of Early Help Arrangements 2014-15. A Kaiser (2015)

Neighbourhoods Partnership to develop E Safety mentoring and awareness raising sessions to be delivered by them to primary school pupils in their area. This work was developed in recognition of the importance of supporting children cope with transitions and the effectiveness of peer education in the area of internet safety. This work across Derby is part of the local E-Safety Strategy and Action Plan that is being taken forward by the Education and Vulnerable Young People sub groups.

7.7 The content and training for the young people was completed in the summer term and the sessions in primary schools are due to commence in September. The effectiveness of this approach will be evaluated and it is anticipated that there will be a range of opportunities including induction visits, direct teaching of Year 6 pupils in feeder primaries and welcome sessions for Year 7 pupils.

7.8 Young people, from Derby Moor Community Sports College, worked with the Derby Safeguarding Children Board to produce a training film on Forced Marriage, "Why Me". This film has been distributed to enable Year 10 pupils in secondary schools to view it. The film has also been distributed to all primary schools to enable staff to understand the subject and its related safeguarding process and is used on the Safeguarding Black and Minority Ethnic children course and on the Forced Marriage course.

7.9 A second film to raise awareness and help reduce Self-Harm called "Count Your Blessings Not Your Problems" was developed through working with young people receiving support from Child and Adolescent Mental Health Services. This film can be accessed via the Derby Safeguarding Children Board website alongside sources of support on the subject of self-harm.

7.10 Both films have received universal praise from pupils and practitioners, including those working within a Mosque in Derby, for the way in which they both raise difficult topics and help the audience understand what they can do to safeguard children and young people.

7.11 A young person, who is a survivor of CSE, and her parents have been involved in the production of a film to help practitioners understand and safeguard young people at risk of Child Sexual Exploitation. Work is being completed in summer to offer a Roma dubbed version, with Slovak and Polish subtitles and provide copies with British Sign Language. This is being done so that children and young people from new and emerging communities in Derby who may be vulnerable and children who have hearing impairment can be helped to keep safe from exploitation.

Audit of participation by children and young people in their Child Protection Conferences or Child in Need Reviews[4]

[4] Audit of participation by children and young people in their Child in Need Reviews or Child Protection Conferences May/July 2014. N Martin (2014)

7.12 Child Protection processes have continued to be monitored to analyse the views of children and young people about the services they are receiving and the specific nature of their individual protection planning arrangements. An audit sample was taken from all Child in Need reviews during May 2014 for children over 4yrs and all child protection conferences during July 2014.

7.13 In Child Protection conferences, nearly 70% of reports reflected the views of the children well. In 54% of conferences, family represented the views of the children, but only two (15%) had access to any writing or pictures from the child. An advocate attended only one meeting (8%) and children attended only two (15%). The advocacy service has been promoted heavily and this sample does not reflect the level of use, which by September 2014 was already exceeding the specified service level.

7.14 In the sample last year, only 33% of reports were felt to adequately reflect the child's perspective, so this is a marked improvement. 50% of families represented their child's views, albeit only partly – which may suggest either better preparation or more focus during meetings. However in last year's sample, four children attended (33%), three contributed by writing or drawing pictures (25%) and three had an advocate (25%). Whist the sample is small, there is certainly no indication of any improvement in more direct participation by children and young people.

7.15 In Children in Need reviews, 56% of reports reflected the views of children well, and in 38% of reviews, family represented the views of the children. This may reflect that these are usually first reviews, however 38% of reviews had access to writing or pictures from the child which is encouraging. Children attended only two (13%). Where they attended, three children had been well prepared, one less so. Three children were not distressed at all, one slightly (not the same child).

7.16 Barriers to effective engagement

- Conferences are still held at Eastmead despite long awaited plans for a move to more suitable premises. Waiting and reception facilities are inadequate and the building is not child-friendly.
- Workers identify insufficient time to undertake the necessary work with children, to either prepare them to attend or to encourage them to contribute in other ways.

7.17 Plans are in place for the Conferences to be held at new premises (the Training and Development Centre on Kedleston Road) when the service moves and this is due to be completed by April 2016. This should improve waiting and reception services and make the service more child-friendly.

7.18 Anecdotally Child Protection Managers are reporting that the preparation of children is improving and they continue to promote the participation of children in child protection conference processes. The conference agendas have been changed so that there is an explicit focus on the wishes and feelings of children.

Participation of looked after children in their reviews

7.19 The annual report of the Independent Reviewing Service[5] sets out how the independent reviewing officers have promoted participation by children and young people in their reviews. In 2014/15, 96.3% of all reviews had children and young people participating in them. This is an increase that has been maintained over the previous four years.

7.20 The service uses the consultation feedback forms for individual children and young people to inform discussions and review decisions.

Young Carers

7.21 A report[6] was presented to the Quality Assurance Group setting out the changes to how young carers receive support in Derby. Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. From April 2015, a Local Authority must carry out a "Young Carers Needs Assessment" to decide what kind of help might be needed if a young carer or their parent/s request this.

7.22 Wherever the Local Authority works with a young carer, that young person will be asked their opinion of the service they receive and how they are being helped through completion of a survey called 'Wishes and Feelings'. The person the young person will be caring for will be asked whether services are in place to support their young carer through completion of a form called 'How was it for you'? This will be completed at every review meeting and feedback from this survey style form will inform the content and delivery of services for that family.

7.23 The Derby Safeguarding Children Board will scrutinise how the authority captures and uses "the voice of the child" in informing the transition to the new arrangements to support young carers.

Processes to respond to complaints from children and young people

7.25 The Local Authority and partner agencies respond to complaints that have been received from both adults and children about their services. Whilst individual agencies have internal arrangements to monitor complaints, there has been no oversight by the Quality Assurance sub group as to whether any concerns are about safeguarding services. The issues raised by children and young people about safeguarding services they have received and the responses to resolve them by agencies will be scrutinised by the Quality Assurance sub group. Relevant performance or quality issues will be incorporated into the future work of the Derby Safeguarding Children Board.

ChildLine School Service in Derby and Derbyshire.

7.26 The NSPCC ChildLine School Service is a national initiative that has continued to be provided across schools in Derby and has progressed well. Parents

[5] Annual Report of the Independent Reviewing Service 2014 – 2015. P Akhtar (2015)
[6] Young Carers Report for DSCB Quality Assurance Group. A Kaiser (2015)

are consulted about their child's involvement in the assemblies that help younger children understand abuse and how they can stay safe. Delivered by volunteers, the ChildLine Schools Service programme uses assemblies and workshops to encourage children to recognise situations where they may need help and to highlight ways they can get support. The sessions are sensitively tailored to ensure topics are covered in a way that children can understand, and have been approved as suitable for nine to 11-year-olds by child protection specialists.

7.27 The service has now visited **264** schools (an additional 94 schools during the last year). A total of **19,934** Derby and Derbyshire Children now know where to get help if they need it.

7.28 The service across Derby and Derbyshire is now almost at the point where a full rolling programme has been established and schools are now being visited for the third time. This means that nearly all Derby and Derbyshire Year 5 and Year 6 children have received the important key safeguarding messages;

- To ensure children have an understanding of **abuse** in all its forms, including **bullying**, and an ability to recognise the signs of abuse.
- To ensure children know how to **protect** themselves from all forms of abuse including **online**.
- To make them aware of how to get help and sources of help (including ChildLine).

8 Policy and Procedures, Guidance and Thresholds

8.1 The Policies and Procedures group have reviewed and updated their terms of reference to strengthen requirements of agency membership and commitments. The group is now chaired by a professional from the community and independent sector.

Derby and Derbyshire Safeguarding Children procedures

8.2 Two significant revisions to the safeguarding children procedures were completed (one of which was brought forward) to ensure compliance with Working Together to Safeguard Children 2013 and other national guidance. This work involved:

- The development of a new procedure about trafficked children and updating of all the specific circumstances chapters, including the children at risk of sexual exploitation procedure, female genital mutilation, abusive images of children;
- Updated recording forms for network and core group meetings for multi-agency use, and;
- Development of a new Derby and Derbyshire Safeguarding Children Boards' Information Sharing Agreement and Guidance for Practitioners document to support effective information sharing.

8.3 The Policies and Procedures group will be revising procedures in the coming year to make sure that there is compliance with the revisions to Working Together to Safeguard Children, associated guidance published in March 2015 and guidance on radicalisation and extremism.

8.4 The Learning and Improvement Framework, in place across Derby and Derbyshire, has enabled local learning from case reviews and audit to help prioritise those areas where practice guidance and assessment tools are most needed.

8.5 Updates have been made to the following assessment tools;

- Early help assessment documents (early help pre-assessment checklist and request for support, early help assessment, team around the family meeting document and guidance for completing a family early help assessment).
- Child sexual exploitation (CSE) risk assessment toolkit.
- Graded care profile for the assessment of neglect.
- Pre-Birth Assessment and Intervention Protocol.

8.6 All four tools have made an impact on local practice and this is illustrated in sections 27 and 34.

Thresholds

8.7 Following the findings from the “Threshold Survey” carried out in 2013/2014 the Derby Safeguarding Children Board has continued to scrutinise the performance information to identify and question trends in “contacts” and “referrals” to the local authority. This enables ongoing oversight indicating changes in how practitioners and managers apply thresholds and the subsequent multi-agency activity to safeguard children. Analysis arising from scrutiny of early help arrangements and referrals to the local authority is set out in section 13. The thresholds and decisions at strategy meetings were scrutinised through the audit of child protection enquires set out in section 15.

Education Sector Guidance and Procedures

8.8 The Safeguarding Children Audit tool for Schools and Colleges has been revised on two occasions during the past year to take into account updated national safeguarding guidance and Ofsted requirements. At the request of schools the formatting has been amended so that education providers can complete the audit electronically.

Impact

8.9 Schools reported to the education sub group how they had found the audit tool very useful and been able to use it creatively to improve safeguarding arrangements such as:

- A Primary Schools’ Education Improvement Partnership used the audit tool (with 12 schools) to reflect on what they had learnt in their individual settings and share examples of action being taken to provide an opportunity for development across all settings.
- Different schools used sections of the audit tool in staff meetings to help reflect on safeguarding issues and improve awareness across the staff team
- Settings have used sections of the audit tool as a method for raising issues across all school staff to establish consistent understanding of expected practice.

- The audit tool has been used specifically with Governors to audit the arrangements. Designated staff reported that this had heightened the emphasis of the audit with the outcome minuted as an official record.
- New staff and designated safeguarding leads have used the audit tool to help them “get to grips” with safeguarding in their new role.

8.10 The safeguarding/child protection policy template for schools and colleges has been updated and a safeguarding poster developed for school staff to highlight key safeguarding information within their setting. Safeguarding posters are currently under development for children and young people. The development of other policy templates such as supporting children in schools with medical conditions policy template is also underway.

8.11 Work to strengthen communications with schools has continued. There has been work to ensure that the contact details for designated safeguarding leads receiving the safeguarding update service emails is up to date. Circulation of these important local and national safeguarding updates has also been extended to cover school business managers and head teachers/principals.

9	**Membership of the Derby Safeguarding Children Board and subgroups**	

9.1 The Derby Safeguarding Children Board membership list for 2014 - 2015 can be found at Appendix 1. There has been consistent representation of the Derby Safeguarding Children Board from most agencies with membership occurring at the right level of seniority and remaining stable, taking into account individual officers changing roles/jobs.

Lay Members

9.2 Lay members are represented on the Derby Safeguarding Children Board and the Child Death Overview Panel (CDOP). Lay members have raised the following challenges regarding safeguarding arrangements in Derby:

- Derby has an increased population of 12.2% and it is of concern that partner agencies report that central government funding has not kept up with this increase and associated needs of the community.
- Workers are reported as identifying insufficient time to prepare children for child protection conferences (Paragraph 7.16). It is requested that further information is obtained to explain why there is insufficient time. Is this as a result of workloads, family reluctance or other reasons?
- Why can neighbouring healthcare foundations offer higher salaries to Health Visitors leading to concerns about recruitment levels (Paragraph 11.7b)?
- Will there be a review of how the new probation arrangements are working locally (Paragraph 11.7d)?
- In the absence of additional resources to support the new arrangements to address extremism, how will the new responsibilities be carried out by the local authority and police (Paragraph 11.7g)?

- Might it be possible to understand the reasons in more detail for why so many of the looked after placements are outside the city boundary (Paragraph 15.39)?
- If there are restrictions on what information can be shared about the arrangements to prevent and respond to extremism, how can the Derby Safeguarding Children Board report on their effectiveness (Paragraph 21.5)?
- Could the suggested workshops to improve the quality of child protection plans be made mandatory for staff to attend (Paragraph 15.1)?
- Are there plans to reconsider why young people involved in serious youth violence were not identified as being at risk from child sexual exploitation? As the current finding is inconsistent with the research by the Children's Commissioner, is the reason for the difference in Derby understood (Paragraph 17.2)?
- Are there plans to do further work to improve the quality of return interviews (Paragraph 18.5)?

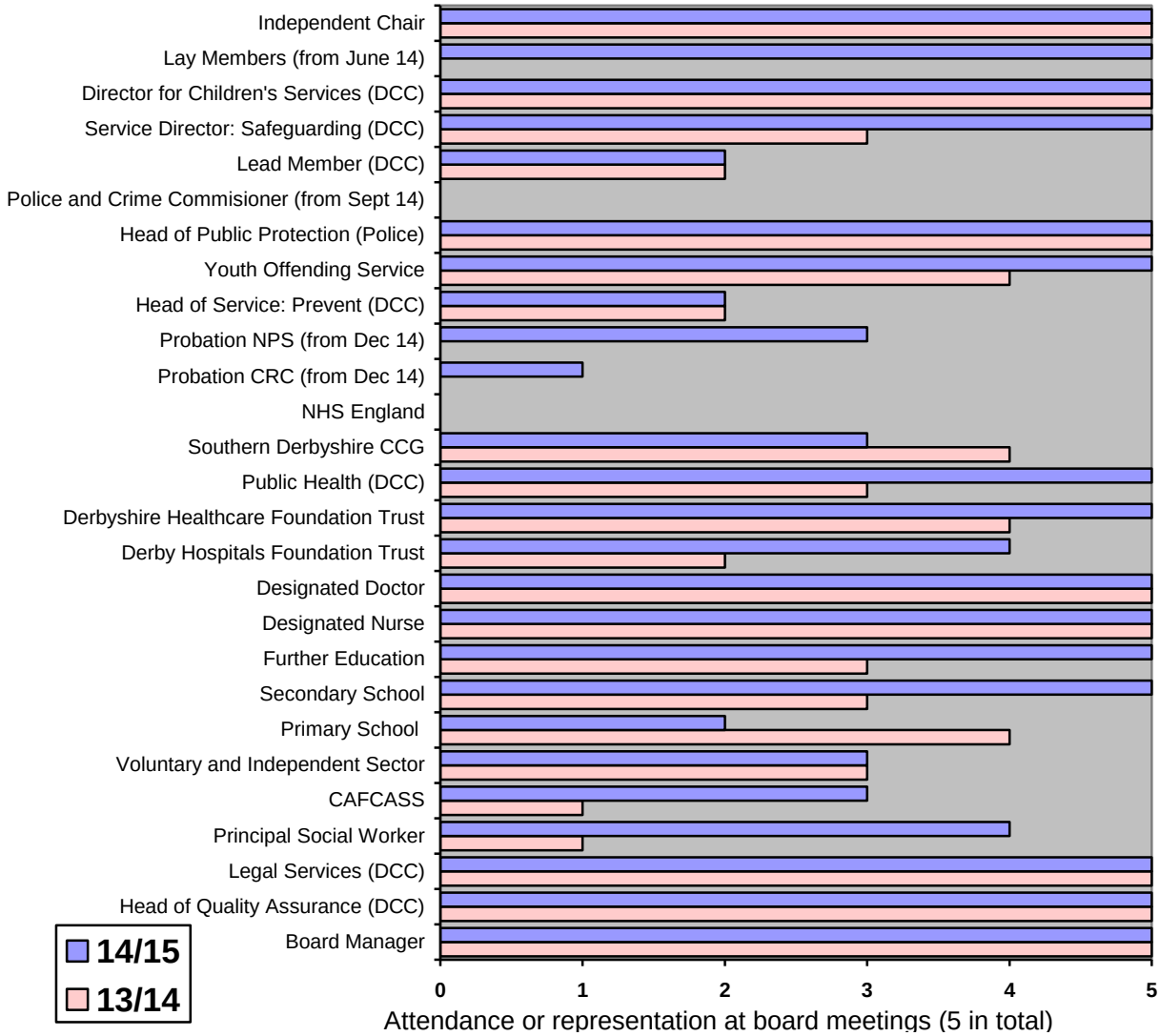
The Derby Safeguarding Children Board will ensure that appropriate action is taken to address the points raised above.

9.3 The lay members said that they feel that "It is an honour to be Lay Members on the Derby Safeguarding Children Board and gives the opportunity to represent the General Public independently of all other Health, Social Care and the Police in the pursuit of protecting vulnerable children. Statutory services in the City are performing as expected however external/ additional impacts/ factors are putting a strain on their ability and capacity to support and protect Children and Young People in the city. There has been no additional resource to combat extremism, the increase in population and the increase on demand of public and health services." The lay members thought that the development of the CSE film in different languages to support the new communities in Derby was "an excellent initiative due to the increase in particular ethnic migrants".

Attendance

9.4 The Derby Safeguarding Children Board holds meetings on a quarterly basis with additional extraordinary meetings being convened where necessary. There were four meetings and one development day during the year.

9.5 Analysis of the attendance set out in the chart below indicates that in comparison with last year there has been an improvement in the attendance with an increase in the number of agencies attending all main board meetings.



9.6 NHS England has been challenged to address the failure to provide representation as required by the national guidance and further action will be taken in the coming year. The Police and Crime Commissioner was invited to attend from September and has been able to provide representation for the June 2015 meeting. The reduction across the sector of managerial posts is a contributory factor in the ability and resilience of agencies with key functions to be able to find substitutes to deputise in critical situations. This is an ongoing situation and will continue to be monitored.

9.7 The Vice Chair (Quality Assurance Chairperson) has been present at all meetings. The Principle Social Worker post has become vacant during the year and a new post holder is awaited.

9.8 A new Lead Member for children's services joins the Derby Safeguarding Children Board in June 2015. Annual attendance at all sub group meetings will be reviewed at the June meeting to identify how well agencies are represented at all sub groups and what action needs to be taken to address identified shortfall. The same approach will be used in following years to assure the Derby Safeguarding

Children Board of attendance over a longer period and whether resource pressures are impacting on the ability of agencies to engage in their roles in sub groups.

10 Budget

10.1 To function effectively the Derby Safeguarding Children Board is supported by member organisations with adequate and reliable resources. Member organisations contribute not only financially but in their contribution to the work of the Derby Safeguarding Children Board. This includes their individual commitment to providing staffing time to carry out work on behalf of the Derby Safeguarding Children Board and the provision of venues and other resources not specified in the financial budget. The budget allocation by agency was agreed as set out below specifically for 2014 - 2015.

10.2 The total budget to support Derby Safeguarding Children Board activity in 2014-2015 was £178 384 (and has remained the same from 2012/2013)

Agency	**Amount**
CYP	£105,309
NHS Southern Derbyshire Clinical Commissioning Group (on behalf of Health Services in Derby/Derbyshire)	£46,430
Derbyshire Constabulary	£24,144
Derbyshire Probation Service	£9,286
CAFCASS	£550
Total contributions	**£185,719**
Total Budget	**£185,719**
Actual Expenditure	**£235,018**
Balance from Reserve	**£47,549**
Money received to develop training films	**£1750**

10.3 The overspend was planned and included the temporary Policy Officer (Quality Assurance) Post. No costs were specifically incurred in respect of serious case reviews. The balance of costs was drawn down from Derby Safeguarding Children Board reserves. The Derby Safeguarding Children Board receives quarterly financial reports to monitor expenditure.

