Derby Safeguarding Children Board

Annual Report 2013 - 2014

Preface

The Children Act 2004 (Section 14a) requires LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles.

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 2013, Chapter 3, paragraph 17)

The report should demonstrate the extent to which the functions of the LSCB as set out in Working Together 2013 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 2013;
- 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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1. Chair's Foreword

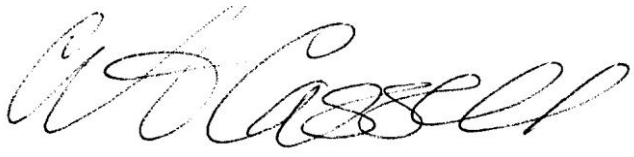
1.1 I am pleased to present the 2013/14 Annual Report for Derby Safeguarding Children Board. This outlines the work of the Board over the year and its evaluation of the effectiveness of safeguarding arrangements within and across agencies in the city. This report reflects the work of the members of Board and the work of all the practitioners, managers and leaders across the various agencies, who work tirelessly to protect children and young people from significant harm.

1.2 The Board has continued to strengthen its activity in co-ordinating safeguarding across the city and in monitoring the effectiveness of safeguarding practice. Improvements in co-ordination have included new procedures to support agencies to work together to give families help when needs are first identified, procedures to help assess the needs of vulnerable parents before their baby is born and a tool to assess the level of risk in a family when there is a referral for domestic abuse.

1.3 We have monitored how well organisations across Derby are working to safeguard children in a range of ways, including through auditing samples of cases, reviewing cases where there has been a tragedy and by asking young people for their views. The Board published two Serious Case Reviews and one learning review in 2013-14. The conclusion of the Serious Case Reviews was that in neither case could the deaths of the children concerned have been predicted or prevented. There were no failings on the part of local agencies. There were, however, areas where practice could be improved and changes have been made. The Board will monitor the impact of those changes on the quality of services provided. The learning review reported on the views and experiences of girls who had given evidence in court after they had been sexually exploited. This has led to improvements locally and has been influential in proposed national changes in the way that such cases are dealt with.

1.4 In the coming year we will continue to focus on early help for families, domestic violence and child sexual exploitation and we will continue to work proactively with our neighbouring authority area to ensure that our activities are coordinated and joined up to keep children safe.

1.5 Finally I would like to thank members of Derby Safeguarding Children Board for their continuing commitment to the work of the Board, challenging their own and other agency performance and raising the profile of safeguarding.



Christine Cassell
Independent Chair

2. Introduction

2.1 This report is the annual review of the work of the Derby Safeguarding Children Board for the business year 2013/2014.

2.2 The purpose of this Annual Report is to:

- provide an outline of the main activity and achievements of the Derby Safeguarding Children Board during 2013/2014
- 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 2014/2016

2.3 The Derby Safeguarding Children Board has two objectives, as detailed in the Children Act 2004 and Working Together 2013 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.

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

2.4 "Safeguarding and promoting the welfare of children" is terminology used throughout this report. Working Together 2013 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."

3. Coordinating Local Work to Safeguard and Promote the Welfare of Children.

3.1 This section sets out what the Derby Safeguarding Children Board has achieved to co-ordinate what is done by each person or body represented on the Board to safeguard and promote the welfare of children in the Derby.

3.2 Our priority actions for **2013 – 2014** were to:

Undertake quality assurance activity in the following areas the impact of the implementation of the multi-agency safeguarding arrangements and the impact of the domestic violence and sexual violence strategy

Report on the effectiveness of early intervention and child protection arrangements to safeguard children and young people.

3.3 Progress against these priorities:

- The Derby Safeguarding Children Board has considered local arrangements alongside lessons emerging from serious case reviews. This has informed a far reaching systemic change in the way in which all agencies identify the impact of domestic abuse and the subsequent action to be taken.

- The Derby Safeguarding Children Board has implemented the use of the Domestic Violence Risk Identification Matrix (DVRIM) by all agencies and further detailed comment is set out in section (17.1).

- The Derby Safeguarding Children Board monitors the effectiveness of early intervention and safeguarding arrangements on a quarterly basis. The local authority has provided improved information indicating early help activity of the multi-agency teams and this is scrutinised alongside referrals to the local authority for social care services and child protection services.

- The challenge of balancing early help and responding proactively to more serious circumstances has been a critical area for the Derby Safeguarding Children Board to evaluate. Alongside the performance monitoring and learning improvement framework, the Derby Safeguarding Children Board undertook a significant piece of research to evaluate the views of practitioners as to their views on the application of thresholds of concern in Derby. The views of over 500 practitioners were gathered during March and April and the initial analysis, at the time of completing this report, is set out in section (14.3).

- The Derby Safeguarding Children Board maintains the view there is sufficient evidence to indicate that there needs to be a continued focus on the two key priorities of Early Help and Domestic Violence with the

additional focus on providing direct information to young people to help them keep themselves safe and access the help they need.

3.4 Additional actions in the **2013 – 2014** business plan focussed on improving the working arrangements of the Board included:

- The safeguarding children procedures were updated during the year and the Early Help Assessment and single Social Care Assessment were agreed and implemented across Derby and Derbyshire. This included multi-agency briefing sessions for 526 staff across Derby to ensure that they were aware of the new arrangements and able to implement them successfully.

- A project was completed with partner agencies to identify consistent and robust training pathways and following publication of *Keeping Children Safe in Education* advice was published to ensure that all education sector providers were clear on the training pathways for all staff. Over the summer the Derby Safeguarding Children Board in partnership with the Derbyshire LSCB will publish a quality assurance scheme for independent training providers to help local commissioners chose good quality external training alongside the specific training delivered to partners by the Derby Safeguarding Children Board.

- The Derby Safeguarding Children Board has issued guidance to identify whether parents or carers have parental responsibility and improve arrangements to identify children who are privately fostered. This was incorporated into the audit tool used by education settings to audit their own safeguarding arrangements. The Derby Safeguarding Children Board has received confirmation that 69% of settings have completed their audit and this is set out in more detail in section (26.3). The annual Private Fostering report was received by the Quality Assurance Group and is commented upon in section (20).

- The Derby Safeguarding Children Board has taken active steps with the Derby Safeguarding Adults Board (DSAB) to ensure that the principles that underpin effective ***Think Family*** arrangements have been shared across the partnership of agencies in Derby. Both the Derby Safeguarding Children Board and DSAB have reviewed their training to ensure that ***Think Family*** principles are ingrained and will, in the coming year, be implementing a joint online booking system to improve access and awareness of safeguarding training for all sectors. The Derby Safeguarding Children Board will continue to work closely with the Derby Safeguarding Adults Board to ensure a Think Family approach keep children and adults safe. ***This will be an action for the coming year:***

Develop working arrangements with the Safeguarding Adults Board to ensure adult and children services are cooperating to promote effective safeguarding.

- Following the implementation of the Multi-Agency Pre-birth Assessment Protocol an initial audit of the effectiveness of joint arrangements to engage vulnerable families at an early stage was carried out and reported to the Quality Assurance Group. A further audit to ascertain the progress that has been made will be carried out in autumn 2014. Further comment about this and other quality assurance activity of the Derby Safeguarding Children Board is included in section (14).

- The Derby Safeguarding Children Board implemented a local Learning Improvement Framework and Training Strategy. The serious case reviews and learning reviews completed during the year have raised challenges to improve practice that have been delivered through the Learning Improvement Framework such as the systemic changes being implemented to improve the assessment and responses to domestic violence.

- The Derby Safeguarding Children Board extended its activity to engage children and young people during the year. Young people were consulted about what would make a difference to improving safety for them in the key areas of their personal relationships and online safety. Members of the young people's counsel attended the Derby Safeguarding Children Board meeting to present their views and inform future work for the Derby Safeguarding Children Board.
- Young people were also involved the development of training materials for the Derby Safeguarding Children Board training programme.

- The annual report from the Child Sexual Exploitation (CSE) Operation Group provides evidence of the continued progress to engage young people, improve their safety and reduce risk of CSE. The Derby Safeguarding Children Board published learning from young people who had been victims of CSE and experienced the subsequent prosecution of offenders.

- During the year the Derby Safeguarding Children Board successfully recruited two lay members for the Board and one lay member for the Child Death Overview Panel who were able to begin their roles at the beginning of summer 2014.

4 Governance and Accountability

4.1 The governance arrangements for the Derby Safeguarding Children Board were reviewed following publication of Working Together 2013 at Board meeting in March 2013 and ratified in June 2013. The governance arrangements now set out not only the work of the Derby Safeguarding Children Board but also the partnership and scrutiny arrangements that exist through a protocol with the Health and Wellbeing Board, Children Families and Learners Board and the Derby Safeguarding Adults Board.

4.2 The Independent Derby Safeguarding Children Board Chair has implemented twice yearly meetings with the Chief Executives and officers of

all partner agencies in Derby (and Derbyshire) to set out the priorities of the Derby Safeguarding Children Board. Partner agencies have been engaged to prioritise safeguarding and promote dialogue at an early stage at a time of significant pressures on services.

4.3 The local authority Chief Executive, in partnership with the Lead Member and Director of Children's Services, scrutinised the work done by 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.