Budget allocation for 2014 - 2015 was:

	Budget	**Expenditure**	**Variance**
Employees Sub Total	£169,918	£202,213	£32,295
Premises Costs Total	£500	£500	0
Transport Sub Total	£1 100	£1,080	- £20
Supplies and Services (Including Training Costs)	£14,201	£31,225	£17,024
Total	**£185,719**	**£235,018**	**£49,299**

10.4 The Derby Safeguarding Children Board agreed to ongoing partner contributions for 2015 - 2016 in the following proportions:

Derby City Council	56.7%
Health - Southern Derbyshire Clinical Commissioning Group on behalf of Derbyshire Healthcare NHS Foundation Trust / Derby Teaching Hospitals NHS Foundation Trust	25%
Derbyshire Constabulary	13%
Derbyshire Probation	5%
CAFCASS	0.3%

11 Derby Safeguarding Children Board Effectiveness

11.1 The Derby Safeguarding Children Board identifies priorities for maintaining and improving its effectiveness through the monitoring and evaluation of progress to complete the business plan. At each quarterly meeting of the Derby Safeguarding Children Board a formal report is presented by the chair of each subgroup and the business plan and the tasks being carried out by each subgroup is scrutinised. This informs the ongoing plans determining what action needs to be taken to improve safeguarding arrangements and how the work of the subgroups is linked together through the learning and improvement framework.

11.2 Section 13 illustrates how quality assurance activity informs learning and improvement across the partnership. This is then checked to see if the intended impact of changes and developments have been achieved.

11.3 The Derby Safeguarding Children Board undertook a self-assessment in June 2014 of its effectiveness using the framework for the inspection of services for children in need of help and protection; children looked after and care leavers and reviews of local safeguarding children boards (Ofsted 2013). A progress report was formally presented to the September meeting.

Risk Register

11.4 The Derby Safeguarding Children Board has put in place a risk register to formally record concerns about multi-agency safeguarding arrangements and action taken to resolve them. The concerns recorded include issues affecting how organisations work together. All concerns are scrutinised by the Independent Chair to ensure that effective action has been taken and escalated as necessary.

11.5 The following are some examples of changes that have arisen as a result of local action taken over the last year:

- Concerns about appropriate representation and engagement by a partner agency were raised with the Chief Executive. Attendance and engagement demonstrably improved.
- Child Protection Conference Minutes were sent home to parents from *some* schools via the children. Guidance issued to all education settings to ensure compliance with Data Protection Act.

- Social workers were refused admission to *some* schools as they didn't have their Disclosure and Barring Service (DBS) check with them. Guidance issued to all education settings to ensure compliance with national guidance that requires appropriate authorisation but does not require DBS checks to be shown.
- At a local (and regional level) challenge continues to secure representation by NHS England.
- At a national level, concerns that the lack of regulation and formal checks of home based self-employed teachers which may leave children exposed to unsuitable "teachers" were raised. This is being followed up to seek to influence improvements to national policy and regulation.

Derby Safeguarding Children Board Self-Assessment

11.6 Self-assessment about the effectiveness of the safeguarding arrangements and the work of partner agencies was carried out at the development day in November. A six months position and challenge statement in respect of emerging issues impacting on safeguarding arrangements in Derby was subsequently completed.

11.7 The following issues were identified by partner agencies as requiring further action and challenge. The outcomes are illustrated below:

(a) Self-Harm and Emotional Wellbeing of young people

The Derby Safeguarding Children Board requested evidence of the quality assurance of services provided to help young people who self-harm and improve their emotional wellbeing. Evidence was submitted by the Derbyshire Healthcare Foundation Trust and clarity was obtained confirming that the governance arrangements sit with the Behaviour Pathway Group for the partnership arrangements between commissioning and provision of services to address self-harm and emotional wellbeing.

(b) Health Visitor recruitment and retention

Derbyshire Healthcare Foundation Trust identified concern about the recruitment (in line with Government policy) and retention of Health Visitors as a result of higher salaries being offered by neighbouring areas. The commissioning responsibilities for Health Visitor will transfer in October 2015 to the Local Authority. The Derby Safeguarding Children Board received assurance from the Director of Commissioning that the recruitment and retention of health visitors was being monitored closely and whilst the numbers were not yet at their full anticipated complement, progress was being made to achieve targets for mandatory visiting. The impact of changes will be monitored through workforce capacity reporting to the Workforce sub group.

(c) Accessing Child Protection Medicals

The Derby Safeguarding Children Board requested that Children's Social Care work with Health Partners to assess and report on the extent of the impact of delays to medicals. This was looked into and whilst there was no evidence of extensive delays, a pathway was issued to clarify how medicals should be accessed and who to raise concerns with about the outcome or completion of timely medicals.

(d) Impact of changes to Probation arrangements

The Independent Chair and Board Managers from the two Derby and Derbyshire Safeguarding Children Boards met with representatives from the two "arms" of Probation (the National Probation Service and Community Rehabilitation Company) to make sure that suitable arrangements were in place during the introduction and transfer of new ways of working. As a result of this there has been an open approach to clarifying operational changes and representation on the main board and sub groups has been achieved. No adverse reports have been received about the inter agency safeguarding of children.

(e) Joint Strategic Needs Assessment (JSNA)

The Health and Social Care Act 2012 introduced duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. The Independent Chair wrote to the Chair of the Health and Wellbeing Board to obtain an up to date Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. As a result of enquiries the Derby Safeguarding Children Board influenced the revision of the strategy and participated in updating the joint strategic needs assessment.

(f) Inter-Agency Safeguarding links with the Police

Inter-agency operational work with the police has changed during the past year with differences planned in the way the different social care departments in the city and county will deal with referrals with the Police. The Independent Chair followed up previous issues raised with both Directors of Children Services and Chief Constable to ensure that arrangements are effective and strategic change supports the work of partners to coordinate the action take to identify, assess and respond to concerns about the welfare of children. It has been agreed that two operational models will be established and children's services are working with adult services and the police to implement new arrangements in Derby during 2015 – 2016. These will be closely monitored by the Derby Safeguarding Children Board.

(g) Changing responsible body for the discharge of "Prevent" measures

The statutory responsibilities of the Local Authority in respect of preventing extremism come into effect in July 2015 (following changes to the Counter Terrorism and Security Act) without additional resource allocation from central government. The Derby Safeguarding Children Board obtained assurance from the City and Neighbourhood Partnership about planned changes to the *Prevent* arrangements as they are implemented and the impact on safeguarding arrangements. Further reports

will be provided to the Derby Safeguarding Children Board to evidence the effectiveness of the arrangements.

(h) Education role of Derby City Council

The Derby Safeguarding Children Board has sought assurance from the Service Director, Learning and Improvement Services to improve clarity and engagement between the work of the Local Authority and the work being carried out to improve safeguarding arrangements in education settings. The Service Director was supportive of the work of the education sub group and attended the serious case review panel. Progress was made and more effective arrangements with education sector partners were achieved through the education sub group. Whilst liaison has occurred, the active and direct involvement of the education service in the joint work with the education sector remains the preferred position and further action will be taken to achieve this in the coming year.

(i) Increasing demand on the Local Authority and partner agencies

Consistent feedback from the Local Authority and partner agencies illustrated the significant increasing demand for services in an environment of unprecedented pressures on resources. The presentations at the development day from individual agencies enabled the Derby Safeguarding Children Board to collectively understand the pressures and have an indication of the potential identified risks to local safeguarding arrangements.

Subsequently the Derby Safeguarding Children Board established a programme of agency reporting at the quarterly meetings to ensure a more frequent oversight of strategic risk and opportunity for challenge. The Local Authority and the Clinical Commissioning Group provided formal reports at the first two meetings in 2015.

(j) Impact of the changing demographics of the population in Derby and the impact of the economic climate

Evidence of demographic changes in the population indicated an increase in families from Eastern Europe living in Derby. The Derby Safeguarding Children Board commissioned a report to understand the impact on requests for Early Help and Safeguarding Services and this was formally reported at a quarterly meeting and subsequently updated.

(k) Voice of the child

Feedback from partner agencies indicated that there was a need to improve evidence of the impact upon the development of services from feedback and voice of the child. The Quality Assurance Group completed an audit of partner agencies to ensure compliance with the Department for Education *Safeguarding Framework* that includes obtaining evidence of the voice of the child being demonstrated in feedback and through influence of the development of services.

(l) Child Sexual Exploitation

Following publication of the “Jay report” into the Child Sexual Abuse scandal in Rotherham, partners involved in the Derby CSE strategy reviewed the report and associated national guidance and carried out a self-assessment against current and proposed standards. Subsequently the CSE Action Plan, that includes all additional actions arising from the self-assessment, was amended and progress reviewed at quarterly meetings of the Derby Safeguarding Children Board.

12	**Single and Multi-Agency Safeguarding Training**	

12.1 During the year **99** courses and training seminars were delivered and **1,948** *(1,462)* participants ***attended courses***. 193 *(166)* participants failed to take up their place on the day of the event. (*Previous Year Figures in brackets*).

12.2 There has been improvement in reducing the total number of DNA’s during the year to **9.9%** *(from 11.3%)*. Further work will be undertaken to ensure that the Derby Safeguarding Children Board has best information about which courses are required and hold agencies to account for ensuring that key staff do indeed take up the training they require to meet identified need.

12.3 The comprehensive annual training report illustrates the effectiveness of arrangements and activity this year has included:

- Establishing an evaluation strategy
- Establishing a quality assurance validation process for independent and single agency providers
- Establishing an electronic booking system in conjunction with the Adult Safeguarding Board
- Developing an E-Learning programme, an Introduction to Safeguarding which is available online
- Listening to the experiences of children and families to incorporate their views into training activities and materials

Learning and Improvement Framework

12.4 The Derby Safeguarding Children Board put in place a local Learning and Improvement Framework (LIF) jointly with the Derbyshire Safeguarding Children Board and statutory partners. The LIF sets out local arrangements for:

- Learning from Serious Case Reviews and Learning Reviews
- Assessing Impacts and Outcomes
- Providing a Range of Learning and Improvement Activity
- Identifying who requires training
- Meeting training priorities
- Core values in learning and training development
- Training Programme development
- Commissioning training
- Quality Assurance
- Course administration

Training priorities for the year 2014 – 2015

12.5 The following priorities were actioned during the year:

- The Training Validation Scheme was launched to quality assure independent and single agency training. Three providers were successful in meeting the required standards and receiving quality assurance approval.
- 350 multi-agency staff attended a half day workshop which included the use of the Domestic Violence Risk Identification Matrix (DVRIM).
- Local audits of the impact of training on practice were carried out to include analysis of the effectiveness of specific courses such as the DVRIM
- 2 seminars on Safeguarding the Under 1's were attended by 70 people.
- There have been two briefing sessions in response to action points from a Learning Review to improve practice (Section 47 Inquiries) and these were subsequently audited to examine the impact on practice.
- A new half day course on chairing safeguarding meetings has been attended by 34 people from both Children and Adults' Services.
- The "Feeling Prepared for Court" training film and "Count Your Blessings, Not Your Problems" training film on young people's experience of self-harm were developed and published on the website.

12.6 Insufficient progress was made to:

- Complete training pathways for staff with key roles for ***all*** partner agencies.
- Obtain evidence of the impact of single agency training from **all** partner agencies

Action will be taken in the coming year to make sure that outstanding activity in these areas is completed.

12.7 The comprehensive annual training report set out in further detail how the following were achieved:

- Opportunities for learning are effective and properly engage all partners
- Young People's Involvement
- Learning from serious case reviews and local reviews
- The effectiveness of Derby Safeguarding Children Board Training
- Derby Safeguarding Children Board Training feedback on courses
- Independent audit of how the training has led to improvements in practice
- Derby Safeguarding Children Board scrutiny of the effectiveness of single agency and independent sector safeguarding training
- Impact of the multi-agency Training Pool

Young People's, Parents and Community Involvement

12.8 Ensuring a child focus on all courses is a priority and the majority of courses now have a skills section to encourage staff to ask "courageous questions" when a concern is identified.

12.9 There has been increased involvement of young people in the design and delivery of training materials. Full detail of their involvement is set out in section 7 above.

12.10 In summary the following resources were developed with young people:

- "Why Me" a film made by years 9 and 11 pupils about Forced Marriage has now been distributed to all Derby schools.
- "Count your Blessings" a film produced with young people receiving services from Child and Adolescent Mental Health Services and is available on the Derby Safeguarding Children Board website and can be used by staff in their work with children and young people in schools and residential settings.

12.11 Filming has begun to capture the experiences of both a survivor of child sexual exploitation and the experiences of her parents. The film will be available in English, dubbed into Roma, with Slovak and Polish subtitles and available with British Sign Language.

12.12 In addition to the above, films presenting the views and experiences of children and young people are included in the Safeguarding Disabled Children and Domestic Abuse courses.

12.13 Following research locally about online safety with primary pupils the Education sub group are supporting plans to train secondary school pupils in E Safety. The older pupils will deliver E Safety awareness raising sessions to year 6 pupils from their local primary schools.

12.14 A bespoke training course was delivered to the Refugee Council and a training session was delivered to the Hamaari Project (a new community project) about Female Genital Mutilation.

Training priorities for 2015 – 2016

12.15 The following key priorities were identified for the coming year:

1. Publish Safeguarding Training Pathways for key staff within Health, Social Care and the Police.
2. Obtain evidence of the impact of single agency training from **all** partner agencies
3. Increase the number of single agencies and independent providers who have completed the training validation scheme.
4. Develop e learning resources on the website.
5. Disseminate the Child Sexual Exploitation awareness film to schools and other agencies.
6. Work with schools to develop secondary school peer trainers to deliver E-Safety Training to year 6 pupils.

13	Monitoring the Effectiveness of Local Work to Safeguard and Promote the Welfare of Children	

13.1 The Derby Safeguarding Children Board scrutinises performance indicators quarterly, commissions audits and uses single agency audit and performance reporting to monitor on an ongoing basis information that helps indicate how thresholds are being applied and whether safeguarding arrangements are effective.

13.2 The Quality Assurance sub group has put in place a record of all recommendations and actions arising from the range of audit reporting that it considers. This record will help to measure the impact of audit completed and what difference is being made as a result of audit activity to service delivery / improvement. Formal reporting of progress and any concerns will be raised with the Derby Safeguarding Children Board.

13.3 Set out below are summaries of the work carried out and analysis that informs the view of the Derby Safeguarding Children Board about thresholds and the effectiveness of arrangements in Derby.

Audit of the effectiveness of thresholds[7]

13.4 A key priority of the Derby Safeguarding Children Board is to seek evidence of the effectiveness of the decision making around thresholds of concern from early help to safeguarding including child protection.

13.5 During March and April 2014 practitioners and managers were asked to indicate how they perceived thresholds are applied and how they seek to resolve professional disagreements about needs and risks. A total of 526 questionnaires were completed and the results gave an overall positive picture of how safeguarding and decision making are perceived by the workforce, whilst highlighting areas for attention and exploration.

Impact

13.6 Follow up work has been carried out during this year to use the survey to drive forward practice and to continue to monitor the effectiveness of the decision making around thresholds. Summaries were produced for individual agencies explaining the views their workforce expressed in the survey and set out areas where development could be extended. The outcomes from the survey were shared with the Derby Safeguarding Children Board training pool members to promote and embed the learning in local training.

14	The Child's Journey: Early Help (Priority Area)	

Audit report on the Effectiveness of Early Help Arrangements 2014-2015[8]

[7] DSCB Full Report re: Thresholds Final. N Cooper (2014)

14.1 A formal report was presented to the Derby Safeguarding Children Board to provide an overview of the impact that early help services in Derby have had over the past 12 months. The report sets out the context of national and local pressures that impact on local arrangements and demonstrates how management oversight scrutinises arrangements through analysis and challenge.

14.2 Children's Social Care has developed a performance framework so that a coordinated assessment of early help activity evaluates the impact that it is having to support families at an early stage and whether this help is reducing referrals to Social Care and the total number of looked after children. Performance measures include evaluation of feedback from children and their families to inform analysis and future service development.

14.3 The view of families is obtained about the effectiveness of early help services. A "Spider-graph" is a tool used with families to measure progress that is used at the start, review and end of early help services. The percentage of spider-graphs completed with an *improving situation* for the families during 2014-15 was 66%.

14.4 Taken alongside the feedback form "How Was It For You?" and the numbers of re-referrals, a benchmark has been established for the first year of the early help performance framework that has informed targets for service development in 2015-16. The report also identifies action that is being taken following the publication of the thematic report from Ofsted *"Early Help: Whose Responsibility?"* (2015). Management oversight of both local and national analysis informs the future action planning of the service.

14.5 Overall, the report presents positive areas of progress and illustrates the impact that local early help services are making alongside areas for further work and development. The report also identifies both national and local pressures that are impacting on services and may reduce the effectiveness of local early help services.

14.6 The Derby Safeguarding Children Board will continue to monitor early help, including a multi-agency audit of the quality of early help assessments, as a priority and receive periodic formal reports on local pressure that may impact on early help and safeguarding arrangements.

Oral Health Project

14.7 In March 2015 the Derby Safeguarding Children Board received a presentation on steps being taken to identify and promote oral health issues having carried out a pilot programme in six primary schools in Derby in areas of deprivation in response to indicators of significant levels of poor oral health. National data shows that 27% of children will have some level of dental disease at age 5; whereas the pilot project found that 47% of children aged 4-5 yrs in these 6 schools have sufficient disease for them to be referred for treatment. The Derby Safeguarding

[8] Report to the Derby Safeguarding Children's Board on the Effectiveness of Early Help Arrangements 2014-15. A Kaiser (2015)

Children Board took action to bring this to the attention of the Health and Wellbeing Board and Children Families and Learners Board to improve access to dental services.

14.8 Public Health continued to monitor progress and updated the Derby Safeguarding Children Board in December confirming that concerns around access to dentists were being addressed by NHS England who agreed to make more funding available to dentists to increase their capability to accept more patients.

14.9 Dental teams are in a position to identify poor oral health, which can be a potential indicator for neglect. Public Health subsequently reported concerns about information sharing practices between oral health services and wider healthcare services for children, and alerted the Derby Safeguarding Children Board about the action that was being taken to raise this with providers. The Derby Safeguarding Children Board will continue to receive reports from Public Health to monitor progress in the coming year.

15	**Children in Need (CIN)**	

15.1 Child in Need (CIN) cases reduced and then increased over the first two quarters of 2014-15 before they plateaued off to a consistent number in the last two quarters. The number of CIN cases in quarter two of 2014-15 spiked to the highest rate (of CIN cases) over the past two years. The number of cases open under CIN in quarters 3 and 4 remain higher than at any other point during 2013-14.

15.2 The report on the effectiveness of early help arrangements explains that the above figures may have changed following internal clarification (within Derby's Children and Young People's Department) that child in need cases can be held within early help teams so long as there has been a Single Assessment completed by a Qualified Social Worker in line with the statutory guidance (Working Together to Safeguard Children - 2015).

15.3 This may mean that cases are being more accurately identified as child in need rather than level 2 (emerging need) in line with the guidance contained within Derby Safeguarding Children Board's thresholds document. This, alongside the local pressures identified in the introduction of the report may account for the increased numbers of CIN cases over 2014-15. (Further commentary is included in section 36.4)

Safeguarding Quality Assurance Notification process

15.4 In order to improve safeguarding practice the Safeguarding Quality Assurance Notification Process was introduced as a six month trial across the multi-agency partnership following a similar scheme being used by Independent Reviewing Officers.

15.5 Child Protection Managers and Child in Need Reviewing Officers will give more formal feedback where there are significant examples of good or poor practice,

with a particular focus on where action is needed to progress a Child Protection, CSE or Child in Need plan.

15.6 This will take the form of a "Safeguarding Quality Assurance Notification" to be sent in the first instance to the relevant manager and practitioner. The impact on improving practice will be evaluated during the coming year and reported to the Quality Assurance sub group.

Audit of Child in Need, CSE and Child Protection Plans[9]

15.7 A total of 28 plans across all locality teams were audited by Children's Social Care to identify the quality of those plans. The audit tool was repeated from previous audits in 2012 and 2013, with slight modification including adopting Ofsted terminology. The audit was completed partly as a group exercise, for consistency. This year only two CSE plans were audited and these were good, however the low number means that it is not appropriate to draw too many conclusions from the sample.

15.8 Overall there was a tendency for some plans to not engage well with men, an area for improvement additionally noted in case file audits. This was particularly the case where there was an estranged father, or a violent relationship. This analysis will be fed into planned work to improve engagement with males in families.

Impact

15.9 In contrast to the previous audit of child protection plans, there has been a decrease in plans rated 'Good', and an increase in those rated 'Requires Improvement'. Areas with most decline include; change focused work, and young people being given specific responsibilities. There is further improvement to be made in outcomes and actions being specific and child focused, as well as accountability and timescales being clearly stated. There has been an improvement on the number of plans which now have measurable outcomes, and those which give parents specific responsibilities.

15.10 There is evidence of previous staff training and development put in place to improve the quality of plans however workforce changes over the year are believed to have impacted on the quality of work. Workforce capacity analysis indicates that there were 16 vacant social work posts (at 31/03/15) which is 15% of the total and 20 agency workers. It is hypothesised that staff turnover, agency cover and a high number of newly qualified staff (23%) are contributory factors to a reduction in the quality of plans. Children's social care provided workshops to improve practice related to child protection processes but these were not well attended.

15.11 In comparison, the audit of Child in Need plans demonstrates that progress has been made since the previous audit and there has been significant improvement across all measures for Child in Need plans. Of particular note are plans being written around outcomes for the child and family, rather than processes, and

[9] Audit of CIN CSE CP Plans April 2015 - report Final. N Anderton-Pope (2015)

accountability for actions. Parents being given specific responsibilities and the outcomes being realistic for the family have also shown progress. Timescales for actions and consideration of ethnicity and diversity continue to require improvement.

15.12 The template for Children in Need plans has been changed so that the completion of timescales stands out as requiring completion by practitioners. This has been effective in improving timescales on sexual exploitation plans. Clarity about the impact of ethnicity and diversity in families still requires emphasis in training so that practitioners habitually include explicit commentary.

15.13 The Derby Safeguarding Children Board will scrutinise progress over the coming year to improve training and development in these key areas and the impact that this has on practice to improve both child protection and child in need plans.

Audit of Child Protection (Section 47) enquiries[10]

15.14 The Derby Safeguarding Children Board undertook this audit to check individual and agency compliance with procedures around completing child protection (Section 47) enquiries, and to check the effectiveness of decisions and quality of work during the investigation process. In addition to the multi-agency Section 47 case file audit, a single agency audit was carried out by Social Care, to evaluate the quality of work undertaken in the course of investigating incidents or concerns around potential significant harm.

15.15 The findings of the single agency audit alongside those of this multi-agency audit were scrutinised by the Quality Assurance Group. The following main areas for improvement were identified:

- The consistency of strategy discussions so that there is clarity about whether a child protection enquiry has commenced or support is being provided as a child in need and whether changes in status of the work being done is clear to all partners.
- The recording of outcomes of the child protection enquires should be more clearly and consistently recorded and shared with partners.

15.16 The audit identified the following good practice:

- Where referrals of high risk domestic violence with children in the household by the police are subject of strategy discussions it recognises the vulnerability of young people in that situation.
- Evidence of young people being consulted about the proposed plans for further action (as part of the enquiries being undertaken).
- Examples of some very positive liaison between agencies with timely action being taken to involve health services in strategy discussion and some high quality child protection plans.

Impact

[10] Report on the multi-agency S47 case file audit 2014 Final. N Cooper (2014)

15.17 The findings of the audit provided evidence that there were no indicators that decisions around the level of seriousness had been problematic in themselves, more that arrangements should be made clearer to improve communication and recording.

15.18 The findings of the audit and a learning review informed the development of Section 47 (child protection enquiry) briefing sessions and their impact is commented on in section 30.

Child Protection Liaison Group and Quality Assurance

15.19 The Child Protection Liaison Group is a forum where issues arising from interagency child protection working can be raised, to enable wider learning. The Group has representation from Designated and Named Health Professionals, Children's Social Care and the Police.

15.20 The group discusses direct experiences and feedback from colleagues in relation to safeguarding cases to problem solve. The group continues to build an in depth understanding of each agency's child protection work that enables them to identify, discuss and address issues that arise and to provide an overview of the recurrent problems.

15.21 The group has a key role linking with the Quality Assurance sub group in Derby (and Derbyshire) to alert both safeguarding children boards to systemic issues at the most serious level of identification, investigation and response to child protection cases.

Children subject of Child Protection Plans

15.22 The Children's Social Care quality assurance service monitors the effectiveness of the specific arrangements for children subject of child protection plans and reports to the Quality Assurance sub group and the Derby Safeguarding Children Board. Further commentary about the numbers of children subject of child protection plans is set out in section 36.24.

15.23 Scrutiny by the local authority of the numbers of child protection plans and trends over the last two years has found that there is a pattern of variable numbers with no clear trend. As such, as improved evidence of early help services is available it would be of benefit to interrogate and identify the numbers of children made subject to child protection plans who have been offered and accessed early help services in the past. The examination of individual early help cases that subsequently were subject of child protection plans will provide greater clarity about those factors that may or may not have impacted on the escalation of need.

15.24 Furthermore, management oversight has identified that an audit should be carried out of a group of children subject of child protection plans, (who have not received a prior early help intervention) to look at whether opportunities were missed for an early help offer that might have subsequently made a difference to that child/family.

15.25 The effectiveness of Core Group working is scrutinised by Child Protection Managers at review conferences. Where concerns have emerged about non-compliance with the child protection plan, the Child Protection Managers have challenged this in the first instance with the social work team manager using the quality assurance notification process introduced during the year. Further scrutiny of the effectiveness of Core Groups across a number of cases will be carried out in the coming year.

Audit of Multi-Agency Attendance at Child Protection Conferences[11]

15.26 The multi-agency attendance at child protection conferences was reviewed at quarterly meetings and at year end. Improved attendance by GPs has not been accomplished and consideration is being given to ways in which this may be achieved and whether promoting the use of written reports by GP's as a minimum requirement would be an appropriate way forward.

15.27 Shortfalls in police attendance have improved as a result of the recruitment of a single civilian member of staff to attend relevant conferences on behalf of operational officers.

15.28 Partner agencies have been asked to formally review progress made during the year to improve attendance where required and report back to the Quality Assurance sub group in October.

Looked After Children

15.29 The numbers of looked after children reduced over 2013-14 but have increased over the past 12 months in line with national trends. As with child protection plans, management oversight has identified that it will be of benefit to interrogate the numbers of children who become looked after over a period of time who have accessed/been offered an early help service/s in the past. Furthermore, a cohort of cases of looked after children (who have not received a prior early help intervention) will be audited to look at whether opportunities were missed for an early help offer that could have made a potential difference to that child/family later on in life.

Independent Reviewing Service for looked after children

15.30 The Independent Reviewing Service[12] annual report was completed for scrutiny by the Local Authority Corporate Parenting Board and will be reviewed by the Quality Assurance sub group.

15.31 The report includes evidence of the audit and challenge (carried out by the Independent Reviewing Service) to improve outcomes for children in care. The Independent Reviewing Officers completed 1,235 statutory reviews during the year

[11] CP Conference attendance 14 15. M Sobey (2015)
[12] Annual Report of the Independent Reviewing Service 2014 – 2015. P Akhtar (2015)

and at year end there were 470 children in care (an increase from 455 in the previous year).

15.32 The Independent Reviewing Officers continue to raise any significant concerns about practice or other issues affecting a child's care plan through the use of a quality assurance notification process.

15.33 Initially the quality assurance notification is sent to the social work team manager for a response to the issues raised. If there is no response or the response is unsatisfactory then the Corporate Parenting Lead will meet with the deputy head or head of service responsible for the case to agree an action plan. If an agreement is not reached then the concerns are escalated. If the concerns are not resolved by senior managers in the local authority then a referral should be made to the Children and Family Court Advisory and Support Service (CAFCASS) for external scrutiny and resolution. This process provides an essential safeguard for children in care.

15.34 The report sets out the detail of quality assurance notifications that were raised by Independent Reviewing Officers on behalf of children in care.

15.35 There were 53 quality assurance notifications raised and this has reduced from the previous year when 63 were raised.

Reason	**2013/14**	**2014/15**
Statutory Requirements Not Met	15	16
Non completion of Significant Tasks	29	20
Drift or Delay	14	10
Persistent Poor Practice	Nil	2
Excellent Practice	5	5
Total	63	53

15.36 Two cases were escalated for resolution to social work Heads of Service in comparison to seven escalated in the previous year. One case was resolved and the second case required further escalation regarding lack of progress by legal services to get clarification concerning an assessment. The concerns were subsequently resolved.

15.37 In addition to monitoring the child's care and progress with the plan at statutory reviews, Independent Reviewing Officers have a responsibility to monitor between reviews. In order for this to be effective and transparent a tracking system has been introduced from April 2014. This has helped to identify cases that need closer monitoring and action and the report concludes that it has reduced the need for more formal Quality Assurance notifications.

15.38 The report sets out evidence of progress to address the health needs of children in care and clearly identifies areas where further work needs to be done to increase health development checks in line with comparator authorities and the national average. This includes making sure that health development checks are completed in a timely manner for children placed out of Derby.

Looked after children placed out of Derby

15.39 The Independent Reviewing Service annual report states that of the 470 children and young people who are looked after, 217(46%) placements are within the boundary of Derby City and the remaining 253 (54%) of placements are outside the city boundary as a result of a lack of local provision (Of the total number, 129 children are placed with foster carers within the city and 218 are placed outside). Whilst the report doesn't specify the exact placement location and distance, it states that many of the children are placed in neighbouring counties including Derbyshire, Nottinghamshire, Staffordshire and Leicestershire resulting in children not being placed too far from Derby.

15.40 The Independent Reviewing Service highlights that improvements are needed to make sure that health development checks are completed in a timely manner for children placed out of Derby.

15.41 The arrangements for monitoring the incidents of children placed out of Derby and the arrangements for the completion of return interviews require significant improvement as a priority and further comment is set out in section 18.

15.42 The Derby Safeguarding Children Board will closely monitor progress to ensure that action is taken to improve the health of children placed outside Derby and that priority action is taken so that robust arrangements are in place to safeguard children who are missing.

Looked after children from other areas placed in Derby

15.43 Derby Children and Young Peoples Department has been maintaining a register of children and young people placed in Derby by other authorities. An interim report[13] has been prepared for the Performance Improvement Board to provide an overview and identify what needs to be done to ensure that we as a council are compliant with regulations.

15.44 The report identifies a significant improvement in the collection and accuracy of data about children placed in Derby whilst acknowledging that this work is to be completed as a priority. Action is being taken to pursue other local authorities who have not supplied appropriate information about individual young people and ensure that Derby City Council's electronic records are up to date.

15.45 The Derby Safeguarding Children Board will closely monitor progress to ensure that remedial action is completed over the coming year to ensure that there is

[13] Out of Authority Children Placed in Derby – Interim Report. P Akhtar (2015)

full assurance that arrangements are in place to safeguard these vulnerable children in Derby.

Care Proceedings

15.46 The Quality Assurance sub group receives updates of the numbers of children and young people subject of care proceedings and analysis of trend information. 82 cases have been issued during the year and 83% of cases have concluded within 26 weeks with the average number of weeks for a case is approximately 22 weeks. The target for the year is to complete 90% of cases within 26 weeks.

15.47 Delays have related mostly to European cases and corresponding with the international authorities has had an impact on this delay. Legal services have kept the High Court Judge who has responsibility over the Midlands Circuit aware of the impact of these delays.

Management Scrutiny of Early Help and Children in Need

15.48 Every month, senior managers across the Children and Young People's Department complete case file audits on specific areas of practice. During the year 52 of 86 (60%) audits were completed on early help cases and improvement in performance is being robustly tackled by the senior management team in the Children and Young People's Department.

15.49 Audit of early help work was completed for cases held by the over 11's teams (two audits), the under 11's teams and Child Sexual Exploitation (CSE) cases. The report to the Derby Safeguarding Children's Board on the effectiveness of early help arrangements sets out the findings and recommendations arising from the audits.

15.50 Both Early Help and Children in Need file audits include scrutiny of the supervision provided for early help and social care professionals. The report presents evidence of the effective management oversight of arrangements.

16	**Domestic Violence (Priority Area)**	

16.1 The Criminal Justice Board and Partnership Agencies provide figures to the Derby Safeguarding Children Board on a quarterly and annual basis.

16.2 Following plans outlined in the previous annual report the Derby City Council Neighbourhoods Overview and Scrutiny Board undertook a review of Domestic Violence and Abuse. The Derby Safeguarding Children Board participated, along with the Derby Safeguarding Adult Board, in the review. The review evaluated levels of domestic Abuse within the city and considered evidence presented in the following areas:

- Prevention/Early Intervention services
- Reactive services
- What victims want the most
- Emerging Trends

- Services required over the medium term
- Multi-agency working
- Tackling Perpetrators
- Raising awareness and understanding

16.3 The final report is pending publication following sign off from the new Council Cabinet. The Derby Safeguarding Children Board welcomes the review and the comprehensive consideration of the impact of domestic violence on people in Derby and will comment on the final report on publication.

16.4 The 2015-2018 Domestic Abuse and Sexual Violence Strategy was approved by the Domestic Violence and Serious Sexual Violence (DV and SSV) Governance Board. Six monthly reports to the Derby Safeguarding Children Board have been provided to illustrate the progress being made by the strategy.

Repeat and serial domestic violence and abuse perpetrators

16.5 The Governance Board has requested that a formal Information Sharing Agreement be developed to ensure that information regarding repeat and serial perpetrators can be shared and recorded by agencies safely. Progress has been delayed in completing this activity and assurance will be sought that the delay is not having an adverse impact on victims.

Domestic Violence Prevention Order (DVPO)

16.6 Telephone interviews were conducted with a number of service users where DVPO's had been successfully implemented however the number who actually engaged with the interviews was much lower than had been hoped for. The feedback received from those who responded was generally very positive in terms of their experience (they were kept updated about the process, it was fully explained to them, it led them to feel safer). However due to the low numbers of those giving feedback further consideration is being given by the task and finish group to look at how further feedback might be obtained to demonstrate the impact of the DVPO's.

Domestic Abuse Scrutiny Panels

16.7 Following a recommendation from the HMIC Inspection, Derbyshire Constabulary is piloting Domestic Abuse Scrutiny Panels. The Domestic Abuse Scrutiny Panels will consider cases of domestic abuse that have been unsuccessful in obtaining a conviction. There have been two meetings of the Domestic Abuse Scrutiny Panels, with another arranged for early October. The meetings are facilitated by the Criminal Justice Board and have been well attended by a core group of agencies. The police have been able to present a wide range of cases and those in attendance have been able to give positive feedback as well as constructive criticism as required. Specific actions for both police and the Crown Prosecution Service have been taken as a direct result of the panel meetings.

Independent Domestic Violence Advocates (IDVA's)

16.8 The full year impact of the increase in demand for victims assessed as high risk is:

IDVA referrals:	**2013**: 324	**2014**: 509
Derby MARAC referrals:	**2013**: 189	**2014**: 414

16.9 Derby City Council who employs the IDVA is undergoing a very significant restructure and as such it is looking as if the IDVA team may move into a new directorate. Referral figures continue to increase however there has been no increase in the size of the team. The team has already received 372 referrals since January 2015. The team also now hosts the role of Court Support Officer as funded by the Office of the Police Crime Commissioner, which offers assistance to those domestic violence victims of lower risk levels who are going through the criminal justice process.

Derby research project

16.10 A project is being carried out with the University of Derby Criminology department to complete 121 interviews with a group of 24 victims of Domestic Violence and Abuse. The aims of the project are to:

(a) Identify and understand the circumstances, conditions and factors that lead to repeated victimisation;
(b) Identify the impact on children living in households where repeat victimisation is taking place;
(c) Develop a profile of those most at risk of becoming repeat victims in order for agencies to develop preventative strategies;
(d) Identify positive and negative experience of the interventions for victims and gain an indication of what works;
(e) Identify if a single service regardless of risk level would be seen as beneficial;
(f) Measure the cost of DV repeat victimisation to the public sector and therefore the savings available through successful early and correct interventions.
Initial feedback to the project is likely in Autumn.

Derbyshire Constabulary

16.11 Domestic abuse remains a priority for Derbyshire Constabulary with regards to safeguarding of victims and prosecution of offenders. 2014/15 saw several changes in the way the police respond to domestic abuse. In December 2013, Derbyshire Constabulary were inspected by HMIC (Her Majesty's Inspector of Constabulary), as a result there were 12 local and 125 national recommendations. Most of these actions have been completed during the previous year.

16.12 The high risk Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) indicator score was reduced from 17 to 14 in March 2014. This caused an immediate 40% increase in high risk cases being dealt with by specialist domestic abuse investigation teams and referrals to Multi Agency Risk Assessment Conference (MARAC) process.

16.13 Restorative justice was removed as an outcome for intimate domestic abuse incidents on 1st April 2014. Positive outcomes reduced slightly but through robust action and focus the charge rate returned to previous levels.

16.14 March 2014 saw the introduction of Clare's Law (the "right to ask" the police where someone has a concern that their partner may pose a risk to them or they are concerned that the partner of a member of their family or a friend may pose a risk to that individual). This process and the meetings to discuss the cases were added to the MARAC meeting agenda which caused a further increase in workload.

16.15 In July 2014, the police embarked on a refresh training programme for domestic abuse and completion of the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment. This coincided with the introduction of a domestic abuse pack to be completed by officers. This saw an increase in the quality of risk assessments and identification of domestic abuse cases.

16.16 Also in July 2014, the Domestic Violence Prevention Order/Notices (DVPO/PNS) were introduced. Derbyshire police embarked on a training regime for all frontline staff and there are two dedicated specialist officers based at Derby who monitor all cases ensure a robust force wide approach. Our statistics for DVPO/PNS for the region are the highest for the numbers presented to court, the numbers successfully granted and enforcement of breaches.

16.17 The increased focus on domestic abuse and added training and use of packs saw an overall increase in the number of cases reported. Officers have now been given the ability to alter the risk assessment score using professional judgement linked to rationale. This has had an effect of increasing the number of high and medium risk cases and reducing standard risk cases.

16.18 December 2014 saw minor changes to the DASH questions and the closure questions on all domestic incidents ensuring officers focussed on safeguarding children in domestic abuse households. All details of children were recorded and where possible spoken to, to provide impact feedback. All instances were then referred to social care where children were identified in domestic abuse incidents. This is now part of a triage process.

16.19 The MARAC process in Derbyshire was reviewed by Safelives (previously called CAADA) in 2014, further improvements were made to the identification of repeat MARAC victims creating a further increase of cases to MARAC meetings.

16.20 In November 2014 due to volume increase a decision was made to change the monthly MARAC meeting at Derby City to a fortnightly approach. This made the meeting more timely for the victim but also spread the number of cases over 2 days making the process more manageable.

16.21 All agencies have seen a considerable increase in the volume to the MARAC process. This has added pressure to resources. A recent DV/SSV board meeting has approved an extra member of staff for the administration team.

16.22 In May 2015, HMIC inspected the Domestic abuse process for Derbyshire including a MARAC meeting. The overall feedback was very good with only minor recommendations mostly within Central referral function. Both HMIC and Safelives have commented positively recently regarding the MARAC process.

Multi Agency Safeguarding Hub (MASH) Development

16.23 In June 2014 it was planned that Derby social care staff to join the police at the Central Referral Unit to develop joint working arrangements in response to domestic violence incidents reported to the police. Derbyshire arrangements, called Starting Point, were being developed separately. The directors of Children's Services in the two Local Authorities had been unable to resolve the complexities and funding demands that joint arrangements would require. The Independent Chair of the Derby Safeguarding Children Board wrote to both local authorities to seek assurance that changes in Derby and Derbyshire would proceed collaboratively.

16.24 Following representation, joint planning meetings were put in place and formal feedback was provided so that the Derby Safeguarding Children Board was assured about the new developments. Social care staff were situated with the police teams (at the Police Central Referral Unit) and established processes for assessing more promptly the domestic violence referrals and identifying priority action to be taken.

16.25 In December 2014 the Derby Safeguarding Children Board received updated information explaining that consideration was being given to the future arrangements for responding jointly about domestic violence incidents affecting children and adults in Derby. All referrals for people living in Derbyshire, not just domestic violence, were to be made to "Starting Point" and this was planned to start in 2015. This meant that the police and social care would need to decide how best to develop the separate arrangements covering people living in Derby.