4.4 The Derby Safeguarding Children Board has actively challenged individual partners to improve safeguarding arrangements and maintains records of such action. To improve partnership working, the Derby Safeguarding Children Board is reassured to see progress has been made to implement systemic changes such as the assessment of domestic violence. Progress has also been made to ensure that all education settings are actively evaluating their own safeguarding arrangements to ensure pupils are safe.

4.5 The Derby Safeguarding Children Board has not only influenced change at a local level, but successfully ensured that changes arising from local serious case reviews have impacted regionally and nationally. This includes changes to processes for the consideration by the family court of Emergency Protection Orders and changes to advice to householders about effective home fire evacuation safety plans.

4.6 The Derby Safeguarding Children Board has reviewed and updated the business plan following quality assurance and evaluation of local safeguarding arrangements. The Derby Safeguarding Children Board sets out the areas that require improvement in the two year business plan (set out in section 29).

4.7 The business plan is delivered by the Derby Safeguarding Children Board sub groups and progress is scrutinised at the quarterly meeting of the Derby Safeguarding Children Board. The evidence of the progress made to improve local arrangements and impact of the business plan is set out in section (14) of this report.

4.8 Each subgroup is chaired by a member of the Derby Safeguarding Children Board or in the case of the subgroups with shared membership with Derbyshire LSCB, the chair person is a member of either Board.

5 Relationship to the Derby City and Neighbourhood Partnerships Boards with responsibilities for children and families

5.1 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)

5.2 A protocol has been established to ensure that there is clarity about the complementary responsibilities of the partnership Boards above. Formal arrangements will ensure that relevant partnership priorities and business plans are shared to enable strategic action to be taken that safeguards children.

5.3 The Derby Safeguarding Children Board ensures that its priorities are shared with the other partnership Boards through these arrangements. Over the last year the Independent Derby Safeguarding Children Board Chair has been an active participant at the Children Families and Learners Board and the Derby City Partnership Leadership Board. 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. Issues that require representation or action at another Board are specifically allocated to a representative from the Derby Safeguarding Children Board to ensure that they are achieved and reported upon.

5.4 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. 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. The Derby Safeguarding Children Board will continue to monitor the impact of organisational changes on local arrangements that keep children safe. ***This will be an action for the coming year:***

Assess and monitor the impact of organisational change on safeguarding arrangements.

5.5 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.

5.6 The children and young people's scrutiny board focusses on safeguarding and child protection arrangements across the local authority and regularly holds officers to account at performance surgeries.

5.7 The Derby Children and Young People's Plan during 2013 – 2015 includes the priority issues raised by Derby Safeguarding Children Board to keep children and young people safe through making sure that they have

access to good quality services at the earliest opportunity, reducing the likelihood of them being exposed to or participating in 'risky' behaviours.

5.8 In July 2014 the Children, Families and Learners Board reviewed the progress made with the delivery of commitments from the Children and Young People's Plan 2013 – 2015.

5.9 The priority outcome ***"More children and young people being safe"*** was reviewed and suitable progress was noted in all but one area. The number of children subject on child protection plans has increased over the year. This key indicator is scrutinised by the Derby Safeguarding Children Board on a quarterly basis.

5.10 The Derby Safeguarding Children Board was consulted on the development of the Children and Young People's Plan and is kept up to date on the review of the plan. The Derby Safeguarding Children Board ensured that the safeguarding priorities set out in its business plan informed the re-commissioning of children's health services across Southern Derbyshire and Erewash Clinical Commissioning Groups in July 2014.

6 Participation of Children and Young People

6.1 The Derby Safeguarding Children Board draws 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 about the services they receive.

6.2 The Derby Safeguarding Children Board has continued 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 (The monitoring and audit section illustrates this in more detail). Additionally the Derby Safeguarding Children Board published learning from young people who had been victims of CSE and experienced the subsequent prosecution of offenders (Operation Kern). This was not only shared widely across agencies but also presented to Youth Justice Board so that lessons could be incorporated within judicial processes.

6.3 Young people were specifically consulted on their views about what would make a difference to improving safety for them in two key areas: personal relationships and online safety. Their responses and presentation at the Derby Safeguarding Children Board meeting in December led to the commission of joint work with young people that will be completed in the coming year. Posters and stickers will set out to improve awareness of what behaviour is acceptable in personal relationships and be displayed in schools in Derby.

6.4 Young people were also involved in producing and acting in a training film to be used to promote awareness of Forced Marriage. Other young people have agreed to be involved in training materials to reduce self-harm. A young person has been involved in all the CSE training courses during the

year. The Derby Safeguarding Children Board has developed its involvement of young people to be active partners and help improve how local safeguarding training makes an impact and keeps practitioners focussed on young people.

6.5 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. The multi-agency teams introduced the forms “How was it for you?” and the Derby Safeguarding Children Board will be scrutinising the first full Early Help annual report in March 2015 to ascertain what they think of the arrangements.

6.6 Participation standards have been implemented by the Derby Children and Young People’s Participation Network in conjunction with young people to provide a consistent best practice approach to working with children, young people and their families. Work is ongoing to establish performance measures against the standards and a pilot is being held in September 2014 to seek to show the impact of their engagement.

6.7 Young People continue to be involved in the Scrutiny Committee and were involved in the Budget consultation across the local authority. Their contributions about a particular third sector service that actively works with young people to safeguard them was felt to have been a positive influencing factor in the funding decision to maintain contributions to the service.

6.8 The Independent Reviewing Officers (IRO) regularly attend the Children in Care Council meetings and the IROs promote "The Children in Care Council Pledge" – pocket sized copies of the Pledge are given out by IROs to children and YP at their review meetings. The IROs ensure that all our children in care are aware of their rights in relation to the care provided to them by Derby City Council.

6.9 The IRO team have worked with the Children’s Right’s Service/ Children in Care Council (CiCC) to develop a feedback form regarding children’s views on their reviews. A format is to be designed and the CiCC will be asked what their preference is. The IRO team will also have a regular quarter page slot in the CiCC newsletter. The IRO service reports annually to the Derby Safeguarding Children Board and this includes the effectiveness of the engagement of children in care.

6.10 The local authority quality assurance service reports annually on the engagement of children and young people within the child protection conference processes.

6.11 The Education Hub has continued to promote ChildLine Schools Service across Derby and Derbyshire to help primary schools protect pupils. Parents 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. The service has continued to visit Derby and Derbyshire schools for the first time as well as beginning to revisit schools for the second time reaching a second cohort of year 5 and year 6 children.

6.12 By the end of March 2014, there had been an increase of active volunteers to a total of 23 who had delivered to over 170 schools in Derby and Derbyshire reaching 10,000 children (since the start of the programme). The programme continues to work towards reaching all primary schools by 2016.

6.13 Children continue to welcome the programme, in their words:

- “I think the 1-2-1 chat is extremely helpful for those who can't speak and need to talk to someone”
- “It was marvolas we all learnt so much that we never knew we all knew the basics but that told us more and I can safly speak for evry one we loved the film we were all engrosed during it”
- “I love childline its helped me through so much thank you childline!!!”
- “They help when you get bullied and always there for you”

6.14 The Derby Safeguarding Children Board has engaged younger children through initiatives aimed at their parents such as the work of midwives and health visitors to make sure all new parents have seen the animated film: “Don’t Shake the Baby”. The Derby Safeguarding Children Board supported training for a wide range of staff so that they could confidently engage parents with the Safe Sleep initiative.

7 Policy and Procedures, Guidance and Thresholds

7.1 The Policies and Procedures group implemented the following policies, procedures and guidance during the year:

Assessments

- Early help assessment (checklist, assessment forms, guidance, leaflets, flowchart) and Social Care single assessment
- Derby children’s services assessment protocol
- Family safety advice guidance (to support completion of family safety checklist in both of the above assessments)

Health documents

- Prevention of non-accidental head injury (multi-agency guidance)
- Guidance for Safe Sleeping (multi-agency guidance)

Revision to procedures

- Amendments to core safeguarding children procedures
- Revision of key specific circumstances chapters
- New supervision guidance

- Joint Runaway and Missing from Home or Care Protocol

7.2 The Education Hub launched a local exemplar safeguarding audit tool for all education settings in Derby. Each setting was required to complete their own assessment of safeguarding arrangements and identify areas for improvement. This included improvements to safeguarding "systems" and multi-agency arrangements across partners that required action by the Derby Safeguarding Children Board. Further detail about the findings of the audit are included in section (26.3).

7.3 The web based safeguarding children procedures were updated and significant engagement was undertaken across partners to launch the Early Help Assessment and Single Assessment for Social Care.

7.4 The Derby Safeguarding Children Board has monitored and evaluated for the effectiveness and impact of local policies, procedures and guidance in a variety of ways.

7.5 Briefings occurred in March and April 2014 and the Derby Safeguarding Children Board sought feedback from 526 practitioners and managers from different agencies about their perceptions of the effectiveness of decision making linked to thresholds and resolution of different opinions about seriousness of needs (See section 14.3).

7.6 Alongside the analysis of the findings from the "Threshold Survey", the Derby Safeguarding Children Board scrutinises 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. For example the scrutiny of increasing numbers of children subject of child protection plans has been raised through this process and is commented upon in more detail in section (27.5).

7.7 The Pre Birth Assessment protocol was implemented across Derby and Derbyshire and an initial audit of the effectiveness of arrangements to support vulnerable parents was carried out and reported to the Quality Assurance group. Having established a baseline for comparison a further audit is planned for October 2014 that will establish the degree to which the pre birth assessment protocol has made improvements and whether further action is needed.