16.25 In March 2015 a meeting was held between local authority representatives and the Assistant Chief Constable and this led to a commitment to the establishment of a Derby City multi- agency arrangement for strengthening inter-agency working. The Derby Safeguarding Children Board has maintained a focus and challenge to ensure that transparent reporting of progress is provided and has been concerned with the need for timely completion of the new arrangements in Derby.

16.26 The Derby Safeguarding Children Board has received an improved quality of evidence of the arrangements that are in place to prevent and respond to domestic violence and abuse during the year. Set against this is the slow progress to establish multi agency safeguarding hub arrangements, first raised as a proposal at the Derby Safeguarding Children Board in March 2013.

16.27 Given the overall complexity and effect of domestic abuse on the welfare of children and adult victims, ongoing scrutiny of arrangements, including the development of the MASH, and their impact will remain a priority for the Derby Safeguarding Children Board.

17	Vulnerable Children and Young People	

17.1 The Vulnerable Young People sub group completed an extensive and complex audit to collate details of 1067 young people accessing targeted services over a specific period to obtain a better understanding of cross population of services used by vulnerable young people.[14] This helped obtain an evidence base for the extent of risk impacting on young people who were vulnerable to one or more of the following: Homelessness, Child Sexual Exploitation, Youth Offending, Living in Care, Gangs/Serious Youth Violence, Missing, Mental Health Problems (including self-harm and substance misuse) and young people at risk of Radicalisation and Extremism.

17.2 The findings illustrated in detail the numbers of vulnerable young people who are accessing services for different needs. Some of the multiple vulnerabilities that young people were receiving support were protected by agencies involved. There were some unexpected results such as no young people involved in serious youth violence were identified as being at risk from child sexual exploitation. This finding was inconsistent with research set out in the Children's Commissioner's report that identified a likelihood of those young people involved in gangs to be experiencing sexual exploitation.[15]

Impact

17.3 The research was summarised for each agency so that practitioners could be made aware of the likely risk factors and to promote consideration of the multiple ways in which teenagers may be vulnerable. The research was used to contribute to the Joint Strategic Needs Assessment and provide an evidence base of the extent of need and to inform commissioning.

New Psychoactive Substances

17.4 Concern was raised at the Derby Safeguarding Children Board meeting in March 2015 about the extent of harm being caused directly to children and young people in Derby taking New Psychoactive Substances (NPS) that were legal for them to buy. (These are substances that have been developed to cause physical and psychological affects that mimic the effects of illegal substances but that have led to 26 deaths in the UK in 2013)[16]

17.5 The Derby Safeguarding Children Board actively participated in multi-agency meetings in May and June in order to develop a strategy and action plan to address NPS use. Robust discussion was held to ensure that the experiences of children and

[14] Report on multi supported young people VYP. N Cooper (2014)
[15] Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups (2013)
[16] Deaths Related to Drug Poisoning in England and Wales. Office of National Statistics (2013) (http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2013/stb---deaths-related-to-drug-poisoning-in-england-and-wales--2013.html#tab-New-Psychoactive-Substances--including-'Legal-Highs'-)

young people in education settings were an essential part of both the development of the action plan and ongoing intelligence/data gathering. The action plan will be published in summer and both the Vulnerable Young People and Education sub groups will be participating in the work to help children and young people make safe decisions about new psychoactive substances.

Children who are not in education, employment or training (NEET)

17.6 The scrutiny of Early Help arrangements[17] reported to the Derby Safeguarding Children Board includes how numbers of vulnerable children and young people who are not in education, employment or training (NEET) are being reduced to improve their safety.

17.7 The NEET strategy has been in place for 18 months and in that time it has made a positive impact locally on key measures and outcomes pertaining to the NEET agenda, such as reducing the NEET figure for the city to 5.9% and the unknown destination figure to 3.4% by March 2015.

17.8 Raising the Participation Age (RPA) data has also seen improvements over the past 6 months and Derby has enjoyed the highest in year improvement in relation to RPA data when compared against neighbouring authorities, comparator authorities and the national average.

17.9 The aim of the refreshed NEET strategy for 2015-16 is to build on these successes of the 2014-15 strategy by continuing to reduce numbers of NEET young people to below 5.5% by April 2016, maintain numbers of unknown destination's below 5%. The progress of the NEET strategy will be reported to the Derby Safeguarding Children Board as part of the Early Help arrangements.

18	**Children who are missing**	

18.1 In October 2014 the Corporate Parenting sub-board received a paper on children missing from care. The paper provided a summary of the current arrangements for tracking and responding to incidents of looked after children going missing. As a result of this Council Members requested a performance surgery, to focus on the return interviews and a further understanding of how this information is used to inform decision making.

18.2 The Vulnerable Young People sub group receives quarterly reports about local arrangements to safeguard children who are missing. A formal report[18] prepared for the performance surgery by the local authority, will be presented to the Vulnerable Young People sub group in July.

[17] Report to the Derby Safeguarding Children's Board on the Effectiveness of Early Help Arrangements 2014-15. A Kaiser (2015)
[18] Missing children – DCC (2015)

18.3 The report sets out to address missing arrangements in respect of all children who are missing, including those who are in care and includes a corporate audit completed to review compliance with the missing protocol.

18.4 The evidence included in the report indicates that there has been an improvement in the scrutiny of missing arrangements led jointly between the local authority and police. The scrutiny of the circumstances of young people who are reported missing on three occasions occurs at the Multi Agency Missing Person's Monitoring Group.

18.5 An audit[19] was carried out to quality assure a sample of 70 return interviews carried out for children and young people who were reported missing in Derby between April 2014 and January 2015. 17 of the children were looked after (in Derby) and 53 were reported missing from home. The audit indicated that "generally, the quality of the completed forms is poor, both in terms of the intelligence and information that can be gleaned from them."

18.6 The Multi Agency Missing Person's Monitoring Group is putting into place a process of involving social workers for children or young people who has had three or more missing episodes to feedback on their analysis of the young person's return interviews and any revisions to the care plan and risk assessment.

18.7 The group is aware that absence (and unauthorised absence) reports need scrutiny, and weekly reports of absences are now being sent by the police to Runaways workers. The group is aware of the need to establish a process in order to make use of these reports – identifying hot spots, early warning of vulnerabilities and/or likelihood of going missing.

18.8 Reports in relation to children missing from education are now delivered each term to the Departmental management team, including a detailed analysis of figures, for detailed analysis and scrutiny. Whilst details of the figures and trends have been provided, further analysis will be sought in the coming year to assure the Derby Safeguarding Children Board that suitable arrangements are in place.

18.9 The audit of the early assessment of Child Sexual Exploitation (CSE) when young people go missing (set out in section 19 below) indicated that missing episodes are taken seriously and this is encouraging. However it should be made clear that this audit did not include quality assurance of the content of the return interview record.

18.10 The Derby Safeguarding Children Board welcomes the improved evidence of scrutiny of missing arrangements and the frankness of the audit findings. In addition to the current scrutiny of arrangements for looked after children who live in Derby it is important that a similar level of scrutiny is established of the arrangements for looked after children from Derby placed out of the city and of those children reported missing from home.

[19] Children and young people missing from care – sample analysis of return interviews. D Brooks (2015)

18.11 Evidence of the impact of the arrangements and how they are helping reduce the frequency of incidence of individual children and young people is currently under developed.

18.12 A comprehensive action plan has been put in place and the Derby Safeguarding Children Board will closely monitor progress to ensure that remedial action is completed and that there is full assurance that arrangements are in place to safeguard children and young people who are missing, including those missing from education.

18.13 The Derby Safeguarding Children Board has participated in the development of arrangements to safeguard children who are trafficked and subject of modern slavery. There are inter-related safeguarding issues for these children and those who are missing. Further work is planned during the coming year in relation to these related strategies.

19	**Child Sexual Exploitation (Priority Area)**	

19.1 The CSE annual report sets out the impact of the local strategy against the three priority areas identified in the Government CSE Action Plan (These are Prevention, Protection and Prosecution) and analysis of evidence indicating the scale and nature of CSE in Derby.

19.2 The CSE annual report sets out how the strategy has impacted on outcomes for young people and the effectiveness of multi-agency arrangements in Derby. The following is drawn from the report and summarised below.

Prevention

19.3 Chelsea's Choice is an applied theatre production, based on real stories of child sexual exploitation (CSE). The play has proved to be a very effective means of raising awareness of CSE and issues amongst young people. The play includes issues of grooming, coercion, isolation, risk taking behaviours and consequences. Alter Ego Theatre Company were funded by the Derby and Derbyshire Safeguarding Children Boards and the Police and Crime Commissioner to deliver this play to year 8 and 9 pupils in schools across the county over a six week period in September and December 2014.

19.4 The play was delivered in 18 schools in Derby, on 2 of those deliveries the audience were drawn from mainstream schools, pupil referral units and special needs schools. The play was also interpreted for deaf and hearing impaired children. The number of young people who attended the play in Derby is 5,090 and approximately 130 professionals.

19.5 The individual events were supported by CSE champions from a range of agencies and the police safer neighbourhood teams. 8 disclosures by pupils were made following the play. Most were low level issues related to understanding of consent and peer on peer sexting. Two disclosures were referred to the police and social care for further assessment

19.6 Partners including the Police, Safe and Sound(Derby) and CSE Champions have delivered community awareness sessions in various locations to approximately 250 members of the community, 450 students at a local college, 20 people from an Eastern European Community youth club and members of the public shopping in the *Intu Shopping Centre* (previously Westfield) on Internet Awareness Day.

19.7 CSE continues to be an integral part of the training delivered by the Derby Safeguarding Children Board and partners. Five CSE courses were planned and three were delivered (two were cancelled due to sickness) and this was one of the priority courses for children's social care practitioners. In addition to the course for Level 3 staff which is regularly updated, the E Learning tool has a specific section on CSE.

19.8 CSE awareness workshops have started for all reactive and non-reactive police officers in the county and this is due to be completed by December 2015.

19.9 Safe and Sound (Derby) have delivered work on CSE that included topics such as: healthy relationships and rights, internet safety, grooming behaviours, perpetrator behaviours and consent to 1,066 children and young people across 8 separate schools from Years 6 to 10.

19.10 Targeted group work was completed in three schools to improve cultural understandings of CSE, acceptable behaviours and basic CSE and perpetrator awareness. ChildLine Schools Service includes CSE in the topics covered in their awareness raising in primary schools (see section 7.26)

CSE Champions:

19.11 In the last year we have developed and expanded the team of CSE Champions. There are now 54 CSE champions, including designated leads in secondary and primary schools. All partner agencies are required to provide a CSE champion within their agency and a manager to monitor CSE work. The champions are expected to complete the full day's CSE training and targeted workshops on all models of CSE (see below) and related factors. They then have responsibility for cascading their learning to their colleagues. Champions also give up to 6 days per year to assist in the delivery of the CSE action plan. For example they supported the Chelsea's Choice delivery in schools and the Say Something if You See Something licensing visits throughout the year.

Workshops delivered to Champions last year:

Workshop	No of Champions	Workshop	No of Champions
Introduction to the role	12	CSE and Autism	19
CSE and the Law	15	CSE and Domestic Violence	24
CSE and Gangs	22	CSE and New Communities	16

CSE and Trafficking	56	Sexual Health and CSE	Cancelled

Protection

19.12 52 new requests for CSE meetings were received and 71 young people were subject of CSE strategy meetings this year, a slight reduction over the previous three years of between 80 and 90.

19.13 Of new requests for CSE meetings, 86% were female and 14% male. This means the number of referrals for males has increased again this year, but is still relatively low. The ethnicity of children and young people newly referred was: White British 32 (62%), BME Communities 20 (38%) of which 12 were non-British White (23%). This is still suggestive of under-reporting from within black and Asian communities.

19.14 45 cases were closed this year, of those 49% (22 young people) had the risk reduced or were considered low risk 24% (11 young people) after intensive support. 9% (4 young people) of closures were due to the young person being escalated to a child protection threshold and 6% (3 young people) were due to the family leaving Derby. Cases are thoroughly reviewed under the multi-agency strategy and are only closed where there is a sustainable reduction in risk to the child.

19.15 It is important to reflect that the vast majority of Derby young people who are at risk of CSE, very few show evidence of actual exploitation and this is consistent with the previous year. This year 73% of cases were closed due to the risk being removed or reduced to low level compared to 40% last year and 28% in 2012/13.

19.16 The CSE strategy meetings are evaluated on an ongoing basis to see whether young person and their family understand why the meeting has been called and whether they feel supported and listened to. Young people attended on average 63% of meetings they were invited to (compared to 42% last year). Of the young people attending meetings, 94% of found the meetings supportive, 92% felt listened to and 100% understood why they were at a meeting. 81% of young people who attended agreed with the plans, 12% agreed partially and 2% disagreed and did not want to engage with them. Some young people did not complete the evaluation forms.

19.17 Parents/carers attended 73% of meetings they were invited to (compared with 48% last year). 100% of parents/carers attending meetings agreed with the plans at the end of the meeting.

19.18 The feedback from young people, their parents/carers and assessment of risk at subsequent meetings illustrates that the CSE strategy is successful in engaging and supporting young people and their families; particularly when support is often set to a backdrop of mistrust, disagreement about levels of risk and challenging behaviours.

19.19 The involvement of the parents and young people in the strategy continues to be fundamental to its success.

Prosecution

19.20 The Child Exploitation Investigation Unit provide a force wide response to Child Sexual Exploitation (CSE) both online and offline and as such are responsible for investigating based both within Derby City and Derbyshire. The data reflected represents the cases for Derby City only.

19.21 Police data

Derby City: CSE	2014 - 2015	2013 - 2014
Referrals	124	93
Crimes	23	23

19.22 Referrals are generated where there is a concern that a child may be at risk of exploitation. Of those 124 referrals, 23 crimes were identified in line with the national recording standards. There have been 16 individuals charged in relation to online and/or offline CSE offences within the City during the year.

19.23 The Derby Safeguarding Children Board wants to make sure that all CSE crimes against children are responded to appropriately and that agencies are held to account for their contribution to investigations and support for victims. Action will be taken during the summer to improve liaison with the Crown Prosecution Service so that the Derby Safeguarding Children Board can be assured that there are effective arrangements in place and monitored on an ongoing basis.

Audit of the early assessment of Child Sexual Exploitation (CSE) when young people go missing[20]

19.24 There is an established link between young people who are vulnerable to sexual exploitation and young people who go missing. Being missing from home for long periods, including overnight, or missing from school for short periods during the day, can be an indicator that a young person is at *risk* of CSE.

19.25 As part of its duty to conduct analysis of the effectiveness of local responses to CSE, Derby Safeguarding Children Board audited the assessments of risk of CSE that were undertaken when young people go missing from home or school and to check that CSE was being considered in multi-agency planning for these young people, in line with local procedures.

19.26 The findings of the audit were scrutinised by the Quality Assurance sub group, CSE Operational Group and Vulnerable Young People's sub group. The audit showed compliance with local procedures against nearly all measures considered and in nearly all cases. Practitioners are routinely discussing missing episodes with Team Managers, CSE Champions or the Child Protection Manager (CSE).

[20] Audit Report Early Assessment of CSE and Missing May 2015 Final. N Cooper (2015)

Impact

19.27 Most young people in the audit had received advice and support regarding risks of exploitation at early stages in concerns about their missing episodes. Practitioners are considering risks of CSE although recording on individual children's records was not always consistent across different agencies.

19.28 Return interviews were completed for those young people who had been reported as a missing person to the police in nearly all cases where one should have happened, with one young person refusing an interview and denied she was "missing", and one was found staying with relatives in another city and remained there and was not seen by Derby workers.

19.29 Practitioners who conduct the return interviews have been trained to spot the signs of CSE and to use the CSE toolkit; ten of the twelve cases where return interviews were recorded were carried out by people known to have attended training sessions regarding CSE or are CSE Champions themselves, the other two cases were conducted by unnamed Police Officers, who's training status is unknown.

19.30 Operation Liberty Information Report Forms (used for sharing intelligence and concerns about CSE with the police) were used appropriately and the audit did not find any situations of the forms not being completed when they should have been.

19.31 Missing episodes are being discussed in multi-agency meetings where it was appropriate to do so. 75% (15/20) of young people were seen as safer and/or receiving on-going support as a result of interventions around them being missing, three were given advice only as part of their return interview before the case was closed, one was monitored and subsequently referred for support, and one was not seen at all as was found to be living with relatives in another city.

19.32 Some of the examples of good practice included:

- An Early Help Assessment was completed by a school setting out concerns about a young person truanting and going missing. The children's practitioner reviewed the detail provided by the school and, alert to early indicators of CSE, contacted the school to find out more about the circle of friends the young person had. Checks were carried out to understand whether there were concerns about CSE for other young people and public profiles on social media were reviewed. No concerns were identified for friends or online and this helped inform the development of an effective package of support for the young person.
- When a young person was identified as being at a higher risk of both missing episodes and CSE, due to her mother's learning disability, the Children's Social Care team took steps to ensure that the mother was supported by Adult's Services. This led to extensive work and engagement of the mother by the social worker. The social worker worked creatively to put an action plan in place, which mother was able to follow, should the young person go missing. This increased reporting of these episodes and provided better information for the risk assessment and protection of this young person.

19.33 The audit of 20 cases provided a snapshot of the impact of the arrangements that have been implemented to safeguard children at risk of CSE over the last five years. It is evident that the risks of CSE are routinely considered at an early stage and that action was taken at an appropriate threshold where needed.

19.34 Recommendations arising from the audit to extend practice were identified and include further audit to satisfy the Derby Safeguarding Children Board that the arrangements continue to safeguard children at an early stage.

20	**Disabled Children**	

20.1 A service delivery report of the Integrated Disabled Children's Service (IDCS) will be provided to the Children and Young People's Improvement Board in August and subsequently the Quality Assurance sub group in November.

20.2 The report will comment on actions that were identified in November 2014 that include ensuring that the correct services were being provided at a threshold appropriate to the needs of the child. The Quality Assurance sub group will report to the Derby Safeguarding Children Board about the effectiveness of arrangements to safeguard disabled children and any further action needed.

21	**Radicalisation and Extremism**	

21.1 Derby has been a priority area in relation to Violent Extremism since 2007 (under the former government's prevent violent extremism pathfinder) and has been a designated priority area since 2011. There is a partnership plan in place to coordinate action being taken to prevent radicalisation and extremism called the Prevent Plan. The Channel programme in the City is Chaired by the Head of Cohesion and Prevent and also attended by the heads of both Children's and Adult's safeguarding.

21.2 The Derby Safeguarding Children Board has promoted multi agency training to raise awareness of extremism. Working to raise awareness of Prevent (WRAP) multi-agency courses have been in place for a number of years and receive positive feedback. E-learning courses are being developed for launch in the coming year to help make sure practitioners are aware of their responsibilities and are able to safeguard children at risk of extremism. The Derby Multi-Faith Centre has provided the one day course Bringing Prevent to the Public Space for 161 safeguarding professionals during the year from Derby and Derbyshire.

21.3 Derby was a pilot site for the Channel programme which is a multi-agency approach that manages risks and safeguards vulnerable individuals being radicalised in the city. The Derby Safeguarding Children Board has been given an overview of the work of the Channel programme that supports a number of vulnerable individuals from various types of extremism. Most of these are adults but a small percentage of these are older children who have been successfully safeguarded from harmful ideas and behaviours.

21.4 During the year awareness raising and educational sessions were provided for around 500 young people in education settings (Act Now for pupils and the Smart Package for pupils and some parents) as part of the Prevent Strategy. School Governors have been provided with Prevent Training.

21.5 The Derby Safeguarding Children Board is currently unable to comment on the effectiveness of the Channel arrangements in detail because the information is restricted and not available for analysis or scrutiny. Action is being taken to seek a greater level of assurance to know whether young people are being adequately safeguarded by the Derby Prevent Plan.

22	**Female Genital Mutilation (FGM)**	

22.1 A multi-agency group meets quarterly to oversee arrangements to safeguard children at risk of female genital mutilation (FGM). Action has been taken to review national guidance and reports from national professional bodies to inform the revision of local procedures. The collection and analysis of anonimised health data and individual case detail has been under review as the national advice has evolved during the year. An action plan is being developed that will strengthen arrangements locally and this will be reviewed by the Quality Assurance sub group.

22.2 The Hamaari Project is working to support members of the East African and Middle Eastern communities in Derby. Partner agency representatives were involved in supporting the multi-agency and community launch of a series of workshops and awareness raising about FGM and its impact that were delivered by the project.