7.8 The Derby Safeguarding Children Board has monitored and evaluated the effectiveness of practice through local and national reviews and this has led for example, to the implementation of wide ranging changes to guidance used by practitioners across agencies to systematically and consistently identify and assess the impact of domestic violence. 325 practitioners attended multi-agency briefings on the use of the new model (developed by Barnardo's) and its impact on practice will be audited as part of the Workforce Group scrutiny of effectiveness in the coming year.

7.9 The Derby Safeguarding Children Board will continue to ensure that developments in national guidance are incorporated into local practice. ***This will be an action for the coming year:***

Ensure that robust arrangements are in place and consistent with Working Together 2013 and associated National Guidance, that Board approved guidance is embedded in partner agency practice.

8 Membership of the Derby Safeguarding Children Board and subgroups

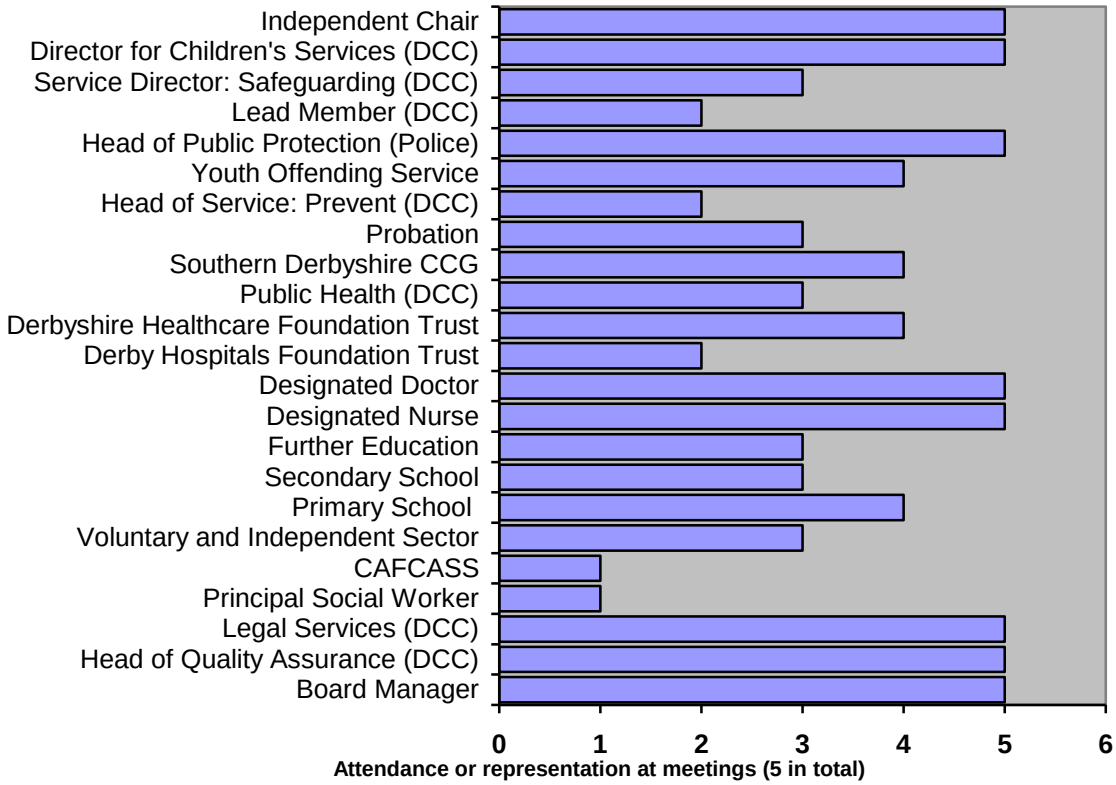
8.1 The Derby Safeguarding Children Board membership list for 2013 - 2014 can be found at Appendix 1. There has been consistent representation of the Derby Safeguarding Children Board from most agencies with membership occurring at the right level of seniority and remaining stable, taking into account individual officers changing roles/jobs.

8.2 Representation on the Derby Safeguarding Children Board from lay members has been put in place with two lay members being successfully recruited to the Derby Safeguarding Children Board and one to the Child Death Overview Panel (CDOP). Training and induction have been provided and plans are in place to ensure that they have every opportunity to become active members of the Derby Safeguarding Children Board over the coming year (attendance at the Derby Safeguarding Children Board commenced at the June 2014 meeting, and at CDOP in May 2014)

8.3 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.

8.4 Analysis of the attendance set out in the chart below indicates that in comparison with last there has been an improvement in the attendance of Derbyshire Healthcare Foundation Trust at board meetings. The Vice Chair (Quality Assurance Chairperson) has been present at all meetings. Changes in personnel have affected CAFCASS representation and this has now been resolved. The Principle Social Worker joined the DSCB in March 2014. A new Lead Member for children's services joins the Derby Safeguarding Children Board in September 2014.

8.15 In 2014, the Government began to introduce a new way of organising the provision of offender services and split probation services across the country into two components: one national probation service (NPS) and twenty one community rehabilitation companies (CRC). The NPS is run on a regional basis and Derby is part of a midlands division. The CRC is made up of the areas of Derbyshire, Leicestershire Nottinghamshire and Rutland. Derby Safeguarding Children Board thus has representation from both the NPS and CRC so that we continue to work together to promote the needs of vulnerable children and their parents.



9 Budget

9.1 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 2013/2014.

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

Agency	**Amount**
CYP	98 111
NHS Southern Derbyshire Clinical Commissioning Group	
(on behalf of Health Services in Derby/Derbyshire)	42 812
Derbyshire Constabulary	21 406
Derbyshire Probation Service	7 135
Derby Community Safety Partnership	7 135
CAFCASS	550
Shortfall of contribution from Reserve	1 234
Total contributions	**178 384**

Total Budget	178 384
Actual Expenditure	220 934
Balance from Reserve	42 550

9.3 The overspend was anticipated and arising from the costs associated with the completion of the serious case reviews that commenced in 2012 and the recruitment of the temporary Policy Officer (Quality Assurance) Post . 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 2013 - 2012 was:

	Budget	Expenditure	Variance
Employees Sub Total	162 428	174 686	12 258
Premises Costs Total	600	500	- 100
Transport Sub Total	1 500	430	- 1070
Supplies and Services (Including Training Costs)	13 856	45 318	31 462
Total	178 384	220 934	42 550

9.4 The Derby Safeguarding Children Board agreed to ongoing partner contributions from 2014/2015 in the following proportions:

Derby City Council	55%
Health - Derbyshire Healthcare NHS Foundation Trust / Derby Hospitals NHS Foundation Trust / Southern Derbyshire Clinical Commissioning Group	24%
Derbyshire Constabulary	12%
Derbyshire Probation	4%
City and Neighbourhood Partnership	4%
CAFCASS	0.3%

10 Derby Safeguarding Children Board Effectiveness

10.1 The Derby Safeguarding Children Board undertook a self assessment 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). The progress made since the last self-assessment, carried out in 2013, is set out below.

Governance

10.2 The Derby Safeguarding Children Board has led the development of a protocol to ensure effective partnership working with the Health and Well-being Board, Children, Families and Learners Board and Derby Safeguarding

Adults Board. This will be fully implemented along with the revised governance arrangements.

10.3 The Derby Safeguarding Children Board successfully recruited Lay Members (two for the Derby Safeguarding Children Board and one for the Child Death Overview Panel) who will be fully involved in the work of the Derby Safeguarding Children Board during the coming year. The independent chair met with the Police Crime Commissioner (PCC) to ensure effective arrangements were in place and the office of the PCC will be invited to be represented on the Derby Safeguarding Children Board.

Regular and Effective Monitoring

10.4 The Derby Safeguarding Children Board has been able to extend its monitoring of early help arrangements following additional data becoming available on a quarterly basis. This has led to analysis of early help cases alongside contacts and referrals to the local authority and the information about those children who are most at risk of abuse and who have child protection plans. Further work is planned to review the data collected and reported so that the Derby Safeguarding Children Board has the most effective opportunity to monitor local arrangements.

Accountability

10.5 The independent chair has ensured that partners hold each other to account at the Derby Safeguarding Children Board and subgroup meetings setting clear tasks and actions to be reported upon. Challenge is encouraged appropriately in meetings and recorded in the minutes. Action has been taken outside of meetings and the effectiveness of the independent chair and the Derby Safeguarding Children Board has been scrutinised by the Chief Executive. Section 11 audits have been completed and the independent chair and board manager have been invited to participate in the Markers of Good Practice reviews of health partner agencies.

Learning and Improvement

10.6 The Derby Safeguarding Children Board implemented, jointly with Derbyshire LSCB a Learning and Improvement Framework. The joint Workforce Sub Group oversees the effectiveness of learning alongside scrutiny of workforce issues. Improving the range of suitable information about workforce pressures that impact on safeguarding arrangements will be the focus of work for the sub group. The learning arising from serious case reviews and learning reviews has continued to link the work of different sub groups.

Policies and Procedures

10.7 Joint work with Derbyshire safeguarding children board has focussed on updating the procedures alongside key guidance. The Early Help Assessment and Single Social Care Assessment was launched at the end of

spring and the Derby Safeguarding Children Board plans to evaluate practitioner views about the effectiveness of thresholds at the launch events.