23	**Accommodation for 16/17 year olds**	

23.1 The new Housing Framework came into service in September 2014 as a much needed provision for 16/17 year old young people. The Housing Related Support (HRS) provision for this age group, along with other contracts, had been greatly reduced in April 2013 leaving the city with one provider of supported accommodation for young people who are not accommodated by Children's Social Care.

23.2 This contract, held by Riverside, provides 30 units of accommodation in shared houses and it remains the primary housing used for homeless young people.

23.3 Prior to September 2014, Housing Options were still in the position of using bed and breakfast accommodation for emergency housing if:

- there were no spaces in the housing related support provision
- there was unmanageable risk to the young person or they posed unmanageable risk to others in the scheme
- they had already been asked to leave the scheme because of their non-compliance with the licence conditions

23.4 Since September 2014 Housing Options have not had to place any 16/17 year olds in bed and breakfast accommodation. In the previous 5 months 12 placements

were made for 11 individuals in bed and breakfast accommodation with an average length of stay of 21 days. It is unsuitable accommodation for 16/17 year olds and is prohibited under housing legislation.

23.5 There is now a clear pathway for 16/17 year olds with referrals, via Housing Options, to Riverside shared housing being the first option. If this is not possible a referral, via Children's Social Care, is made into the Housing Framework.

23.6 The introduction of the Housing Framework has meant that a young person who has complex needs, but who does not want to be accommodated by the local authority, will have access to suitable accommodation.

23.7 The local authority housing department reports that there is swifter assessment of young people by Children's Social Care and 'joined up' working in many cases. However, there appears to still be some delay in getting assessments completed and a worker allocated if referrals are made through some of the multi-agency teams.

23.8 Although the local authority housing department hasn't placed anyone into bed and breakfast accommodation, it is unclear whether any placements have been made by Children's Social Care directly as there is no central record or requirement to notify such arrangements. This will be further scrutinised in the coming year.

24	**Youth Offending**	

24.1 Derby City Youth Offending Service was inspected against the 'short quality screening' assessment at the end of September 2014. Whilst onsite the three inspectors from HMI Probation tracked 20 cases meeting with case managers to assess the quality of work against four key criteria of:

- Reducing the likelihood of reoffending.
- Protecting the public.
- Protecting the child or young person.
- Ensuring that the sentence is served.

24.2 The lead inspector carried out this inspection and the last 'full inspection' against the Core Case Programme in March 2012. She was able to see the impact of the actions that were put into place to address findings and recommendations from 2012 and fed back that clear progress had been made from the last inspection.

24.3 The Youth Offending Service carried out a review of Transition Arrangements for the young people who transfer to adult services during the period of their sentence. A comprehensive report[21] set out a review of current arrangements and performance.

24.4 Overall, reoffending rates across the city have been on an improving trajectory and rates (reoffending and offences per offender) are below national

[21] Derby City Youth Offending Team – Transition arrangements – Follow up inspection (June 2015), Summary of current arrangements and performance. DCC (2015)

averages. The report identifies key features that include that there is good communication between all agencies including; case discussions between Youth Offending Service and National Probation Service and meetings that engage the young person and their parent / carer to make sure there is full awareness and a safe transfer to adult-based services.

24.5 Derby will be one of 6 areas to participate in a thematic inspection of Transition Arrangements in early summer. Inspectors will be visiting the National Probation Service, Community Rehabilitation Company and the Youth Offending Service. The outcome of the thematic inspection and areas for development will be considered by the Vulnerable Young People sub group.

24.6 Derbyshire Constabulary, the Youth Offending Service and two local authorities put in place procedures[22] to safeguard young people under 18 in police custody and have been actively monitoring numbers of children in custody overnight. This has led to a significant reduction in numbers to a very small number of cases that are very closely scrutinised to make sure appropriate decisions have been made. Future quality assurance of the arrangements will be obtained and reported on.

24.7 Youth Offending numbers increased quarter on quarter throughout 2013-14 but have reduced significantly over the last 2 quarters of 2014-15. Youth Crime Prevention Officers (who are co-located in locality Multi-Agency Teams) work with those young people at risk of offending. More in depth work is needed to examine whether their work has led to preventing these young people from entering into the formal youth justice system.

24.8 In January the East Midlands Resettlement Consortium was established with funding for the next 3 years to support the successful transition of young people from custody back into the community. Derby Youth Offending Service is taking a lead (regionally) on the project that is putting additional services in place to help improve 7 pathways that have been shown to promote successful resettlement. These include key protective factors such as securing appropriate accommodation, education/ training/ employment, accessing support for substance misuse problems and support for mental health and health needs.

25	**Private Fostering**	

25.1 Historically the reported numbers of privately fostered children in Derby has been low and as of the 31st March 2015 there are a total of 5 children and young people who had a current private fostering arrangement.

[22] Derbyshire Constabulary, Derbyshire Children and Younger Adults Department, Derbyshire Youth Offending Service, Derby City Children and Young People's Department - Young People under 18 in Police Custody Procedure (2014)

25.2 The number of new reported private fostering arrangements during 2014-2015 has remained the same as the previous year.

25.3 Overall Derby has improved compliance to statutory visiting across all areas and there is a well-established and robust reviewing system in place for Children in Need which includes this group of children and young people. All reviews are now given priority for privately fostered children and are independently reviewed by a Children In Need Reviewing Officer.

25.4 In order to improve awareness of private fostering letters were sent to all schools and General Practitioners within Derby in November 2014 and then repeated again April 2015 alerting them to their responsibilities to identify children/young people who may be privately fostered.

25.5 The admission details of *every* child who started in a Derby school were checked during the summer term to make sure that the parental responsibility for that child was recorded. It was not clear who had parental responsibility for 96 children and young people and the school for each of these children has been contacted to verify who has parental responsibility and where they are living. This has been established as a method of identifying on an ongoing basis potential private fostering arrangements. A full report will be presented to the Quality Assurance sub group in November following the start of the new school year to illustrate whether this approach has identified additional privately fostered children.

26	**Children and Young People who are victim of crime**	

26.1 Derbyshire Constabulary's priority and focus continues to be the safeguarding of children. To that end there are specialist Child abuse teams working across Derby City and County providing support and enforcement 7 days a week including a specialist call rota for out of hours investigations. There is also a specialist Child exploitation and on line investigation team based at Ripley Headquarters again providing a force wide safeguarding and enforcement capabilities.

26.2 Within the Central Referral unit at Ripley, there are 3 Child abuse specialist Detective Sergeants solely committed to multi agency engagement and decision making around safeguarding/criminal investigation identification.

26.3 Changes to the National Crime Recording Standards(NCRS) came into effect in 2014/15 whereby previous allegations of child abuse would be investigated until confirmed on a referral, now all allegations made from professionals are recorded as crimes immediately at the point of disclosure and the investigation continues within the specialist teams. This has increased the volume of crime recording. There has also been a year on year increase in the volume of child referrals received and processed. This adds to the crime recording and overall officer/central referral unit workloads.

26.4 Each quarter a number of child referrals are audited for quality within Derbyshire Constabulary as part of the NCRS process. This has given focus to

ensuring crimes are recorded for every allegation and in a timely manner. As of April this year all criminal allegations are required to be recorded within 24 hours.

26.5 In 2014 HMIC inspected the Public Protection crime recording quality and remarked that 'working practices had improved significantly and continue to do so'.

26.6 Although Derbyshire Constabulary has not yet been inspected specifically in respect of child protection practice by HMIC, 9 published HMIC inspection reports have been reviewed and the common themes examined against local practice. This has increased local focus and emphasis on the Think Family campaign internally ensuring officers consider safeguarding of children a priority at all times.

27	Impact of the Learning and Improvement Framework	

27.1 The learning and improvement framework pulls together much of the work of the Derby Safeguarding Children Board. The learning arising from quality assurance work is driven by priorities set as a result of considering case work and identifying those areas for improvement.

27.2 For example the Pre-Birth Assessment and Intervention Protocol was implemented across Derby in 2013 and has been updated. The need for the protocol was identified as a result of learning reviews and practice was subject of audit activity before it was fully implemented to establish a baseline and be clear where improvement was required. At the end of 2014 further audit work was carried out to demonstrate the effectiveness of these arrangements and its impact on arrangements for vulnerable babies and their parents.

27.3 The 2014 audit[23] gave a mixed picture of the progress that has been achieved. There were examples of good information sharing and positive multi-agency working including positive pre-birth planning and the clearer identification of risks. However there were elements of the Protocol that were not being adhered to, most notably delays to the commencement of assessments by Children's Social Care.

27.4 The audit demonstrated that the Pre-Birth Assessment and Intervention Protocol has begun to have an impact however the full potential is adversely affected in those cases that require the early involvement of Children's Social Care. Concern about progress was monitored by the Quality Assurance sub group and escalated to the Derby Safeguarding Children Board. A formal report on progress by Children's Social care to the Quality Assurance sub group is expected in August and will be subject of further assurance in the coming year.

27.5 Equality and Diversity is woven through the learning and improvement framework and the work of the Derby Safeguarding Children Board. Specific issues that have arisen as priorities during the year are safeguarding arrangements in

[23] Report on pre-birth multi-agency case file audit 2014. N Cooper (2014)

relation to new and emerging communities in Derby and measures to safeguard children from female genital mutilation.

28	Serious Case and Learning Reviews	

ED12 SCR

28.1 A serious case review published in the previous year (ED12) made recommendations to ensure that Multi Agency Risk Assessment Conferences (MARAC) about Domestic Violence consider the children of perpetrators whether or not they live in the same household. Audit activity identified that the safety of all children is being considered at meetings.

28.2 In October the police commissioned an independent audit[24] of the effectiveness of local Multi Agency Risk Assessment Conference (MARAC) arrangements and reported the findings to the Quality Assurance sub group. The audit provided a broader evaluation of local arrangements and reported on the significant increase in numbers of referrals. An action plan was implemented by the police in January.

28.3 Examples of changes arising from the action plan include:

- The numbers of referrals where the scoring of medium risk has increased from the lower standard risk cases which is interpreted as reflecting positively that officers are using their half day training and professional judgement to assess the case overall in a more effective way.
- Repeat incidents of domestic violence of cases previously considered at MARAC have increased as the previous “gatekeeping” process was removed and all repeat incidents (in a rolling 12 months period from the previous incident) are referred to MARAC as a high risk.
- An escalation process is being developed to identify victims of 5 incidents or more in a rolling 12 month period who have not been flagged as a high risk to MARAC. This will lead to further consideration of what action should be taken to support the victim.

DD12 SCR

28.4 The Derby Safeguarding Children Board published the serious case review report into the tragic death in 2012 of a baby boy, known for the purpose of the review as DD12. He was born with very complex medical needs and during his short life he had significant levels of support from a wide range of professionals including health and children’s social care.

28.5 In February 2012, concerns about his safety were considered by the Family Proceedings Court following an application for an Emergency Protection Order (EPO). The EPO was not granted and the Court determined that the injury being considered was accidental. DD12 returned home. Shortly after this, in May 2012,

[24] Report for Derbyshire Governance Board. J Vickress CAADA (2014)

DD12 died as a result of internal bleeding caused by a head injury. His father pleaded guilty and was convicted of his manslaughter in 2013.

28.6 DD12's complex needs were being met by a number of health providers working together and the case has emphasised the need to provide coordinated early help across all children with disability services where families are experiencing difficulties.

28.7 Once a suspicious injury had been identified, decisive action was taken by all agencies. More robust advice to the Magistrates should have been provided and the impact of the decision by the Magistrates that this injury was definitely accidental was significant. It left professionals unsure how to work with the family and whether there were ongoing child protection concerns.

28.8 Despite this DD12 was seen regularly by trained professionals who did not see significant indicators of concern.

28.9 Serious case reviews often identify lessons that have been learnt before but this one is unusual. The review does not identify major failings in respect of agencies working together; it identifies features of good practice. However, there are lessons about ways in which professionals felt tied by decisions. He was not an invisible child, but one who was well known to local agencies during his short life and action was taken to try to protect him.

28.10 Her Majesty's Courts and Tribunal Service (HMCTS) have assured the Board that specific advice was issued to all legal advisors on the management of any application for an emergency protection order; all such applications are now referred to the senior family lawyer on site to ensure appropriate supervision.

28.11 In light of this case, there is careful reflection when Emergency Protection Orders are sought when there is no safe alternative and to ensure that there is sufficient evidence to support the application.

28.12 Further work was undertaken to understand how effectively men in households were engaged with. The Quality Assurance sub group undertook an audit during the year to understand how individual agencies carried out their work to safeguard children with men.

28.13 The audit indicated that agencies do not consistently and systematically record the details of men in households and that there needs to be an improvement in their engagement.[25] Agencies undertook to raise this and emphasise the need to improve the recording and evidence of how Think Family principles were reiterated to promote the work with men in households. A further audit is planned in the new year to see whether sufficient progress has been made.

Learning Review

[25] Report on the recording of father's and male carers' details. N Cooper (2014)

28.14 A learning review was carried out during the year. The specific details of the case may identify and lead to harm for the family members involved and are not published.

28.15 Some of the key areas considered by the review included:

- Importance of the effective management and investigation of concerns around suspected familial sexual abuse.
- Management and exploration of concerns around neglect and unmet needs of vulnerable children including assessment of living conditions.
- Cross geographical transfer of children and young people and management oversight in children social care in Derby and Derbyshire.
- Children Missing from Education.
- Working with new emerging communities and cultural issues.
- Working with Vulnerable Young People and transition into Adult Services.

28.16 As a result of involving young people in the review, they helped identify that further action was needed to safeguard their welfare and this was taken.

28.17 The review led to developments such as Section 47 (Child Protection Enquiry) Briefing Sessions (described below) and action to improve transfer of cases on a regional basis.

Learning from BDS12 a SCR in Derbyshire

28.18 The review BDS12 led to changes to the assessment and automatic sharing of information with health visiting services in Derby and Derbyshire about concerns that parents of young children were misusing substances. There were some reservations that the changes may potentially impact on parents (particularly single parents) accessing treatment. This was due to an assumed impact of service users not being willing to share information (which is now not optional) and choosing to decline treatment. However there has been no observed adverse impact to parents accessing or remaining in treatment.

Impact

28.19 In 2014/15 a number of service users (3) lodged formal complaints with Phoenix Futures (Derbyshire Healthcare Foundation Trust partner in providing drug treatment in Derby) in relation to the referral of cases to social care around risk issues. In each case an investigation found that the Phoenix Futures staff and wider multi-disciplinary team had taken the correct decision in referring to social care. It is felt within the service that this is a vindication of the work undertaken in the wake of SCR BDS12 to review risk assessment within the service, reinforcing the Think Family approach and to ensure staff are addressing risks and challenging where required.

29	**Child Death Overview Panel (CDOP)**	

29.1 The fifth Derby City and Derbyshire County Child Death Overview Panel Report[26] will be presented to the Derby Safeguarding Children Board in September covering the activity for the period of January 2013 to the end of March 2015. This will enable reporting in line with the reporting of other Derby Safeguarding Children Board activities and enable effective scrutiny of arrangements.

29.2 This report provides information on trends and patterns in the child deaths reviewed during the reporting period and makes recommendations to the two Safeguarding Children Boards and other relevant bodies such as the Health and Wellbeing Board based on the analysis and findings from these reviews. The report also provides assurance that CDOP is meeting its statutory functions as set out in Working Together to Safeguard Children Guidance (2015).

29.3 The report illustrates improvements in the effectiveness of the work carried out by the Panel. This includes promoting the active participation of the role and views of the lay member and recognition that it was not always clear exactly where action had been taken and completed. This is something that has been recognised and changes have been made to improve recording of actions in the future.

29.4 The report illustrates the work that has been completed following the reviews of child deaths and examples include:

- A new pathway for contacting the Derby Teaching Hospital, Kids in their Environment (KITE) team members out of hours and in exceptional circumstances has been put in place as a result of reviewing a specific case where death was expected, but not anticipated to deteriorate so quickly
- Communications regarding car seats and dangerous dogs has been circulated
- A campaign to raise the awareness of nappy sac campaign has been undertaken, with the support of Royal Society for the Prevention of Accidents (ROSPA)
- Recognition that smoking in pregnancy (SiP) is a modifiable factor in child deaths reviewed by CDOP. In February 2015, Derby Teaching Hospital having worked with Derby City Public Health and Southern Derbyshire Clinical Commissioning Group agreed that carbon monoxide screening will be done with pregnant women to help identify those who do smoke, as per National Institute of Clinical Excellence (NICE) guidelines. This will enable them to access smoking cessation services in a timelier manner. Implementation of this programme began in July 2015.
- Since 2008, our BabySafe group has been working hard to promote multiagency safe sleep arrangements for young babies to reduce sudden unexpected deaths in infancy, producing a safe sleep assessment tool which has been adopted by other areas, the production of Local Safeguarding Children Board (LSCB) guidance to support safe sleeping babies and infants and LSCB guidance on the prevention of non-accidental head injury. We have promoted the key messages about keeping babies heads safe and management of a crying baby through a Parental Education Programme

[26] Derby and Derbyshire Child Death Overview Panel Annual Report – January 2013 to March 2015. H Sultan and S Raju. (2015)

which uses a DVD called “Shaking the Baby is just not the Deal”. This is supported by the use of information leaflets and a commitment statement which parents are asked to sign as proof of completion of the programme and demonstrate commitment to keeping baby safe. Both programmes are fully supported by child and family teams and Midwifery Services provided in Derby City and Derbyshire.

30	Impact of Multi - Agency Safeguarding Training	

30.1 The impact of Inter Agency Derby Safeguarding Children Board safeguarding training on practice was audited during the year and reported on in detail in two reports submitted to the Quality Assurance sub group and the annual training report.

30.2 The audit undertaken this year focussed in detail on two courses (building on the 10 courses audited last year) that were key areas emerging from the Learning and Improvement Framework.

Domestic Violence Risk Identification Matrix (DVRIM)

30.3 The DVRIM is a toolkit for use by all agencies to identify the potential impact of domestic violence on children in a family. Between May 2014 and September 2014 390 staff attended one of 19 half day briefing sessions. The DVRIM was evaluated at the end of the briefing sessions[27]. Over 95% of people completed a form. Out of a possible score of 8 - 7.2 reported that the course increased their confidence. 7.1 reported that they felt more skilled and the overall rating for the briefing was 6.9.

Impact

30.4 In addition to the evaluation sheets at the end of the briefing 55 phone calls were conducted with the 390 attendees. 50/52 responded that they had been able to share their learning about the use of the DVRIM and just under half had been able to use the tool in their practice in the few weeks after the course. Additional interviews were carried out with 12 staff in key roles such as Child Protection Managers, a Team Manager and Manager of the Independent Domestic Violence Advisor service, Children in Need Reviewing Officers and Trainers. The additional feedback highlighted themes and suggestions for further improving multi-agency practice and were included in the report on the implementation of the DVRIM.

30.5 While it is too early to comment on the wide scale impact of such a systemic development, initial evaluation indicates that DVRIM helps staff to reflect on the reality for each child in the family, the protective factors, the risk factors and issues relating to Black and Ethnic Minority Communities.

Section 47 (Child Protection Enquiry) Briefing Sessions

[27] Feedback Report on the Implementation of the DVRIM April 2015. N Feldman (2015)

30.6 In February 2015 two briefing sessions were held to bring together the learning arising from the Learning Review and the Section 47 Case file Audit[28] to improve the way joint decisions are made and recorded by the police with children social care and health services.

Impact

30.7 In total, 54 people attended the two workshops: 24 children's social care, 17 police and 13 health services. The evaluation forms consistently showed good or very good in response to questions about increased confidence, increased skill and overall rating.

30.8 Participants reported[29] the following progress had been made since the completion of the Learning Review and practice had changed in the following ways:

- **Attendance:** There is better representation by education staff at strategy meetings and there is improved representation now from health services and the police at child protection conferences. Strategy meetings at hospitals are very well attended; this needs to be replicated in other areas such as Children in Care strategy meetings where the police and children's social care are most frequently present.
- **Clarity of purpose of meetings and setting up meetings:** Participants felt there is now more clarity about the purpose of meetings and there has been a general improvement in liaison and responding to sharing information about cases.
- **Recording:** The children's social care data recording system has been updated with a new system during 2015 and as a consequence a new pro forma will help both record the progress of strategy discussions or meetings and child protection enquiries and is improving feedback to other agencies.
- **Investigations:** Joint visits (police and children's social care) have increased in frequency and nearly always occur for child sexual abuse investigations and they are being considered in the case of physical abuse.
- **Further development:** Practitioners reported that there were areas for further development and progress will be reviewed over the coming year to continue to promote learning and improvement.

E Learning training: Introduction to Safeguarding

30.9 Following the launch of the E Learning training on the Derby Safeguarding Children Board website, responses from 60 people who had completed the training were analysed to ensure that it was fit for purpose and an effective method of training.

Impact

30.10 Participants found the content useful and the course easy to use. They all illustrated specific goals for their individual practice as a result of completing the

[28] Report on the multi-agency S47 case file audit 2014 Final. N Cooper (2014)
[29] Report on the Section 47 Briefings May 15. N Feldman (2015)

course. The analysis overwhelmingly affirmed the important value and effectiveness of the training course as an introduction to safeguarding and has improved access for anyone wanting to establish a foundation for safe practice and future learning.

31	**Partner Agency Safeguarding Reports, (S11) Audit and Analysis**	

Markers of Good Practice visits

31.1 During summer 2014 the Independent Chair of the Derby Safeguarding Children Board and Board Manager joined the Southern Derbyshire Clinical Commissioning Group in the quality assurance visits to health providers in Derby.

31.2 Health providers demonstrated evidence of compliance with the markers of good practice and section 11 standards for their assessment of the year 2013/2014. The visits enabled the Board to explore the evidence of the effectiveness of arrangements and talk directly to a range of professionals involved in driving forward safeguarding within their agency. These visits were particularly helpful.

31.3 Follow up reports were provided to the Southern Derbyshire Clinical Commissioning Group by health providers demonstrating what action was planned to continue to drive forward improvement. This action planning and progress was subsequently scrutinised as part of the reporting to the quality assurance group described below.

Section 11 and Markers of Good Practice self-assessments 2014 -2015

31.4 The Quality Assurance Group obtained updates from agencies to demonstrate the changes that had been brought about by activity arising from the Section 11 and Markers of Good Practice self-assessments that had been carried out in the previous year.

31.5 Partner agencies were asked to demonstrate the following:

(a) Progress made against identified actions from the previous year
(b) A summary of any issues that had arisen during 2014 / 2015 where action had been taken to ensure compliance with S11 standards
(c) How feedback had been obtained from staff about the effectiveness of the changes impacting on them,
(d) Key areas identified for future action as a result of any of the above points

31.6 S11 audit updates were received from: Derby City Council (Children's Social Care), Derbyshire Constabulary, Derbyshire Healthcare Foundation Trust, Derby Teaching Hospitals NHS Foundation Trust, Ripplez, CAFCASS, Probation (Both the Community Rehabilitation Company and National Probation Service) and Youth Offending Service.

31.7 A report[30] summarising the updates will be presented to the Quality Assurance sub group in August. This report describes how agencies have demonstrated the action taken as a result of previous audits (for example audit of how learning from reviews has informed improvement in staff practice). Some partner agencies were able to provide feedback demonstrating those issues that have changed or emerged, linked to the S11 standards, over the last year and what has been done to improve safeguarding arrangements as a result.

31.8 The Derby Safeguarding Children Board will over the coming year strengthen the section 11 process to ensure that agencies provide consistent and clearly illustrated feedback and analysis, based on internal audit, of whether standards are being met. The Board will seek more detailed analysis of the impact of arrangements and whether all agencies are responding actively to changing standards and national guidance in relation to safeguarding responsibilities.

DFE Children Safeguarding Performance Framework

31.9 The Children's Safeguarding Performance Framework (DfE 2015) was scrutinised by the Quality Assurance sub group and agencies reported on compliance with the framework and areas for improvement. During the coming year the sub group will be working to ensure the actions arising from the review lead to improvements in reporting arrangements where needed to establish a robust system wide framework.

32 Allegations against staff, carers and volunteers

32.1 The Workforce Group will review and scrutinise the annual report about allegations against staff, carers and volunteers and report on progress to the Derby Safeguarding Children Board.

32.2 In summary, there were 171 referrals to the Local Authority Designated Officer for allegations (LADO) in the specified time period compared with 114 (2013-14), 104 (2012-13) and 102 (2011-2012). As agreed last year, these figures now include contacts where it is quickly established that these do not meet the criteria for LADO; 89 of these referrals (52%) were felt to meet the threshold. Last year's figures will have included only a small number of these, so this is not indicative of a significant change in activity arising from allegations against staff, carers and volunteers.

A table illustrating referral figures is set out below

AGENCY	2012-3	2013-4	2014-5	
			Threshold met	Advice only
Agency Fostering	1	5	1	4
Agency Residential Care	7	8	8	3
DCC Fostering	7	12	8	2

[30] DSCB S11 Audits QA Report for 2014 2015. M Sobey (2015)

DCC Residential Care	6	13	4	6
CYPD	2	2	1	1
DCC other	2	2	0	1
Child care	12	5	17	13
Primary school	18	19	16	19
Secondary School	22	19	13	13
College	0	4	3	2
Health	2	8	5	5
Police	2	0	0	0
Faith group	5	0	5	1
Sports			0	3
Transport provider			1	2
Voluntary sector	9	3	2	5
Private sector	8	4	0	3
other	1	10	0	0

32.3 There has been a striking increase in referrals from child care providers, even more when taking into account advice-only contacts. Otherwise the distribution of referrals across agencies is broadly the same as previous years, and with numbers being very small it is not possible to identify any trends. Referrals remain very low for the Police; they have been challenged on this in the past, with assurances given, but it may be helpful to obtain data from the Professional Standards team to evidence that any complaints relating to children are also subject to allegations processes.

32.4 The nature of concerns being referred to the LADO remain broadly similar to previous years. There is an increase in issues relating to conduct overall; these include concerns “by association” which were extended to apply in schools as well as child care establishments in January this year. Many of these however are the ones which fall below the allegations threshold. As identified last year, we have clarified the distinction between inappropriate behaviour at work, and conduct outside work.

Quality Assurance of the LADO processes

32.5 Sampling of the records shows good quality and thoughtful advice to employers and others; threshold and areas for inclusion under LADO procedures has some variability but the team engages in a sharing and challenge process which promotes a shared approach to the public. Case files still show inconsistencies in the recording of the outcome of the investigation and in recording of recommendations in minutes, and there are some examples of incomplete records. This needs to be improved. There is a process for tracking referrals and progressing cases which is helpful, but still has scope for improvement.

32.6 The need for more robust auditing of allegations against staff, carers and volunteers alongside the County has been raised and options are under

consideration. The LADO annual report demonstrates rigorous self-assessment of the service and clear actions for the coming year. The action plan for the coming year will be agreed by the Workforce sub group.

33	Capacity of the Workforce	

33.1 The Derby Safeguarding Children Board is required to scrutinise arrangements for maintaining a safe, sufficient and effective workforce. Initial workforce capacity reports were obtained at the end of 2014 and provided early indications of the challenges arising to some partner agencies over a short period within the year. It was decided that figures for a full year should be obtained from all relevant agencies and scrutinised in detail.

33.2 The Workforce sub group commissioned capacity reports in respect of the following key front line roles:

1. Front-line social workers
2. Police Officers (Public Protection Unit)
3. Community Midwives
4. Paediatricians (Derby Teaching Hospitals NHS Foundation Trust)
5. Health Visitors
6. School nurses
7. CAMHS practitioners
8. Looked After Children Nursing Team
9. Community Paediatricians
10. Family Nurses
11. Designated Nurses and Designated Doctors (Southern Derbyshire CCG)

33.3 Workforce group partners will present their reports at the joint workforce sub group meeting held in July and a summary of the relevant issues will be provided to both Derby and Derbyshire Safeguarding Children Boards in September.

34	Impact of Policy and Procedures	

34.1 Four assessment tools were updated during the year and have made an impact on local practice. There has been a rise in the use of the Early Help Assessment and it is an important element to local Early Help arrangements and their impact as reported above in sections 14 and 19. Plans are in place for evaluating the quality of Early Help Assessments in the coming year.

34.2 The updated CSE risk assessment toolkit is evidenced as making a difference in both the early assessment of children who are missing and the work being undertaken to assess and reduce the risk of child sexual exploitation as reported in section 19 above.

34.3 The updated Graded Care Profile is now part of the consideration of the assessment of risk of neglect and ongoing significant harm at child protection conferences. Better informed assessments and plans around neglect may be a

contributory factor in a reduction in numbers that has become apparent towards the end of the reporting year.

34.4 The Pre-Birth Assessment and Intervention Protocol was implemented across Derby in 2013 has been amended and is now in use across Derbyshire and comment about its impact is set out in section 27 above.

35	Licencing	

Licenced Premises

35.1 A multi-agency campaign, *See Something Say Something*, was carried out during the year to publicise the risks of Child Sexual Exploitation with visits to 82 licenced premises including Hotels, Bed and Breakfasts, Takeaway Food outlets, Licensed shops, Taxi Companies and Public Houses.

Impact

35.2 The awareness campaign was well received with establishments displaying posters in staff areas, displaying stickers and updating company rules. The owners of some establishments weren't available and further follow up contact is planned. In cases where there was a refusal and reluctance to engage with the campaign arrangements were made to monitor closely the establishments carrying out their responsibilities as a licenced premises appropriately. Following on from the campaign there is good evidence that hotels and other licensed premises are sharing their concerns with the police. The licencing arrangements are embedded as part of the CSE strategy and are working well to safeguard children.

Licensing and Environment Services

35.3 All teams within the Environment and Regulatory Services recognise their responsibilities and are committed to safeguarding children and vulnerable adults whilst undertaking their statutory duties and will, where appropriate, address and advise on issues of safeguarding within businesses that they visit. They also work with internal and external partners to ensure that safeguarding is embedded into the operation of businesses within the City.

35.4 A review of the Licensing Protocol took place following Professor Jay's report and more specifically related to the Louise Casey report into Rotherham City Council. The latter in particular, in identifying common threads between taxi licensing and child sexual exploitation, led to a comprehensive review in Derby of the Council's licensing administration system. The recommendations, all in line with the Casey report, are to be agreed at a council meeting on the 2nd of July 15. The Derby Licensing protocol has also been updated to ensure safeguarding, licensing and Police teams work effectively together.

36	Derby Safeguarding Children Board Performance and Outcome Measures	

36.1 Analysis of Demographic Data: Derby Population, Children receiving Early Help (Targeted) Services, Children in need, Children in Care and Children Subject of Child Protection Plans

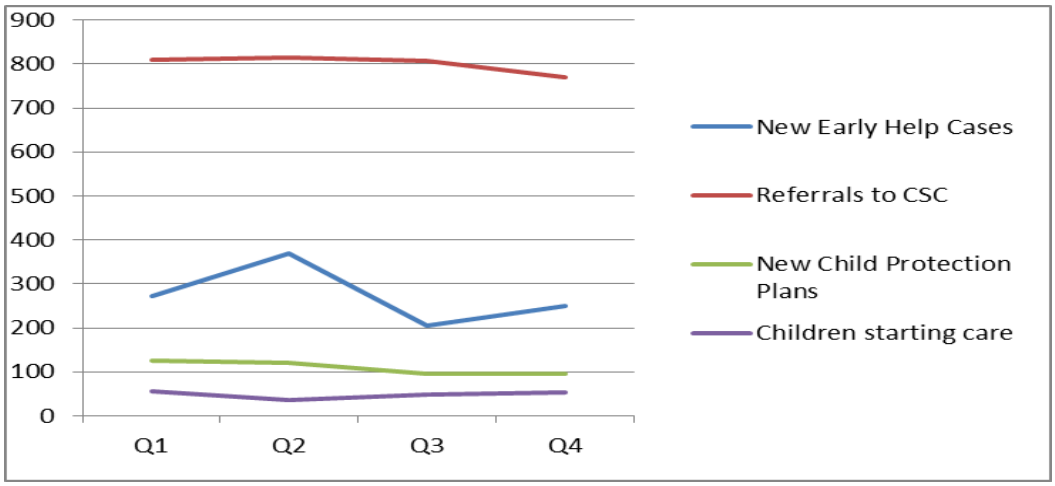
Ethnic Group	Derby Population 2011 Census	Early Help Services	CIN	Children in Care	Child Protection Plans
Asian or Asian British	**12.5%**	**5.4%** [5.7%] (5.1 %)	**12.5%** [10.3%] (8.4 %)	**3.3%** [2.4%] (2.4 %)	**12.3%** [9.2%] (15.5 %)
Black or Black British	**2.9%**	**2.5%** [2.2%] (4.3 %)	**3.4%** [3.4%] (3.8 %)	**2.5%** [3.7%] (3.2 %)	**3.0%** [3.1%] (1.3 %)
Dual Heritage	**2.9%**	**11.8%** [8.1%] (6.6 %)	**9.3%** [12.9%] (12.0 %)	**13%** [11.3%] (11.3 %)	**11.7%** [11.9%] (9.9 %)
Not recorded	Nil	**18.8%** [21.0%] (6.8 %)	**9.3%** [4.9%] (5.1 %)	**0.6%** [0.2%] (0.2 %)	**1.7%** [2.0%] (3.9 %)
Other	**1%**	**1.0%** [4.3%] (4.8 %)	**2.6%** [1.4%] (2.3 %)	**4.4%** [3.5%] (2.2 %)	**5.7%** [1.7%] (4.3 %)
White British	**75.3%**	**55.9%** [53.2%] (63.4 %)	**57.4%** [62.3%] (65.2 %)	**69.9%** [75.4%] (79.2 %)	**56.0%** [67.0%] (62.1 %)
White Other	**4.9%**	**4.7%** [5.6%] (9.0 %)	**5.4%** [4.7%] (3.1 %)	**6.3%** [3.5%] (1.5 %)	**9.7%** [5.1%] (3.0 %)

[2013 – 2014 figures in brackets**]** **(**2012 - 2013 figures in brackets**)**

36.2 The demographic figures for children subject of child protection plans relate to small numbers of children and small changes in numbers can cause notable changes. Asian or Asian British children access early help services in continued low numbers in comparison to the population yet have increased as children in need. Early help services have increased the recording of children with dual heritage. It is not clear whether the recording of dual heritage is symptomatic of the way ethnicity is recorded across services and has particularly affected changes numbers in respect of Asian or Asian British and White British. Increases in the New European Communities in Derby are reflected in the increase in the “White Other” demographic recording. Greater analysis of demographic factors will be requested for Early Help services in particular for the coming year.

36.3 Requests for Services

Overall trends for requests for services over the year are illustrated below.



Children in Need[31]

36.4 A child in need is one who has been assessed by children's social care to be in need of services. These services can include, for example, family support (to help keep together families experiencing difficulties), leaving care support (to help young people who have left local authority care), adoption support, or disabled children's services (including social care, education and health provision.)

36.5 Derby had 2,444 children in need at 31st March 2015 which equates to a rate of 422.6 per 10,000, which is very much in line with the comparator average from 2013-14 which was (422.8). Derby saw a reduction of 122 cases compared to last year.

36.6 45.2% of all open cases at 31st March 2015 were Female and 52.2% were Male. Derby had 52 open cases dealing with expected babies as at 31st March 2015 (2.1% of all cases)

36.7 30% of all open cases at 31st March were aged 10 to 15 years old, 28% were aged 5 to 9 years old, 21% were aged 1 to 4 years old. Almost 9% of our cases were either babies aged under 1 or expected babies (216 cases out of 2444)

36.8 12.6% of all children in need cases at 31st March 2015 had a disability recorded (308 children from 2,444). This is an increase from the previous year where 5.6% of CIN cases were identified as disabled. This increase can be attributed to a wider data collection exercise undertaken during 2014-15 rather than an actual increase of disabled children. All children's teams were asked to partake in the

[31] Children in Need, Child Protection, Referrals and Assessments (2014-15) Published: July 2015 Derby City Council

census rather than just the Disabled Children's Service as was done in previous years.

36.9 Learning (8.3%), Communication (5.9%) and Personal Care (5.7%) were the most frequently used disability codes during 2014-15, which is the same as the previous two years.

36.10 26.3% of cases in Derby were open for a duration of less than 3 months as at 31st March 2015. This is slightly higher than the comparator and national averages from 2013-14 (both 24.8%).

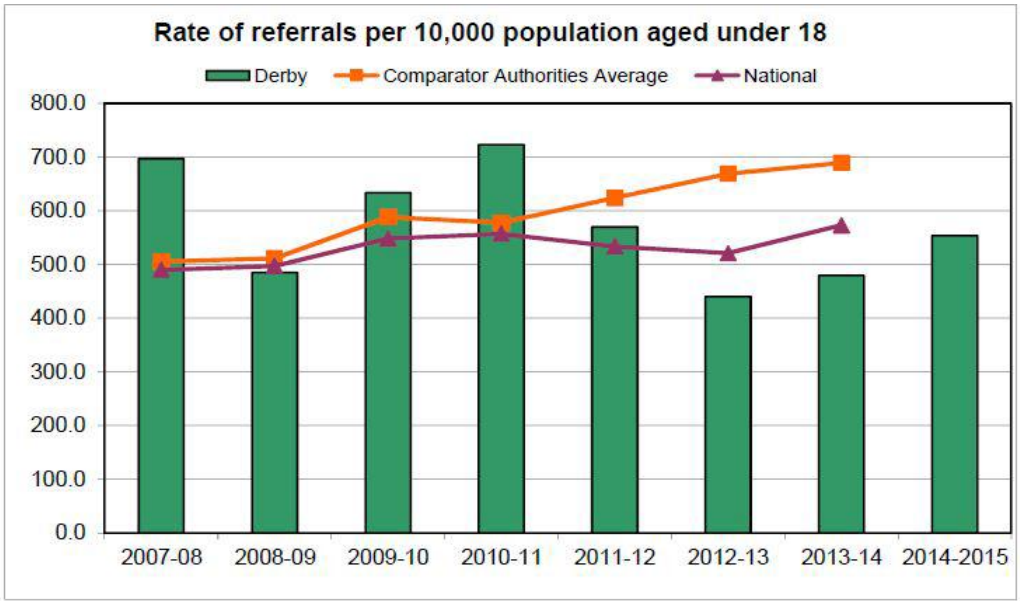
36.11 41.3% of cases in Derby were open for a duration of 1 year or longer as at 31st March 2015. Last year's figure was 49.3% which is a reduction of 8%. The 2013-14 comparator figure was (48.4%) and the national figure was (46.8%).

36.12 74% of all children in need cases at 31st March 2015 were open due to CN1-Abuse and Neglect (CN1) (1809 out of 2444), 13.7% were open due to CN2-Child's Disability and 7% were open due to CN3 - Parent's disability or illness

36.13 2995 children ceased to be a child in need during 2014-15. 46.5% of these cases had been open for less than 3 months (1393 out of 2995). 18.6% of these closed cases had been open for one year or more. (557 out of 2995)

Referrals

36.14 Derby had 3201 referrals during 2014-15, which is an increase of 435 referrals from the previous year. Derby's rate of referral for 2014-15 is 553.5 per 10,000 population which is slightly below the 2013-14 national rate of 573.0 and the comparator authority average rate of 689.2. This is a slight increase from Derby's rate in 2013-14, when the rate was 479.4



Single Assessments

36.15 Derby moved away from the recording of separate initial and core assessments at the end of 2013-14. Single assessments were in place from 1st April 2014 so we don't have any historical trends to compare against currently.

36.16 2074 Single Assessments were completed during 2014-15. 84.5% of these were completed within the required timescale of 45 working days.