Children missing and children at risk of child sexual exploitation (CSE)

10.8 The Derby Safeguarding Children Board continues to monitor the impact of arrangements to protect vulnerable young people. There is good quality data demonstrating the positive impact of the CSE strategy that improves the lives of the young people at risk of CSE. Further work will be carried out to improve how the effectiveness of the arrangements to deal with children who are missing is analysed.

Case File Audit

10.9 The Derby Safeguarding Children Board has completed a range of audit work as part of the quality assurance work plan. This includes case file audit and a specific case file audit is planned for July 2014 to examine and analyse the effectiveness of child abuse referrals and enquiries (under section 47 of the children act 1989). The planned audit of cases is linked to evaluating the effectiveness of changes arising from case reviews. Following these audits it is planned that further case file audits will be extended to include the involvement of practitioners and families.

Influence and Priority Setting

10.10 The Derby Safeguarding Children Board has presented its priorities to the Leadership Board for the Derby City Partnership which includes all essential partner agencies. The implementation of the partnership protocol will further improve the arrangements and over the next year the Derby Safeguarding Children Board will continue to “dig deep” to see if agencies are putting effective arrangements in place. The Derby Safeguarding Children Board has been explicitly invited to contribute to the Health Commissioning planning for the coming year.

High Quality Multi Agency Training

10.11 The Derby Safeguarding Children Board has continued to successfully demonstrate the impact on practice of the high quality training delivered by the training coordinator and multi-agency training pool. The training coordinator will be focussing on priorities that include working with partners to identify more clearly the training pathways for key staff and implement electronic booking arrangements to improve access and monitoring.

Engagement with Young People

10.12 The Derby Safeguarding Children Board engaged young people directly during the year, with the Youth Counsel participating at a board meeting to set out its views about the messages that could most usefully help children and young people keep themselves safe. Following this presentation,

work commenced to develop with young people information about violence in personal relationships and e safety.

Measuring impact

10.13 The Derby Safeguarding Children Board reviewed how it monitors the work of the sub groups to complete the business plan and new arrangements were put in place to improve the effectiveness of monitoring. Specific reports were published to demonstrate more clearly to the local community how the actions undertaken as a result of local case reviews had made a difference to the safety and services provided to children and their families.

11 Inter Agency Derby Safeguarding Children Board Safeguarding Training

11.1 A new training coordinator took up post in September 2013 and has worked very effectively with the multi-agency training pool to provide a full multi-agency training programme, quality assure the impact of training on practice and work with young people to produce training films to use with practitioners in Derby.

11.2 During the year **80** *(78)* courses were delivered and **1,462** *(1,319)* participants ***attended courses***. 166 *(170)* participants failed to take up their place. (*Previous Year Figures in brackets*).

11.3 There has been some marginal improvement in the total number of DNA's during the year. 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.

11.4 The Derby Safeguarding Children Board has worked constructively with the Derbyshire Safeguarding Children Board to ensure effective arrangements are in place through the joint Workforce Group and Training Provider Group and effective links with Derby Safeguarding Adults Board were developed.

11.5 The Derby Safeguarding Children Board and the training pool reviewed and updated the training content incorporates current policies and procedures as well as the lessons from Serious Case Reviews. Alerts were provided when there are additions to website resources and ad hoc training events were held such as the Child Sexual Exploitation conference, the Disclosure and Barring Service Conference, and the Early Help briefings.

Learning and Improvement Framework

11.6 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 2013-2014

11.7 The following priorities were actioned during the year:

- Derby and Derbyshire Safeguarding Children training programme was amended to include: Effective Support and Supervision, the Toxic Trio (domestic abuse, alcohol/substance misuse and parental mental health difficulties) and streamlining the Everybody's Business and Working Together training course.
- The DVD *'Don't Shake your Baby'* was updated for multi-agency use in Derby/Derbyshire. 350 copies were then circulated for use with staff and parents alongside advice leaflets on responding to a crying baby and safe sleep advice. The DVD is available on the website.
- 80 staff have been assessed as competent on completing the *"Safe Sleep"* E-learning package.
- Eight multi-agency briefings in Derby were put on during March – May 2014 to launch the use of the *Early Help Assessment, Single Social Care Assessment and changes to local procedures*. (All places were fully booked and the total attendance was 586)
- Sixteen multi-agency staff attended a 'training the trainers' course in January 2013 in preparation for 14 briefings about the use of the *Domestic Violence Identification Matrix* by all agencies in Derby. (It is planned that by July 2014, over 300 staff will have been trained in the use of the tool.)
- All courses were updated to ensure national and local learning from reviews kept practitioners up to date and informed.
- Local audit of the impact of training on practice were carried out to include analysis of the effectiveness of specific courses.
- A wider quality assurance audit of practitioners' views about thresholds and safeguarding arrangements was carried out to inform the Board of the wider effectiveness of its work.
- Young people were involved in the development and filming of training materials. A young person continued their involvement in participating in the delivery of the CSE course.
- Learning materials were made available on the Derby Safeguarding Children Board website
- The Derby Safeguarding Children Board worked closely with the Derby Safeguarding Adults Board to produce "Think Family" principles for individual partner agencies to use to embed "Think Family" in practice. "Think Family" principles were embedded within safeguarding children

courses and progress reported on at the end of the year. The planned implementation of new electronic booking arrangements will incorporate in a single place access to safeguarding courses for both adult and child practitioners.

11.8 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

Training priorities for 2014 – 2015

11.9 The following priorities were identified for the coming year:

- Publish Safeguarding Training Pathways for key staff within each agency.
- Equip single agency representatives with the skills and recourses to deliver in house safeguarding training to Level 1 and Level 2 staff and volunteers.
- Continue to evaluate the impact of learning on practice.
- Implement the Training Validation Scheme to establish an approved list of independent training providers who meet local quality assurance standards.
- Develop e learning resources on the website for easy access to certificated and non- assessed safeguarding resources.
- Continue to support the multi-agency training pool in the delivery of courses which enhance the competence and confidence of staff working with children, young people, parents and carers.
- Implementing an electronic booking system.

11.12 Elements of the training priorities are key to the effectiveness of local training and these will specifically be included in the business plan**. *This will be an action for the coming year***

Establish consistent and robust safeguarding training and development pathways within agencies and ensure that single and multi-agency training is quality assured.

12 Children who are missing

12.1 The Derby Safeguarding Children Board continues to monitor children who are missing on a quarterly basis. When a child or young person is missing, there are arrangements to analyse and respond to the situation *at the time.* The Missing Persons Monitoring Group subsequently meets to consider how agencies are responding to individual cases on a monthly basis. The group is chaired by the Head of Service with operational responsibility for the local authority's response to missing children, and includes representatives from across agencies: Police, Health, Independent and local authority children's homes and the Multi-Agency Team (MAT).

12.2 The group considers all looked after children (LAC) and young people who have been missing over the preceding month, implementation of the Runaway and Missing protocol and issues relating to any emerging trends, risks and 'hot spots'. Members of the group plan joint working or disruption activities as appropriate. The group also discusses management of cases where there is cause for concern for children and young people who are missing from their home address. These cases will often become evident because of repeated missing episodes.

12.3 During the year 2013 – 2014 there were a total of 518 *(654)* missing episodes recorded of children and young people. Of these there were 338 missing episodes recorded from "home" address and 180 missing episodes from children's homes, foster care and other settings.[1] The impact of these arrangements is commented upon in more detail in section (18.1) (Previous year figures in brackets)

12.4 The three locality Runaways Workers each spend time based co-working alongside Missing Person Unit police officers. This has led to improved communications and some very quick responses from the police where a need for disruption activity has been identified. Independent homes are represented at the monthly missing persons monitoring group meetings, ensuring good on-going communication.

12.5 The Runaway and Missing Protocol is being reviewed following changes to national guidance and local arrangements and will be published in July 2014. The arrangements indicate a continued downward trend in the number of missing episodes as well as the number of individual children who are going missing.

13 Child Sexual Exploitation

13.1 The child sexual exploitation (CSE) work in Derby is driven by a multi-agency partnership and action plan coordinated through the Derby Safeguarding Children Board. Derby has a well-developed strategy on CSE and works with young people and families who are at risk of or have experienced sexual exploitation. The virtual team model operated in Derby

[1] An episode is when a young person is recorded as missing. A single young person can be recorded as missing on a number of occasions and these would be recorded as episodes.

has achieved national recognition through OFSTED and the Office of Children's Commissioner for our proactive and 'excellent joined up approach' (Ofsted 2012, OCC 2013).

13.2 The CSE operational group reports on the progress being made and effectiveness of the Derby CSE strategy. This includes the analysis of the impact of arrangements and effectiveness of the multi-agency work with individual young people alongside developmental work being identified and undertaken in Derby.

13.3 During the year the developmental work has included:

- A multi-agency CSE conference (attended by 205 practitioners in Derby and Derbyshire) with materials and recordings of the presentations successfully published on the Derby Safeguarding Children Board website.
- A learning review was undertaken with young people into their experience of Court Proceedings following a prosecution of perpetrators of CSE (Operation Kern Review was published on the Derby Safeguarding Children Board website).

The impact of these arrangements is commented upon in more detail in section (19.1)

13.4 The CSE operational group additionally undertook research in three Derby schools to gather an understanding of the online behaviour of children and young people and how they are able to keep themselves safe online. The results of the research will be presented to the Vulnerable Young People sub group in July 14 and inform work across Derby to improve safety from exploitation.