36.17 Of the 2074 Single Assessments completed during 2014-15, Domestic Violence was identified as an Assessment Factor in almost 55% of all assessments. This could be against the child (343 cases,16.5%), the parent/carer (672 cases, 32.4%) or another person (124 cases, 6.0%)

36.18 33.2% of all Single Assessments completed during 2014-15 had Mental Illness as an identified Assessment Factor. This could be identified as the child (195 cases,9.4%), the parent/carer (430 cases, 20.7%) or another person (63 cases, 3.0%)

36.19 Alcohol and Drug Misuse also featured highly within the Assessment Factors for 2014-15. 20.9% of all factors were attributed to alcohol misuse - child (38 cases,1.8%), the parent/carer (328 cases, 15.8%) or another person (68 cases, 3.3%). 19.4% of all factors were attributed to drug misuse - child (53 cases, 2.6%), the parent/carer (273 cases, 13.2%) or another person (76 cases, 3.7%)

36.20 126 assessment factors were logged against children and young people who were at risk of self harming (6.1%), 156 assessment factors were logged due to socially unacceptable behaviour (7.5%), 88 factors were logged due to Child Sexual Exploitation (4.2%) and 74 factors were logged for Young Carers (3.6%)

Section 47 enquiries and initial child protection conferences

36.21 The number of Section 47 enquiries completed in Derby during 2014-15 has increased again for the fourth year running, rising from 327 in 2011-12 up to 480 in 2014-15. There has been a steady increase seen in the comparator authority average over the past six years. The gap between Derby's numbers and the comparator authority average is widening. The average number of enquiries completed in our comparator groups was 1089 in 2013-14.

36.22 The conversion rate in Derby remains much higher than those seen in our comparator authority group and nationally. 95.4% of Derby's Section 47 enquiries resulted in an initial child protection plan this compares to 45.8% seen nationally in 2013-14.

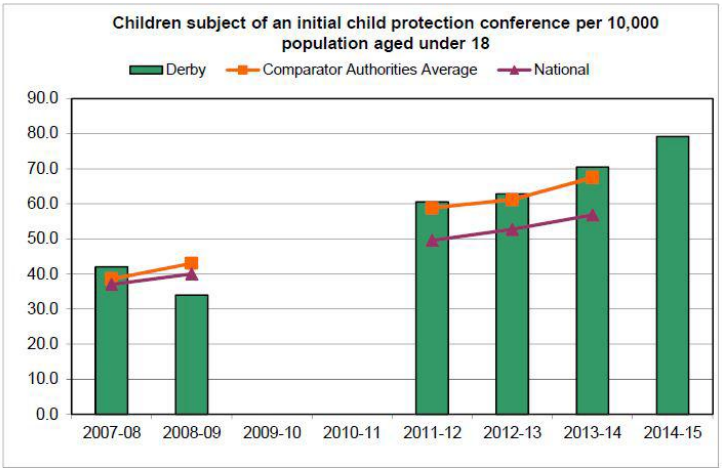
Children who were the subject of a child protection plan

36.23 458 initial child protection conferences were completed in Derby during 2014-15. This is the highest number we've seen in Derby over the past eight years. We

are in a similar position to our comparator authorities with a rate per 10,000 of 79.2 compared to 67.5 for our comparator average and 56.8 nationally.

36.24 314 children in Derby had a child protection plan as at 31st March 2015, this equates to a rate of 54.3 per 10,000 children. This is the highest figure we've seen over the past eight years.

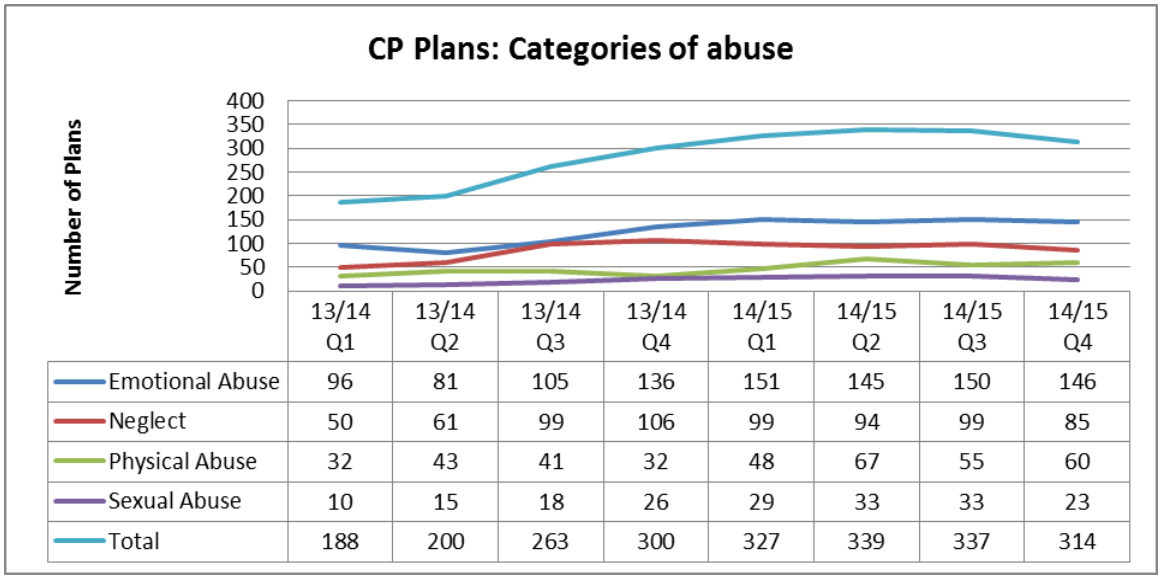
36.25 Derby's figures continue to be in line with the comparator authority average, though the national average rate is lower at 42.1. The actual number of children with a child protection plan at year end increased from 300 in 2013-14 up to 314 in 2014-15.



36.26 Derby had 436 children who became the subject of a child protection plan during 2014-15, of these 48 (11.0%) became the subject of a plan for the second or subsequent time. This compares to 15.8% nationally and 13.9% for our comparator authority average seen in 2013-14.

36.27 Derby had 422 children who ceased to be the subject of a child protection plan during 2014-15, of these just three children (0.7%) had been on a plan for more than two years. This compares to 4.5% nationally and 5.9% for our comparator authority average seen in 2013-14.

36.28 54% of children with child protection plans were seen during 2014-15 by the lead social worker in accordance with their plan.



	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Emotional Abuse	96	81	105	136	151	145	150	146
Neglect	50	61	99	106	99	94	99	85
Physical Abuse	32	43	41	32	48	67	55	60
Sexual Abuse	10	15	18	26	29	33	33	23
Total	188	200	263	300	327	339	337	314

36.29 The figures above illustrate the overall numbers of children subject of child protection plans over the last two years and trends in respect of the category of abuse that was the main concern.

Children subject of Child Protection Plans with a Disability or Learning Difficulty

36.30 There are 10 children who have disabilities and are subject of child protection plans (as of 31st March 2015). Whilst the numbers are small there is a slight reducing trend (noting that the numbers have changed during the year). Further exploration of arrangements to safeguard children with disabilities with a child protection plan will be included in the wider review in the coming year.

	2011-2012	2012-2013	2013-2014	2014-2015
Total children with disabilities subject of CP Plans	21	12	12	10

Crime where the victim is a child

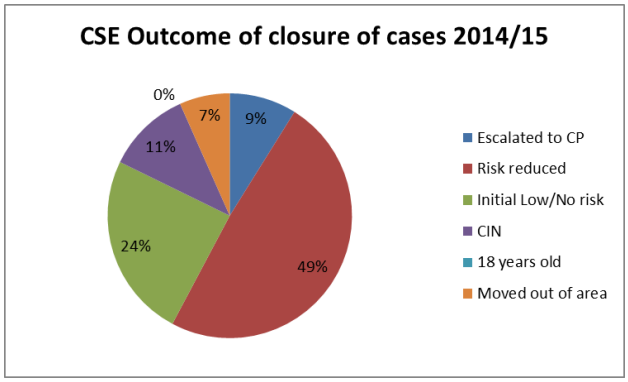
Recorded Crime (Derby City)	**2012-2013**	**2013-2014**	**2014-2015**
Crime Type	Crimes with Victim aged under 18	Crimes with Victim aged under 18	Crimes with Victim aged under 18
Rape	29	40	63
Other Sexual Offences	63	90	168
Violence with Injury	286	271	343
Violence without Injury	212	162	169

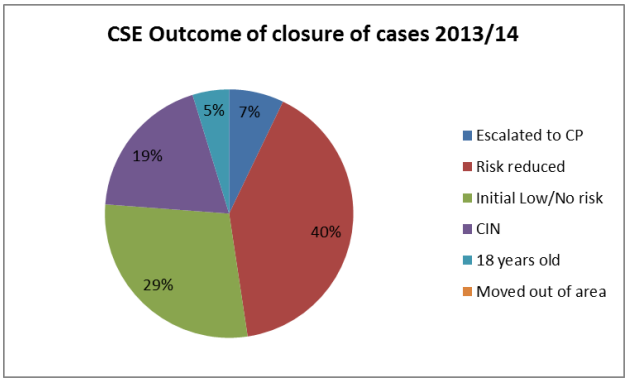
36.31 Changes to the National Crime Recording Standards(NCRS) came into effect in 2014/15 whereby previous allegations of child abuse would be investigated until confirmed on a referral, now all allegations made from professionals are recorded as crimes immediately at the point of disclosure and the investigation continues within the specialist teams. This has increased the volume of crime recording.

Child Sexual Exploitation

Risk Reduction

36.32 There has been an increase, compared with the previous year, in the risk reduced at the point of the closure of cases subject of CSE Strategy Meetings. This year there were no cases closed as a result of a young person becoming 18 years old. Previous year's figures are set out below





Missing Children

36.33 The definitions of how missing episodes reported to the police and absences (when children and young people are not where they should be) were changed last year. Therefore the figures between the two years are not directly comparable. The Derby Safeguarding Children Board has asked for greater levels of assurance about the impact of missing interviews and the impact of the missing person management group consideration of individual young people who are missing for 3 episodes (missing from home and care). This is in addition to improving scrutiny of the reporting of missing episodes of children placed out of Derby.

	2013-2014	**2014-2015**
Total number missing (Episodes)	518	**332**
Missing from Home (Episodes)	338	**211**
Missing from Home (Individual YP - From April 2015)	N/A	**N/A**
Missing from DCC Children's Homes (Episodes)	100	**106**
Missing from DCC Children's Homes (Individual YP)	48	**62**
Missing from Independent Homes (Episodes)	53	**39**
Missing from Independent Homes (Individual YP)	20	**17**
Missing from Foster care (Episodes)	23	**18**
Missing from Foster care (Individual YP)	10	**9**
Missing from Other Settings (Episodes)	4	**10**
Missing from Other Settings (Individual YP)	3	**6**

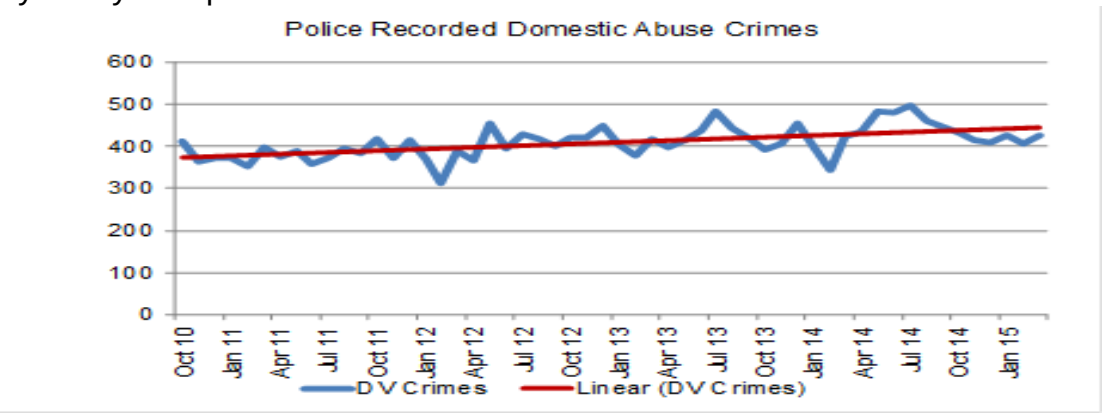
36.34 During the year the local authority took action to ensure that figures for children missing from education were up to date and held centrally on one system. This has led to an improved data set that will permit comparison and analysis in the coming year.

Children Missing from Education	From 1 September 2014 – July 2015
Number reported missing (referred to CME tracker)	63

Identified and traced	383
Cases closed due to gone abroad	106
Number untraced	0
Active working on	14

Domestic Violence

36.35 There has been a continued increase in recorded domestic violence incidents by Derbyshire police.



36.36 Figures from the Crown prosecution service indicate that the conviction rates for domestic violence in Derbyshire have remained above the national average and the East Midlands.

Domestic Violence Court Conviction rates for all age ranges

Domestic Violence Court Convictions	Rate for year 2012-2013	Rate for year 2013-2014	Rate for year 2014-2015
Derbyshire	75.1%	76.4%	76.4%
East Midlands	74.1%	76.0%	75.0%
National	73.5%	74.6%	Not available

Multi-Agency Risk Assessment Conference (MARAC)

36.37 Figures for MARAC cases illustrate the significant increase that has occurred over the last year. The changes to the scores given to risks to the victim changed over the year and a lower score was introduced as the threshold for referral to a MARAC along with greater consideration given to the professional judgement of police officers concerned about medium risk cases.

MARAC Cases by Centre	2012-2013	2013-2014	Apr 2014 to Mar 2015	% Change in latest year	3 months to Mar 2015
Alfreton	90	186	246	32.3%	77
Buxton	79	100	115	15.0%	28
Chesterfield	165	183	264	44.3%	67
South Derbyshire	17	54	103	90.7%	28
Derbyshire (Excl City)	351	523	728	39.2%	200
Derby City	168	214	466	117.8%	115
Derbyshire (Incl City)	519	737	1,194	62.0%	315

36.38 MARAC meetings held for high risk cases where children are living in the household have reduced to 63% of all high risk cases (from 78% in the previous year). This reduction may be affected by the reduction in the scoring and subsequent overall significant increase in MARAC cases.

Derby City - Households with children				
Apr 2014 to Mar 2015	Yes	No	Not known	Total
High Risk	574	335	7	916
Medium Risk	2,011	1,772	101	3,884
Standard Risk	762	603	23	1,388
Not Applicable	2,809	2,286	115	5,210
Total	6,156	4,996	246	11,398

Conviction Rates: Sexual offences

36.39 Year to date figures for Derbyshire show a conviction rate of **80.4%** (compared to 80.4% and 72.7% in the previous two years). The National rate is 77.5% and the East Midlands rate is 80.2%

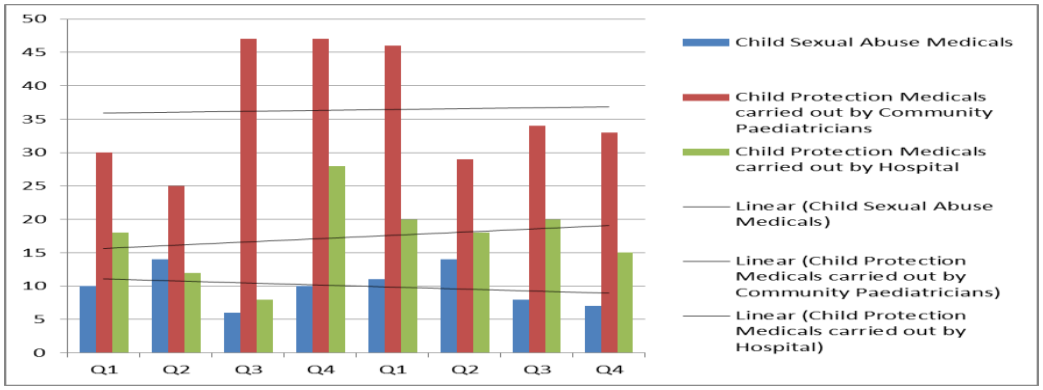
Conviction Rates: Rape

36.40 Year to date figures for Derbyshire show a conviction rate of **68.6%** (compared to 64.9% and 62.1% in the previous two years). The National rate is 56.9% and the East Midlands rate is 68.6%

36.41 The figures above illustrate continued upward trend in the successful conviction of domestic violence, sexual offences and rape against East Midlands and National figures. (Rates are currently not available for conviction of offences against children)

Child Protection Medicals

36.42 Medicals carried out following concerns about sexual abuse show a downward trend. Consideration will be given to looking in more detail at how agencies respond to concerns about sexual abuse in the coming year. The significant rise in physical abuse medicals in Q4 of the previous year was not sustained over the last year.



Parental Substance Misuse

36.43 Over the past 36 months there has been a significant change in the presentation within substance misuse treatment services with the advent of initially MCAT and then 'legal highs' referred to as New Psychoactive Substances (NPS). The number of individuals presenting for treatment for NPS increasing in-line with national prevalence.

36.44 Whilst the majority of those individuals who are accessing treatment for NPS related support do not have children with them, a high number are parents and therefore likely have contact with children. Parents using NPS/Amphetamine as their primary drug and accessing structured treatment in 14/15 was 27/57 (47%). For the first 3 months of 15/16 at present this sits at 13/39 (33%) and will increase as the year continues and more individuals access treatment*. The outreach non-prescribed team set up in April 2014 (now part of Derby Drug and Alcohol Service) has meant that the service is in advance of other areas in terms of providing pro-active interventions with this new client group.

36.45 It should also be recognised that those using NPS accessing treatment may not provide the whole picture. Our local intelligence from the Liaison Team at Royal Derby Hospital has shown that the age range of those using NPS to a level where they require access to A&E is broad and therefore it is essential that this issue isn't seen as one that only effects young people. The A&E admissions also highlights the fact that NPS use can have a significant detrimental effect on a user's mental health, leading to a variety of unpleasant physical symptoms and unpredictable behaviour.

36.46 The legal status of these drugs has increased their popularity with users often referring to the fact that 'legal highs' being legal by definition meant that they were safe or sanctioned in the same way as alcohol or tobacco. At the other end of the treatment spectrum NPS use has also adopted by both heroin users (often to replace other stimulants like crack) as well as a number using these via an intravenous route.

36.47 This change in drug profile has presented a particular challenge for those within the drug treatment field, as experienced substance misuse professionals have been challenged to up skill themselves and update their knowledge to keep on top of this trend. Likewise those working within the child protection field over the past 10 years have become increasingly adept in working with heroin and alcohol users as these risk factors become increasingly prevalent factors within cases. However NPS drugs have more in common with stimulants like amphetamine (cathinones) or cannabis (synthetic cannabinoids) and can then be harder not only to detect the use of but also present different risks and present an additional challenge for schools and social care practitioners to keep up with in terms of their training and knowledge.

36.48 The number of parents with opiate substitute treatment (those on methadone or buprenorphine) has remained stable over the past 3 years within Derby. This currently sits at 270 parents in 2013/14 and 267 and in 2014/15.