13.5 The vulnerable young people group will continue to scrutinise the local arrangements to safeguarding young people from CSE, those who are missing and those who are vulnerable from a range of factors. ***This will be an action for the coming year:***

Coordinate agency responses to children and young people who are vulnerable to the risks of: Child Sexual Exploitation, Missing children and those missing from education, Online abuse, homelessness, radicalisation, substance misuse, self-harm and gangs.

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

14.1 The Quality Assurance Group is responsible for coordinating the monitoring and evaluation of the effectiveness of the local arrangements to safeguard and promote the welfare of children and advise partners, the Children, Families and Learners Board and the Health and Well-being Board on ways to improve.

Quality Assurance Audits

14.2 The audit reports, set out below, were received during the year. The audit reports examine different aspects of the “safeguarding system” so that together, the Derby Safeguarding Children Board is able to have an overview of the system and where actions are needed to improve local arrangements.

Audit and evaluation of the application of thresholds

14.3 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. Threshold guidance was published in 2012.

14.4 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. They were also asked about their awareness of Derby Safeguarding Children Board procedures that are now online and their ability to seek further guidance about their concerns.

14.5 Questionnaires were completed anonymously at multi-agency briefing sessions throughout March and April 2014 that were publicising the implementation of the Early Help Assessment (to replace the Common Assessment) and the Single Social Care Assessment. A total of 526 questionnaires were completed.

14.6 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.

14.7 The audit revealed that the 87% of the workforce was aware that Derby Safeguarding Children Board procedures are now online and 99% know who, within their agency, they could take advice from if they were worried about a child. (It is essential that all staff can obtain advice and guidance if they are in any way worried about a child)

14.8 Similarly encouraging responses were evident for the qualitative questions, particularly the numbers regularly finding agreement around early help and risk of harm and of those being able to voice their opinions when in disagreement.

14.9 When all professionals are in agreement of risk and need, better decisions and integrated planning will be better placed to deliver improved outcomes for young people. It is clear that further work is needed to achieve consistently high levels of agreement on levels of need across agencies.

14.10 The Derby Safeguarding Children Board will co-ordinate further dissemination and training activities, across agencies and will conduct further periodic audits to check understanding of thresholds.

Report on the Pre-Birth Multi-Agency case file audit

14.11 Following a local learning review, the Derby Safeguarding Children Board undertook to review and update guidance for practitioners to improve multi-agency early help for pregnant women to improve outcomes for the children before and following birth.

14.12 Children's and adult's services jointly developed a Pre-birth Protocol to address timely and effective interventions during pregnancy to support expectant parents.

14.13 A multi-agency case file audit was carried out (October 2013) to establish a baseline assessment of existing practice (17 cases were audited). This will be followed up to evaluate the progress and impact of the implementation of the multi-agency pre-birth protocol put in place to improve how agencies provide better early help(October 2014).

14.14 The sample specifically included cases that were open to the Substance Misuse Pregnancy Advisory Services (SMPAS), in which the unborn child had siblings. A total of 17 cases were identified and data was obtained from Substance Misuse Specialist Midwives, Children and Young People's Department and Health Visitor Services.

14.15 The audit report indicated a high level of multi-agency working in the sample group; with cases being held in health departments, social care and a variety of other statutory and Voluntary, Community and Independent sector services.

14.16 The quality assurance group will consider whether the implementation of the protocol will improve those areas of practice where improvements were identified from the audit. These include:

- Information about the coordination of home visits by agencies and whether prescribed drugs are kept safe and fathers engaged with the process of assessment and improvement.
- Whether the implementation of early help assessment processes are enabling effective interventions and promoting better coordination of services for mothers (avoiding duplication).
- Qualitative analysis of the inter agency services provided and the view of practitioners and parents about the effectiveness of arrangements.

Audit of child protection, child sexual exploitation and child in need plans

14.17 The quality assurance group reviewed the audit undertaken by lead members of the LA quality assurance team. The main themes arising from the audit are set out below:

Child Protection Planning

14.18 A total of 30 current child protection plans across all locality teams were audited in August 2013 to identify the quality of those plans. This repeats an audit undertaken in 2012.

14.19 Overall, there was evidence of improvement in the quality of Child Protection Plans with the number of plans with measures considered poor or missing to have reduced overall. Clarity of accountability and achievable outcomes were the best features of the plans audited, with 80%+ seen as good, and one only seen as poor. This was an improvement on the previous year, as was the reference to change-focused work in plans, with a slight increase in those seen as good and now none seen as poor. Use and specificity of outcomes is good or satisfactory in over 90% of plans, an improvement from around 85% and 70% last year. There were the some concerns about time frames, measurability of outcomes and consideration of ethnicity as areas where improvement could be made.

14.20 Although the audit did not look at the impact and effectiveness on outcomes, the Child Protection Managers reported that good quality plans have made an enormous difference to the effectiveness of the work, the effectiveness of the core group and outcomes for the child. They also observed differences where plans are clearly "owned" by the family and the core group, rather than completed separately by the social worker and imposed on the others, and most obviously where plans are a live tool in constant use in the work with the family, compared with plans which sit on file until the next conference.

Child sexual exploitation planning

14.21 These plans were not audited in 2012 as processes were relatively new. A total of 8 plans were audited by the child protection managers (not involved in CSE strategy). This initial audit identified that at least half the plans were assessed as good.

14.22 Particular strengths are the achievability of outcomes and accountability for actions, identifying a range of agencies. Identification of responsibilities for parents and young people, and the use of change-focused work were also generally good. There were the similar concerns about time frames, measurability of outcomes and consideration of ethnicity in the plan.

Child in need planning

14.23 A sample of 17 child in need plans across Localities was subject to the same audit. Child in need planning was identified as requiring the greatest level of development. (Contextually it is noted that not all Child in Need reviews are independently chaired).

14.24 Plans could not be located on the files of 7 out of the 17 cases audited. Where plans were found, the quality was less good than for the other types of plans and in contrast to those audited last year.

14.25 The report included a review of actions identified previously and set out an updated action plan against which progress will be scrutinised by the Quality Assurance Group.

Audit of Child Protection Plans that ended at the first review

14.26 Statistics had revealed a significant number of child protection plans which were ended at the first review. The quality assurance group reviewed the audit undertaken to evaluate whether the decisions to end a child protection plan at the first review were premature or whether the plan had been necessary.

14.27 A three month period was audited and during this time child protection plans were ended at the first review for 17 Children from 7 families (ages 1 yr – 15 years).

14.28 In summary, the audit indicated that on the whole other agencies agreed with the recommendations made by social care that a child protection plan was no longer required. Some of the audits identified other approaches to a child protection plan which may have been equally successful, although this was not apparent before or at the initial conference.

14.29 There were no particular issues raised in terms of consistency of thresholds between teams bringing cases to conference and teams subsequently ending plans or of a different application of threshold by the chair of the meeting. Opportunities to improve practice across partners were identified and are being taken forward by the child protection managers who chair the meetings.

14.30 Alongside this audit, the quality assurance group began to receive figures illustrating attendance at child protection conferences by agencies and whether reports were appropriately provided. These figures have begun to be monitored and action taken where individual agencies are not meeting the expected standard.

Audit of children who became subject of a Child Protection Plan for a second or subsequent time

14.31 The purpose of the audit was to provide retrospective quality assurance of the decision and safeguarding arrangements in respect of the number of children who are subject to Child Protection Plans for a second or subsequent time.

14.32 The key question was whether appropriate action or services had addressed the needs and risks to the children when it was decided that the first child protection plan was no longer required in light of the fact that circumstances had subsequently led to a second or additional child protection plan.

14.33 In summary the audit found that decision making in child protection conferences is complex and is influenced by multiple factors, such as, the information available at the time, the delivery of the intended plans, the engagement of the family, and the ability of professionals to work with the families in ways that clearly understand whether 'change' is achievable, sustainable and safeguards children.

14.34 In 6 cases (60%) the audit identified that decision making and plans were appropriate and safeguarded the children. In 4 cases (40%) retrospective reflection on the decision making indicate that in hindsight the decision to cease the first child protection plan for those children may not have been appropriate.

14.35 The audit was able to provide reflection on the factors, from the learning in these cases that will improve decision making in similar cases in the future.

Annual Report of the Independent Reviewing Officer (IRO) function

14.36 The Annual Report in respect of the Independent Reviewing Officer (IRO) function was reviewed by the Quality Assurance Group. The numbers of Children in Care have decreased and this trend appears to be continuing. Care proceedings are being more frequently completed within 6 months and this is speeding up the process for children to achieve permanency, either returning to their families or being placed for adoption. The Exit from Care Team has made a difference is supporting plans for children to leave care safely and this team is due to expand.

14.37 The Independent Reviewing Officers continue to closely monitor all care plans and with the new tracking system (to be implemented in 2014) any delay or drift in cases will be minimized, leading to better outcomes for children. Lower caseloads have meant that the IROs will be able to see every child before or after each review if they do not attend and therefore carry out their duties and responsibilities as outlined in the IRO Handbook.

14.38 The annual report includes evidence of the audit and challenge (undertaken by the IRO service) to improve outcomes for children in care. 1187 child in care reviews were held from April 2013 – March 2014.

14.39 Senior managers completed 75 file audits co-ordinated by the Head of Service (Quality Assurance) and any issues picked up in these audits were fed through to the IRO. The standard of work overall for children in care was reported as better than average for all cases, and very good for children being placed for or awaiting adoption. However in around 20% of cases the standard of recording and management oversight and supervision was an area for improvement alongside the need for recorded assessments to be up-dated more frequently and prior to a planned move.

14.40 In cases where an IRO has significant concerns about practice or other issues affecting a child's care plan then they send a Quality Assurance Notification Form to the manager involved outlining the issue and requesting action be taken. If the response is not satisfactory then the issue will go to stage two of the process whereby the Senior IRO will meet with the Deputy Head of Service responsible. The Dispute Resolution Process has four stages and can lead to a referral to CAFCASS. This process provides an essential safeguard for children in care.

14.41 The report set out the detail of challenge raised by IROs on behalf of children in care. The detail indicates that IROs have actively raised concerns and have sought appropriate resolution in the interests of the children.

14.42 The main issue that led to the most Quality Assurance Notifications was Statutory Visits not being carried out within prescribed timescales (15 occasions). Action has been taken to improve this and the recording of statutory visits has been prioritised for monitoring.

14.43 There IRO service identified the need for improvement in legal documentation being provided in cases subject of care proceedings. This was subject of escalation and plans put in place with legal services. The IRO service will continue to monitor the outcome and planned improvement.

14.44 The report sets out evidence of additional action taken to challenge and reported that the cases were successfully resolved at stage 2 of the Dispute Resolution Process. The report sets out the sustained progress achieved increasing the number of children who have participated in their reviews during the year (2011/2012 - 81.9% participated; 2012/2013 - 95.1% participated; 2013/2014 - 95.7% participated).

Looked After Children Placed Outside of Derby City Report

14.45 The Derby City Council reported to the Derby City Council’s Children and Young People’s Overview and Scrutiny Board and the Corporate Parenting Sub-Board on both recent and historical trends relating to looked after children placed out of the city

14.46 The analysis presented within the reports looked at all children placed outside of the Derby City boundary (excluding adoption placements) and considered the recent changes to Care Planning Regulations that highlighted further requirements when placing looked after children 'at a distance'.

14.47 The report found that generally for children placed out of the city they are subject to fewer placement moves and this is a trend that has remained consistent since 2011. Based on sample analysis of statutory visits, at the end of March 2014, children placed outside of the city have a higher percentage of visits in line with statutory requirements, with those placed in Derbyshire being 16% higher than the total looked after cohort (irrespective of placement location).

14.48 There were no systemic concerns raised about safeguarding arrangements and the report identified areas for improvement. The Derby Safeguarding Children Board will continue to monitor progress and will complete the assurance of arrangements for children from outside Derby who are placed in the city. ***This will be an action for the coming year:***

Review the safeguarding arrangements of children in care living in Derby and in the care of other Local Authorities.

Disabled Children Report

14.49 In August 2012 Derby City Council's disabled children's services were inspected as part of a thematic inspection covering 12 local authorities. The report evaluated the effectiveness of work to protect disabled children and young people at all ages from early support to the identification and responses to child protection concerns.

14.50 The Light House provides an Integrated Disabled Children's Service (IDCS). It is a multi-disciplinary, multi-agency service aiming to meet some of the needs of disabled children and their families. The team work with children and their families in Derby and some children and families in the south of Derbyshire.

14.51 The report identified a robust single point of access and a clear understanding and appropriate thresholds from early help through children in need to child protection. Following learning from a serious case review internal processes have been tightened up and the transfer protocol between teams extended to include IDCS to avoid delays in allocation and a loss of information during transfer from reception services.

14.52 The audit identified good partnership working with health and education colleagues and good communication between IDCS and the safeguarding team, with a linked Child Protection Manager who offers advice and has delivered briefings for the teams. Areas for development were identified and annual progress will be reviewed by the quality assurance group.

New Communities

14.53 The Derby Community Cohesion and New Communities Strategies promote the partnership work of a range of agencies and council departments to minimize potential risks to individuals and communities. The Derby Roma Complex Cases arrangements were established in 2007 in order to provide a single coherent approach in meeting the needs of this group of vulnerable families. The arrangements ensure that all agencies have due regard to the complex needs of families including the safeguarding requirements for Roma children and adults.

14.54 During the year it became apparent that there were increasing incidences of neglect noted amongst Roma families and a disproportionately high number of cases in care proceedings compared with the demographic population in Derby. The Local Authority established a multi-agency task group to look into the safeguarding arrangements in respect of Eastern European families.

14.55 A learning review has been commissioned to consider the effectiveness of safeguarding arrangements for a Roma family.

14.56 National guidance developments, local learning and analysis of cases indicate that a more in depth review of safeguarding arrangements should be carried out for specific groups of vulnerable children or young people. ***The following will be actions for the coming year:***

Review the safeguarding arrangements for

- ***Young people from Derby who are Young Offenders.***
- ***Children and young people from new communities in Derby.***
- ***Children and young people at risk of Female Genital Mutilation.***

15 impact of Policies and Procedures

15.1 Alongside the audit and evaluation of the application of thresholds (as above) the Derby Safeguarding Children Board has scrutinised the impact of policies and procedures. This has been achieved mainly through examining how effectively the system brings together policies, procedures and practice to impact on performance and outcome measures.

15.2 For example the Derby Safeguarding Children Board has continued to monitor trends across the year in respect of the relationship between early help assessments, referrals to the local authority, children who receive services as children in need and those who become subject of child protection plans or children in care. The data is set out with commentary in section 27.

15.3 The analysis of these trends, alongside learning and serious case reviews, helps identify whether particular policies and procedures are effective or are needed.

15.4 The Derby Safeguarding Children Board identified that, as a result of findings from local reviews and trend data, further development should occur in the way that domestic violence and abuse was assessed and responded to in a more consistent way across agencies. Action has been taken to implement the use of the Domestic Violence Risk Identification Matrix.

15.5 The Derby Safeguarding Children Board has taken active measures to ensure that it understands whether the intended improvements arising from the implementation of policies or procedures (such as the Pre Birth Protocol illustrated above) are evident and making a difference.

15.6 The Derby Safeguarding Children Board partner agencies participated in the implementation of the Early Help and Single Assessment processes during the year, as above. The effectiveness of the new processes will be subject of analysis next year and are anticipated to have an impact on the follow up analysis of Early Help arrangements, set out below.

16 Early Help (Derby Safeguarding Children Board Priority Area)

16.1 The Derby Safeguarding Children Board continued to receive updates on the early help strategy and the development of Multi-Agency Teams that provide early multi-agency engagement with families requiring additional support. The vulnerable young people's sub group has the particular oversight of factors impacting on teenagers including the effectiveness of the coordination of early help arrangements. The subgroup will report in summer 2014 on the correlation and relationship of multiple factors that impact on this age group and make them more vulnerable to inform strategic planning.

16.2 The Children and Young People's Department provided an annual report on the effectiveness of early help services. These include, across the city, Multi-Agency Teams (MATs), who are co-located with Social Work teams in an integrated locality based model and are linked with Children's Centre's as part of the city's broader early help offer. Also located within the early help offer, is the space@connexions, which is a city centre based youth 'one stop shop, which delivers careers and health advice, including sexual health services, drug and alcohol services and the Leaving Care Team.

16.3 In order to help demonstrate the impact of early help services, Derby Children and Young People Department (CYPD) has developed a performance framework (implemented April 2014). The purpose of this framework is to develop a coordinated assessment of early help activity and support evaluations on the impact that it is having on associated services / measures (i.e. referrals to social care and the total number of looked after children).

16.4 There will be no targets set for the first year as baselines are established for each of the measures. Summary reports will be available at the different reporting levels to support supervision, team meetings and strategic discussions through local Senior Management Team meetings or the

CYP Improvement Board. Full analysis will therefore be included in the next annual Derby Safeguarding Children Board report.

16.5 The current report from the CYPD provides evidence of the impact of early help services between 2013 - 2014.

16.6 In summary, the report indicates that there may be evidence of around 800 cases expected on average to be worked at an Early Help level. The publication of the *Threshold Document* has led to a more consistent application of professional judgements. A temporary increase in the numbers of children in need cases that had previously been worked as early help cases is interpreted as a consequence of the clarification of how seriousness different levels of need should be judged.

16.7 The number of Early Help Assessments being completed has increased, which displays a greater recognition of emerging needs being identified by partner agencies and universal services.

16.8 Overall, the picture presents both positive areas and areas for further work in relation to the impact of early help services. The cases being referred for early help have seen an increase in complexity and the improved data collection and analysis implemented this year will provide a clearer indication of the impact of early help when reported in 2015. ***This will be an action for the coming year:***

Review the effectiveness of early intervention and child protection arrangements to safeguard children and young people.

16.9 Details of the analysis are included in section (27).

17 Domestic Violence (Derby Safeguarding Children Board Priority Area)

17.1 The Criminal Justice Board and Partnership Agencies provide figures to the Derby Safeguarding Children Board on a quarterly and annual basis. The Criminal Justice Board reports that in the context of long-term reductions in crime recorded domestic violence flagged crimes continue to increase and now account for around 1 in 10 crimes (in 2007/08 it was 1 in 20). Although police recorded domestic violence crime numbers are increasing, there is still a substantial gap between the number recorded and the expected victimisation rate. Improved recording and confidence in reporting are being helped by publicity campaigns and proactive work across all agencies and the Voluntary, Community and Independent sector.