Child Deaths

36.49 The Child Death Overview Panel reported on Child Deaths for the period of January 2013 to the end of March 2015[32] to bring reporting in line with this annual report

36.50 The report sets out the child deaths considered by the panel for both Derby and Derbyshire. The categories of deaths are as follows:

Category of death	Percentage of deaths
Perinatal/neonatal event	37.4%
Chromosomal, genetic and congenital anomalies	19.1%
Sudden unexpected unexplained death	12.2%
Malignancy	8.7%
Acute medical or surgical condition	8.7%
Infection	6.1%
Trauma and other external factors	4.3%
Chronic medical condition	*
Total	100.0%

Modifiable Factors

36.51 The report identifies that for both Derby and Derbyshire 26 of the 115 completed cases where modifiable factors were identified. These are factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

36.52 As a result of the extended reporting period it is not possible to compare figures from previous reports; however the following issues were identified for both Derby and Derbyshire areas:

- In 77% of cases where modifiable factors were identified the child was male
- In the majority of cases where modifiable factors were identified, the child was less than 1 year of age. In addition, there were a significant number of cases where modifiable factors were identified in the 1-4 and 10-14 age categories.
- Whilst the White British ethnic category constituted the majority of cases, there was a near 50-50 split between incidents with modifiable factors identified in White British children and those from other ethnic backgrounds. The most notable proportions arose within the Pakistani (19.2%) and White Other (15.4%) cases. The former is likely to be explained by the high proportion of cases where consanguinity arose within the family.
- The majority of cases with modifiable factors originated from the more deprived local quintiles of 1 and 2

32

Derby and Derbyshire Child Death Overview Panel Annual Report – January 2013 to March 2015 – H Sultan and S Raju. (2015)

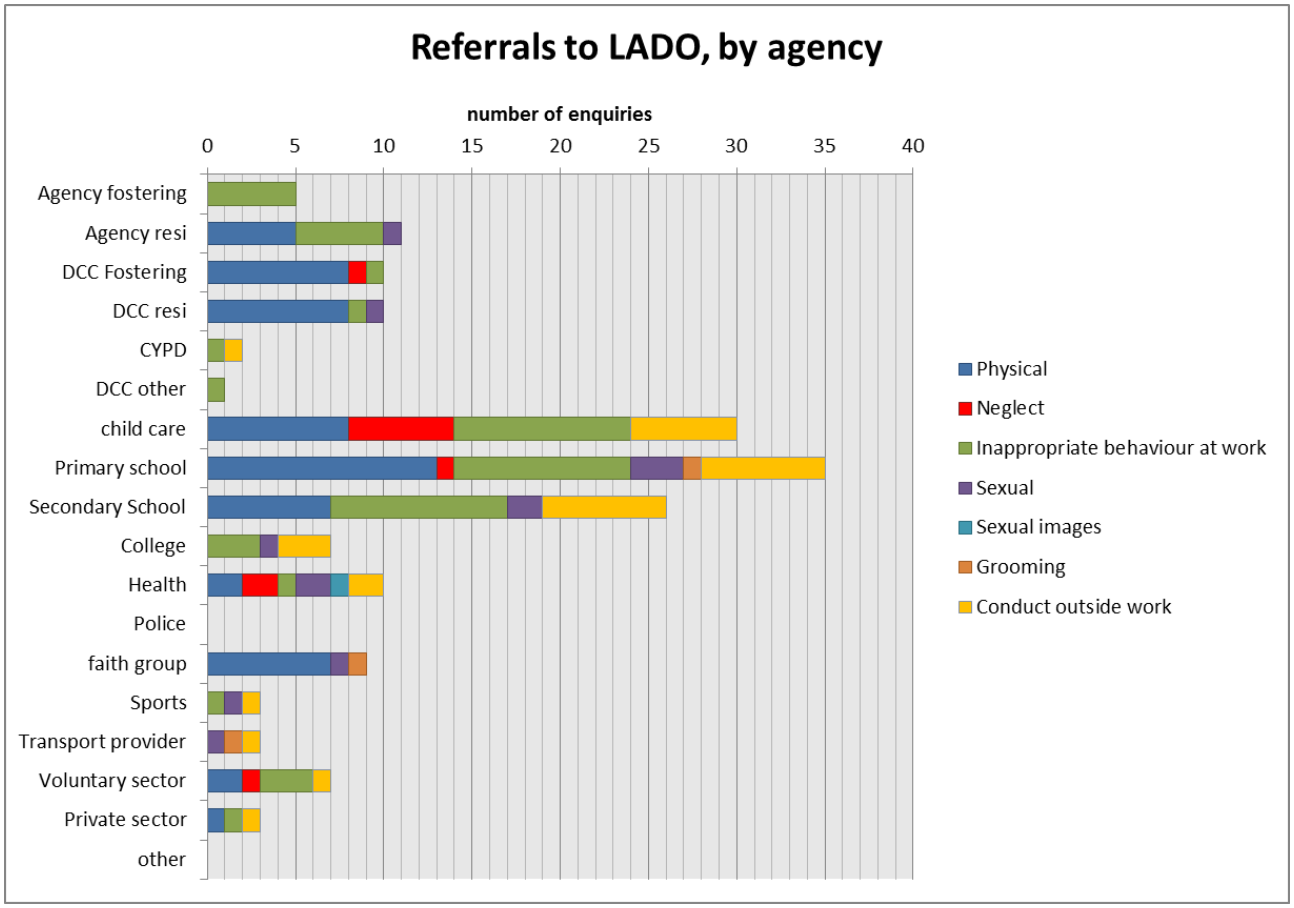
36.53 Most significantly commentary is included about the number and proportion of cases grouped by modifiability and safeguarding issues. Those cases with modifiable factors identified demonstrate a markedly higher proportion of children with safeguarding issues, with 39% of those known to social care and 27% known to the police.

Number and proportion of modifiable cases with associated factors Factor	**Number of modifiable cases**
Acute/sudden onset illness	14
Other chronic illness	14
Access to health care	13
Prior medical intervention	13
Smoking by a parent/carer in household	9
Smoking during pregnancy	8
Sensory impairment	7
Poor parenting/supervision	7
Alcohol/substance misuse by a parent/carer	6
Co-sleeping	6
Prior surgical intervention	6
Learning disabilities	5
Motor impairment	<5
Consanguinity	<5
Epilepsy	<5
Asthma	<5
Domestic violence	<5
Other disability or impairment	<5
Emotional/behavioural/mental health condition in child	<5
Allergies	<5
Emotional/behavioural/mental health condition in a parent or carer	<5
Housing	<5
Child abuse/neglect	<5
Total number of modifiable factors	**129**

36.54 The most common factors across modifiable cases were acute/sudden onset illness and other chronic illness – both of which are intrinsic to the child. This was followed by factors relating to service provision – access to health care and prior medical intervention. The most common factors in the family and environment were smoking by a parent/carer in the household (9; 35%) and smoking during pregnancy (8; 31%).

Allegations against staff

36.55 The distribution of referrals across agencies is broadly the same as previous years, and with numbers being very small it is not possible to identify any trends. Referrals remain very low for the Police.



Outcomes

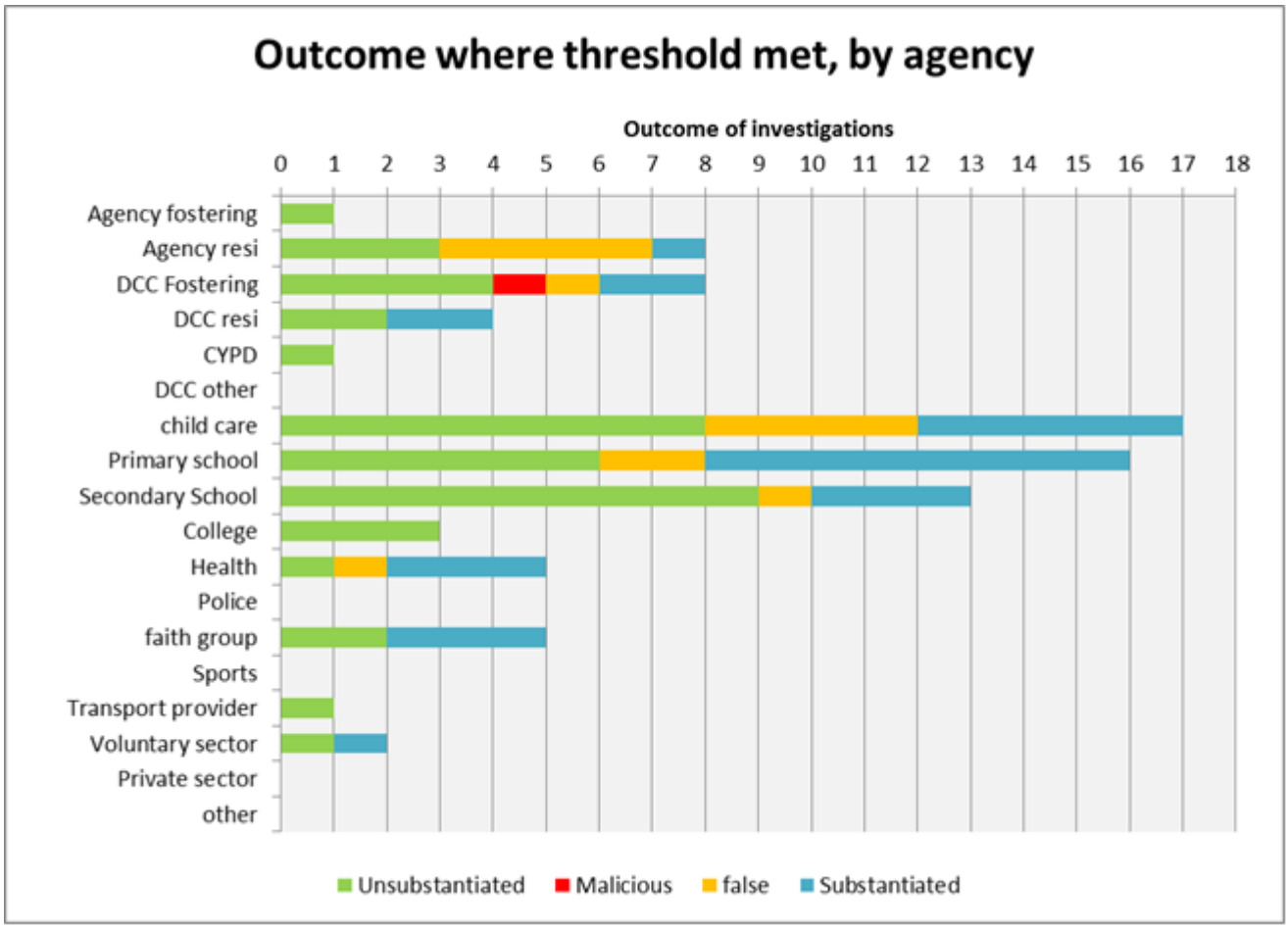
36.56 Resolution categories have been amended to conform with Government guidance from 2013:

- Substantiated: there is sufficient evidence to prove the allegation;
- Malicious: there is sufficient evidence to disprove the allegation and there has been a deliberate act to deceive;
- False: there is sufficient evidence to disprove the allegation;
- Unsubstantiated: there is insufficient evidence to either prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.

36.57 The use of the terms "prove" and "disprove" are unfortunate as this implies a judicial process, beyond all reasonable doubt. However, in keeping with Working Together 2013 (now replaced), we consider whether there is sufficient information to support an allegation, or otherwise, on the balance of probability.

36.58 The deleted category “unfounded” accounted for 41% last year and has effectively been split between “false” and “unsubstantiated”. The proportion “substantiated” has increased from 26% to 33% this year, and is particularly apparent in schools and child care settings. Numbers of false or malicious allegations remain extremely low.

36.59 The high number of “advice only” implies a very low threshold amongst organisations, including Ofsted. The relatively low number, even where threshold is met, of allegations which are substantiated, suggests that the LADO threshold is certainly not too high and there may be merit to developing a simple screening tool for managers to use before referring to LADO.



37	**The Derby Safeguarding Children Board Commentary on the Effectiveness of Safeguarding Arrangements in Derby**	

Sufficiency statement

37.1 Overall the Derby Safeguarding Children Board judges that the way in which agencies and their staff have worked together has kept children and young people safe. The information gathered shows how staff are alert to possible problems and have taken action to keep children safe. This report also recognises that it has become more challenging as the availability of services is decreasing. Steps have been taken to keep up to date with what changes mean for children, young people, their families and staff and how they are all affected.

37.2 The Derby Safeguarding Children Board recognises that progress has been made in many areas, but there is still much to do.

37.3 The Derby Safeguarding Children Board invested in a temporary Project Officer Quality Assurance during the year (finishing in May 2015). This enabled the Derby Safeguarding Children Board to drive forward quality assurance. The level of increased activity to find out how well arrangements are working is demonstrated in the greater depth of analysis and evidence in this report. Partner agencies will consider whether to establish a similar post during the coming year.

37.4 The Derby Safeguarding Children Board will continue to closely scrutinise the level and demand for services alongside the ability of agencies to meet this demand and keep children and young people safe. The formal reporting of these pressures has been embedded into the Derby Safeguarding Children Board agenda and the work carried out between the Independent Chair and the Chief Executives of partner agencies across Derby and Derbyshire.

37.5 In this coming year we need to make sure we increase the ways in which children, young people and their families are able to tell us if they are safe and receiving the support that will keep them safe.

37.6 We need to make sure that staff can tell us what they think about the support that is being provided by their own and other agencies. We need to know whether they are concerned about changes to the way organisations are providing services and whether this is making children and young people less safe.

37.7 We need to make sure all organisations are able to show us what support their staff provide to keep children and young people safe and how they can demonstrate that their services are making a difference.

37.8 In addition to existing priorities, we will extend particular scrutiny of arrangements to safeguard children who are missing.

38	**Action plan for Derby Safeguarding Children Board 2015 - 2016**	

38.1 Review how “the voice of the child” informs the local authority of the effectiveness of the new arrangements to support young carers.

38.2 Obtain assurance from partner agencies about complaints and concerns raised by children and young people about safeguarding services they have received and what action has been taken.

38.3 Ensure that agencies complete outstanding training pathways for staff with key roles and provide evidence of the impact of single agency safeguarding training on their practice.

38.4 Continue to monitor the effectiveness of Early Help, Domestic Violence and Child Sexual Exploitation Arrangements as three priority areas in Derby.

38.5 Evaluate the impact on practice of the use of the Safeguarding Quality Assurance Notification process.

38.6 Improve the engagement with males in families.

38.7 Scrutinise progress to improve training and development to improve both child protection and child in need plans and obtain assurance about the effectiveness of Core Groups.

38.8 Improve the attendance by agencies at child protection conferences and in particular participation or representation of the views of GP’s.

38.9 Obtain assurance about the completion of health development checks in a timely manner for looked after children placed out of Derby and assure the effectiveness of arrangements are in place to safeguard looked after children in Derby.

38.10 Obtain assurance that arrangements are in place to safeguard children and young people who are missing, including those missing from education.

38.11 Report on the effectiveness of arrangements to safeguard disabled children

38.12 Obtain assurance about the effectiveness of the Channel arrangements and the impact on children at risk of radicalisation and extremism.

38.13 Obtain assurance that all education settings have identified which adults have parental responsibility for pupils registered at the setting.

38.14 Evaluate the ongoing impact of the Pre-Birth Assessment and Intervention Protocol.

38.15 Strengthen the section 11 process to ensure that agencies provide consistent and clearly illustrated feedback and analysis, based on internal audit, of whether standards are being met.

38.16 Obtain the views of staff on what they think about the support that is being provided by their own and other agencies and the effectiveness of local safeguarding arrangements.

Derby Safeguarding Children Board Membership (Appendix 1)

Derby Safeguarding Children Board Membership 2014 - 2015

Member	Role	Agency
Christine Cassell	Independent Chair	**Derby Safeguarding Children Board**
Charlotte Convey	Lay Member (DSCB)	**Member of the community**
David Lindop (until December 2014)	Lay Member (DSCB)	**Member of the community**
Colin Barker	Lay Member (CDOP)	**Member of the community**
Andrew Bunyan	Strategic Director for Children and Young People	**Derby City Council Children and Young Peoples Directorate**
Councillor Fareed Hussain	Lead Member	**Derby City Council Council Member**
Andy Smith (from August 2014)	Service Director (Early Intervention and Integrated Safeguarding)	**Derby City Council Children and Young People Directorate**
Nina Martin	Head of Service Quality Assurance	**Derby City Council Children and Young People Directorate**
Suanne Lim	Head of Youth Offending Service	**Derby City Council Youth Offending Service**
Phil Watson (until December 2014)	Principal Social Worker	**Derby City Council Children and Young People Directorate**
Dawn Robinson	Head of Service - Prevent	**Derby City Council City and Neighbourhood Partnerships**
Cathy Winfield	Deputy Director of Nursing	**Derby Teaching Hospitals NHS Foundation Trust**
Lynn Woods	Chief Nurse and Director of Quality	**Southern Derbyshire CCG**
Carolyn Green	Chief Nurse and Executive Director of Nursing & Quality Safeguarding Lead	**Derbyshire Healthcare NHS Foundation Trust**
Hamira Sultan (from September 2014)	Consultant in Public Health (Lead for Child and Maternal Health)	**Derby City Council Public Health**
Jenny Evennett	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Michelina Racioppi Designated Nurse	Designated Nurse (Vice Chair from 09/14)	**Southern Derbyshire CCG**
Neville Hall	Assistant Director Derby Cafcass	**CAFCASS**

Janie Berry Kaye Howells	Director of Legal and Democratic Services / Principal Lawyer	**Derby City Council** **Legal Services**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Sheila Wright	Assistant Chief Executive Officer - Offender Management (Derby City)	**The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company**
Karen MacLeod	Director NPS Derbyshire	**National Probation Service** (Midlands Derbyshire Local Divisional Unit Cluster)
Simon Emsley	Head teacher	**Schools - Primary**
Liz Coffey	Principal	**Schools - Secondary**
Anita Straffon	Vice Principal Learner Journey	**Further Education College**
Nathalie Walters	Representative for the Children and Young People's Network	**Safe and Sound (Derby)**
Alan Charles (from October 2014)	Police and Crime Commissioner	**Office of the Police and Crime Commissioner**
Danielle Burnett	Experience / Quality and Safety Manager	**NHS England**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**

Derby Safeguarding Children Board Membership 2015 - 2016

Member	Role	Agency
Christine Cassell	Independent Chair	**Derby Safeguarding Children Board**
Charlotte Convey	Lay Member (DSCB)	**Member of the community**
Colin Barker	Lay Member (DSCB and CDOP)	**Member of the community**
Andy Smith	Strategic Director (Acting)	**Derby City Council** **People Services**
Councillor Sara Bolton	Cabinet Member for Children and Young People and Safeguarding	**Derby City Council** **Council Member**
Maureen Darbon (from September 2015)	Service Director (Early Intervention and Integrated Safeguarding)	**Derby City Council** **People Services**
Nina Martin	Head of Service Quality Assurance	**Derby City Council** **People Services**
Suanne Lim	Head of Youth Offending Service	**Derby City Council** **Youth Offending Service**

Vacancy	Principal Social Worker	**Derby City Council** **People Services**
Dawn Robinson	Head of Service - Prevent	**Derby City Council** **City and Neighbourhood Partnerships**
Jim Murray	Deputy Chief Nurse	**Derby Teaching Hospitals NHS Foundation Trust**
Lynn Woods	Chief Nurse and Director of Quality	**Southern Derbyshire CCG**
Carolyn Green	Chief Nurse and Executive Director of Nursing & Quality Safeguarding Lead	**Derbyshire Healthcare NHS Foundation Trust**
Hamira Sultan	Consultant in Public Health (Lead for Child and Maternal Health)	**Derby City Council** **Public Health**
Jenny Evennett	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Michelina Racioppi Designated Nurse	Designated Nurse (Vice Chair from September 2014)	**Southern Derbyshire CCG**
Janie Berry Kaye Howells	Director of Legal and Democratic Services / Principal Lawyer	**Derby City Council** **Organisation and Governance Directorate**
Joy Smith	Service Manager Derby Cafcass	**CAFCASS**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Sheila Wright	Assistant Chief Executive Officer - Offender Management (Derby City)	**The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company**
Karen MacLeod	Director NPS Derbyshire	**National Probation Service** (Midlands Derbyshire Local Divisional Unit Cluster)
Simon Emsley	Head teacher	**Schools - Primary**
Sue Bill	Acting Principal	**Schools - Secondary**
Anita Straffon	Vice Principal Learner Journey	**Further Education College**
Nathalie Walters	Representative for the Children and Young People's Network	**Safe and Sound Derby**
David Peet (from June 2015)	Chief Executive	**Office of the Police and Crime Commissioner**
Danielle Burnett	Experience / Quality and Safety Manager	**NHS England**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**

Glossary of Abbreviations

Abbreviation	Meaning
BME	Black and Minority Ethnic
CDOP	Child Death Overview Panel
CFLB	Children, Families and Learners Board
CIN	Children in Need
CSE	Child Sexual Exploitation
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence
DBS	Disclosure and Barring Service
DCC	Derby City Council
DSCB	Derby Safeguarding Children Board
DV and SSV	Domestic Violence and Serious Sexual Violence
DVPO	Domestic Violence Prevention Order
DVPO/PNS	Domestic Violence Prevention Order/Notices
DVRIM	Domestic Violence Risk Identification Matrix
DVRIM	Domestic Violence Risk Identification Matrix
FGM	Female Genital Mutilation
HMIC	Her Majesty's Inspector of Constabulary
HRS	Housing Related Support
IDVA's	Independent Domestic Violence Advocates
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
KITE	Kids in their Environment
LAC	Looked after child or children
LADO	Local Authority Designated Officer
LIF	Learning and Improvement Framework
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
NEET	Not in education, employment or training
NPS	Nnew Psychoactive Substances
NPS	New Psychoactive Substances
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education
S11	Section 11 Children Act 1989
S47	Section 47 1989 Children act
SAB	Safeguarding Adults Board
SiP	Smoking in pregnancy
TVS	Training Validation Scheme