17.2 In March 2014 Derby City Council requested that the Council Cabinet work together with the Neighbourhoods Board and the Police Crime Commissioner to review domestic abuse. Six proposals were agreed:

a) consider and evaluate the levels of domestic abuse within the City
b) ‘dip sample’ the way that cases have been managed and their outcomes

c) discuss and disseminate the best possible levels of professional practice within the City
d) consider setting up a strategic countywide group to enhance the work of domestic abuse specialists, such as the Independent Domestic Violence Advocates
e) make recommendations to Cabinet about future resources, training and awareness
f) urge Government to consider seriously the call by domestic violence specialists that 'coercive control' be made an offence'

17.3 The Derby Safeguarding Children Board has monitored the progress of the Domestic Violence and Sexual Violence strategy (that covers both Derby and Derbyshire). Reports have been received at the quarterly meetings and at the quality assurance group. The effectiveness of the strategy was reviewed and a revised strategy will specifically focus on three planned themes:

- Provision - To provide high quality and consistent services which meet the needs of victims at a local level
- Protection - victims of domestic abuse and sexual violence are protected and perpetrators are held to account for their behaviour
- Prevention - identify and prevent domestic abuse and sexual violence by engaging and raising awareness with victims, perpetrators, professionals and all communities

17.4 The Derby Safeguarding Children Board independent chair plans to meet with the Derby and Derbyshire lead officers to agree how the revised strategy can be evaluated over the coming year so that the impact can be clearly understood.

17.5 The Derby Safeguarding Children Board has continued to monitor the progress of changes to the way in which domestic abuse referrals from the police are screened at an early stage by children's social care staff based at the central referral unit in police headquarters.

17.6 The anticipated developments over the last year were delayed but these have been resolved and it expected that the new arrangements will be implemented during summer 2014. The Derby Safeguarding Children Board will ensure that as implementation occurs the new arrangements will be scrutinised to ensure that they integrate with existing safeguarding children procedures and enhance safeguarding processes locally. ***This will be an action for the coming year:***

Monitor the impact of the local Domestic Violence and Sexual Violence Strategy and the implementation of the new Multi-Agency Safeguarding Arrangements.

17.7 Following evaluation of themes arising from local and regional learning about the response to domestic violence and abuse, as above, the Derby Safeguarding Children Board implemented the use of the Domestic Violence Risk Identification Matrix (DVRIM). The use of this tool by all agencies is planned to improve consistent assessment and analysis of the risk to

individual families and inform judgement about next steps to be taken to safeguard them.

17.8 Multi-agency and single agency training has been provided 325 frontline practitioners on its use. Alongside this the Derby Safeguarding Children Board invested in the training of 60 frontline social workers to use the model to inform evidence and analysis based assessment for complex cases where child protection plans or court action was required.

17.9 The impact of the implementation of the Barnardo's DVRIM will be assessed over the coming year. Early indications are that where it has been used, better informed analysis and evidence is being presented to Child Protection Conferences and practice is improving. One participant reflected on the impact of using the DVRIM and reported that "In the past I haven't wanted to call it domestic abuse because I didn't want to damage my relationship with the mother, but now I will talk to her about why I am calling it domestic abuse"

Multi-Agency Risk Assessment Conference (MARAC)

17.10 All DV incidents identified as high risk by police or other agencies are subject to a MARAC. The measure of the effectiveness of arrangements being put in place to reduce the risk to victims (some of whom have children) is best evaluated through the number of victims being considered at a subsequent MARAC. Successful support and interventions would ideally see the number of repeat referrals reducing. The current target of repeat referrals to MARAC is 27%. In Derby there were 214 cases discussed at MARAC during the year of which 25 were repeat cases (12%).

17.11 Of the 214 cases 166 cases (78%) had children living in the household. Figures for the number of repeat cases where children were present are not currently available.

18 Children who are missing

18.1 The Missing Persons Monitoring Group completed an annual report setting out the number of missing episodes that occurred during the year, analysis of the local arrangements and recommendations for the coming year.

18.2 When the police receive a report of a missing child or young person they categorise the episode as missing or absent, dependent on vulnerabilities - including consideration of age and history. At subsequent review(s), and always after 24 hours, the young person will be categorised as 'missing'.

18.3 The annual figures indicate that there was a significant reduction in the numbers of episodes reported during the October to December period. This was consistent with a change in the reporting arrangements consistent with national guidance. Overall, and in the context of the changes to the recording of missing episodes, there has been a reduction in the numbers of young people living in care who are reported as missing.

18.4 Return interviews have helped reduce missing episodes and the vulnerability of children. They are completed, within 72 hours of return, with a young person by an independent worker unless the young person prefers to be interviewed by their carer. The Runaways (or key) worker will, dependent on the reasons for going missing, support the young person to explore alternative solutions to running away.

18.5 Return interviews continuing to be an effective way of identifying children and young people at risk of significant harm. They help reduce, and prevent, further episodes of running away by helping young people understand the risks involved in being away from their family or carers.

18.6 Additionally information from the return interview is sent to the police, providing intelligence that may indicate a need to further investigate any reported names, addresses or 'hotspots' and plan disruption activities, in particular where sexual exploitation and/ or abuse is a feature.

19 Child Sexual Exploitation (CSE)

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). The CSE annual report sets out an illustration of the impact of the strategy that is summarised below.

19.2 The numbers of new referrals (48) has reduced compared to last year's figure (64). From information shared at regional forums, we are comparative to other cities of our size, but have fewer children and young people on Child Protection Plans for the issue of CSE.

19.3 It is important to reflect that the vast majority of Derby cases are at risk of CSE, very few show evidence of actual exploitation. A higher number of cases were closed during this year (42 cases in comparison to 35 last year). This year 40% of cases were closed due to the risk being removed or reduced to low level compared to 28% last year. Cases are thoroughly reviewed under the multi-agency strategy and are only closed where there is a sustainable reduction in risk to the child. Only 7% were escalated to child protection in comparison to 36% last year.

19.4 There was a 50% increase in the number of boys referred to the strategy; however research indicates that the ratio of boys to girls at risk or exploited is 1-4, so this increase is interpreted as indicative of an improvement in the identification of boys at risk of CSE.

19.5 The analysis of the levels of risk to young people as a result of engagement to the strategy shows that there is a significant reduction of risk for the majority of young people. The levels of risk and additional vulnerability factors are measured at every meeting including network meetings. The "official" risk rating is recorded at the CSE strategy meeting. Of the young people assessed as high risk at their initial meeting 85.7% had the CSE risk removed or reduced within 3 months (54% in 2012-13, 45% in 2011-12). This

is a significant improvement on previous years and demonstrates increasing effective interventions with these young people.

19.6 The Child Protection Manager visited and spoke to 100 % of young people subject to the strategy before the meetings. These visits are arranged to ensure that the young person and parents/carers understand why they are coming to the meeting and to explain the process. The attendance at meetings is 42% of young people and 48% of family (last year 68 % of young people attending meetings and 77.5% of meetings being attended by the parents or carers). This is a reduction in the numbers attending in previous years. However we have a high number of referrals for young people who cannot attend meetings due to underlying medical or learning needs and a higher number of professionals meetings in this period.

19.7 The involvement of the parents and young people in the strategy is fundamental to its success, so this is an area for improvement and monitoring in the coming year.

19.8 Evaluation forms for young people indicate that they find CSE meetings very positive. Of the young people who attended meetings, 100% felt listened to, 100% found the meetings supportive (92% previous year), 100% have a better understanding of CSE issues and 87% (previous year 96%) agreed with the CSE plan agreed at the meeting. Often the reason to disagree with the plan is related to actions taken to disrupt or prosecute the person who is deemed to pose a risk to the young person.

19.9 The CSE strategy includes the disruption and aiding the prosecution of alleged offenders. In Derby over the last year the Police Child Sexual Exploitation Investigation Unit (CEIU) has dealt with:

Referrals	Investigated	Disrupted	Crimes	Arrested
94 (Individual)	23 (Cases)	56 (Individuals)	23 (Recorded)	9 (Individuals)

The police continue to tackle Child Sexual Exploitation in all forms as a top priority.

19.20 The CSE strategy was reviewed and an updated action plan for 2014 – 2015 has been agreed. A learning review following “Operation Kern” was completed during the year and is commented upon in section (23.13).

20 Private Fostering

20.1 The Quality Assurance Group scrutinised the Private Fostering annual report that provided details of the number of Private Fostering arrangements made to the Local Authority and the statutory responses to these.

20.2 Historically the reported numbers of privately fostered children has been low. There has been a reduction of 40% in the number of new reported

arrangements in comparison to the previous year. The numbers appear disappointing given the efforts that have been made to raise awareness amongst all professionals and staff. Despite numbers being low this is in line with the experiences of other neighbouring authorities and nationally little progress has been made in increasing the number of notified private fostering arrangements (Ofsted, 2014). Most regions nationally with the exception of 3 saw a fall in the number of notifications in 2012 compared to 2011 and this trend appears to be continuing this year within Derby, highlighting that under reporting remains a key issue.

	2005/ 06	**2006/ 07**	**2007/ 08**	**2008/ 09**	**2009/ 10**	**2010/ 11**	**2011/ 12**	**2012/ 13**	**2013/ 14**
No of new private fostering arrangements	15	11	8	5	2	5	5	10	6
By Gender									
Male	6	3	3	0	0	1	0	4	3
Female	9	8	5	5	2	4	5	6	3
By Age									
Under 1	1	0	1	0	0	0	0	0	0
1 to 5	0	1	0	0	0	0	1	2	0
6 to 9	0	0	0	0	0	0	1	0	1
10 to 15	13	8	6	5	2	5	3	8	3
16 and over	1	2	1	0	0	0	0	0	2

20.3 Overall the numbers of privately fostered children have been low since 2005/06 until 2012 when notifications increased by 50% which may have been attributable to the publicity campaigns and integration of private fostering within multi- agency training courses. However, despite significant focus on this from the CYPD Quality Assurance service and through the Derby Safeguarding Children Board there has been a 40% reduction in the reporting of new arrangements when compared to last year.

20.4 The report indicated that once identified there was evidence of good work in the majority of cases that is compliant with regulations and those children are being well supported. Recommendations were identified to achieve this level of support in all cases.

20.5 The Derby Safeguarding Children Board has received a response from 72 schools in Derby indicating that they have audited their safeguarding arrangements and these include identifying whether adults have parental responsibility and whether private fostering arrangements are identified. Further work will be undertaken to complete an audit and continue to promote awareness of private fostering.

21 Allegations against staff, carers and volunteers

21.1 The Workforce Group scrutinised the annual report that informed the Derby Safeguarding Children Board and partners of the number and outcomes of allegations against staff, carers and volunteers and the effectiveness of the Local Authority Designated Officer (LADO) service for managing these allegations.

21.2 In summary, the annual report confirmed that there were 114 referrals to the LADO in the specified time period compared with 104 last year and 102 in 2011-12. The LADO team additionally takes a significant number of queries, which have not all been recorded where it is quickly established that these do not meet the criteria for LADO. Anecdotally the team consider there has been an increase in contacts overall, the 114 referral reflecting only those which clearly meet the criteria. A record of contacts will be kept in future.

21.3 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 were challenged about internal processes and assurance has been received indicating that processes are correct and any allegations relating to children are being responded to appropriately.

21.4 The nature of concerns being referred to the LADO remain broadly similar to previous years, with a slight decrease in allegations of physical abuse (from 44%) and increase in allegations relating to conduct (from 16% - generally issues arising in personal lives and behaviour outside work).

21.5 This year has seen a significant change in public awareness of the allegations process, with high profile cases in the national media and the increasing activity of the Disclosure and Barring Service (DBS) and governing bodies. The implications of the outcome of allegations investigations for professionals are significant; potentially life changing, and understandably individuals are seeking to obtain access to the information shared and to challenge outcomes.

21.6 Employers are not always confident in their role and responsibilities, and sometimes refer to "decisions" from LADO meetings, rather than using the recommendations to inform their disciplinary procedures.

21.7 Minutes of meetings are made available to subjects on application, once the investigations are complete, and are redacted for this purpose. Legal advice is taken as necessary.

21.8 The electronic recording system now allows all allegations to have a record created with the referral, communication, decision and minutes of meetings to be held electronically in one place. These records have restricted access where they involve Council staff. The separate database has been maintained to allow reporting and analysis and is also a useful tool for the team, pending the design of the new electronic recording system which will incorporate this capability.

21.9 One of the team delivers training to managers as part of the Derby Safeguarding Children Board safeguarding training programme on a regular basis; and the programme of briefings for CYPD managers has been concluded. A leaflet for employers has been developed and is issued to those making a referral.

21.10 LADO reports from both Derby City and Derbyshire County have been shared with the Workforce sub-groups of both Local safeguarding Children Boards and issues followed up by partners as necessary. An action plan has been identified to further drive forward improvements in the coming year.

22 Impact of the Learning and Improvement Framework

22.1 The Derby and Derbyshire Learning Improvement Framework includes how the learning from case reviews will be incorporated into changes and improvements to practice through learning and development activities.

22.2 The learning and impact on practice that has arisen from Serious Case Reviews and Learning Reviews is set out below where it has not been previously commented upon (such as the Pre-birth protocol and the DVRIM). Embedding the Learning and Improvement Framework and ensuring that the impact of practice arising from local learning is assured is included in the business plan. ***This will be an action for the coming year:***

Implement Learning Improvement Framework and collate findings of QA actions including reviewing the impact of the revised pre-birth multi agency arrangements to promote early help and the impact of the Preventing Suicide and Self Harm Strategy.

22.3 The work undertaken to ensure that there is effective safeguarding training and development in Derby is commented upon in sections (11) and (25).

23 Serious Case and Learning Reviews

23.1 The Serious Case Review (SCR) Panel is responsible for undertaking reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. The SCR Panel ensures that Ofsted are notified of all serious incidents considered as required.

23.2 The SCR Panel ensures that:

- relevant cases are considered and serious case reviews are carried out according to regulations and guidance
- all organisations carry out their roles in respect of serious case reviews
- action plans from serious case reviews and learning reviews are implemented, monitored and evaluated.
- staff in all agencies are aware of the outcomes of serious case reviews and their part in action plans
- learning is disseminated across partner agencies

23.3 During the year the Derby Safeguarding Children Board published two serious case reviews and a Learning Review. (A further serious case review was published in April 2014 but is not commented upon in this report).

23.4 In order to promote learning and accountability explanatory reports were published alongside the serious case review reports that explained what has changed in Derby as a result of the reviews and the impact on practice with children and their families. A summary of the impact of the learning is set out below.

CD09 SCR

23.5 The publication of the serious case review into a case referred to as CD09, was significantly delayed by the Coroner's Inquest. Following the judgement about the accidental cause of the death of the young person, the Derby Safeguarding Children Board decided that it was appropriate that the report be removed.

23.6 Although it is appropriate that the report be removed, it is noted that the learning from the case lead to changes to services and practice that improved outcomes for young people.

23.7 Evidence from a quality assurance survey of health staff in 2013 indicated that nearly half of them were aware of the self-harm guidance. This demonstrated improved awareness whilst confirming further areas for action such as improving access to appropriate training. The Derby Safeguarding Children Board training programme has continued to include courses on *Working with suicide and self-harming behaviours* and has taken action to make sure all relevant staff are able to access the courses. An additional course was introduced that explores *Risk assessment in complex cases and where there is poor family and child engagement*. Both courses received good feedback and have been reviewed and updated since their implementation.

23.8 The arrangements to safeguard children who are missing were reviewed and improved. The Derby Safeguarding Children Board receives a quarterly report of the numbers of young people who go missing. The figures indicate that the development of these arrangements have helped reduce the numbers of children who are missing.

ED12 SCR

23.9 The death of any child is a profound tragedy and creates distress for the family, the community and the professionals involved. This serious case review, referred to as ED12, concerned the deaths of six children and created national concern and a wish to understand why the events that took place occurred.

23.10 The review concluded that there was no evidence whatsoever that the intention to start the fire that killed the children was known to any agency and that the intention could not have become known prior to the event.

23.11 The review identified a number of recommendations that have been completed. Changes and improvements to the arrangements in Derby include evidence that Multi Agency Risk Assessment Conferences (MARACS) consider all children who possibly remain at risk from the perpetrator and individual agencies have completed the actions identified by the review.

23.12 National Fire Safety messages were publicised to having fitted, working tested smoke alarms on each level of a domestic property with the recommendation for a practised, familiar escape plan that is familiar to anyone in the property (family, friends and visitors) and that smoke detectors are additionally located in bedrooms and that they are easily heard throughout the property.

Operation Kern Learning Review

23.13 The Derby Safeguarding Children Board commissioned a learning review of Operation Kern and the associated activity by a number of agencies following the arrest and prosecution of 12 males for sexually exploiting young women in Derby. Operation Kern followed immediately on from Operation Retriever, also involving sexual exploitation, which was the subject of a serious case review. It was recognised that there was an opportunity for further learning from Operation Kern in the following context:

- A young person's journey of support before, during and after Court
- A parents/carers experience of the support and trial
- A professional's journey through a complex Child Sexual Exploitation (CSE) trial, identifying any organisational and procedural barriers to service delivery.

23.14 The learning review included contributions from a number of young people who had been involved in the trial, some parents and practitioners.

23.15 The evidence from the learning review was that partnership arrangements to support children through the trial worked best in the early and latter stages of the investigation. When the complex abuse enquiry strategy was no longer in place there was evidence of good single agency practice but little consistent communication or information sharing between key partners relating to the trials. Throughout the investigation and trial there was a high level of commitment from various agencies to supporting and safeguarding the victims. In the latter stages, multi-agency meetings were effective

23.16 The impact of media attention was significant and very time consuming. Although it was generally well managed and co-ordinated, this was not always the case and at times agencies responded unilaterally, leaving others to react or catch up. There is scope for improved co-ordination around these very high profile cases.

23.17 The trial was very successful with 11 out of the 12 defendants being found guilty, they will serve a combined sentence of 42 years and 7 months (at the time of publishing the report one defendant had not been sentenced).

23.18 However, the report concludes that this was at some considerable cost to the victims and witnesses. Current Court processes were in effect abusive of the young people; they reported feeling distressed, degraded, exposed, unsafe at Court and in the community, prevented from leading a normal life. The impact on agencies has also been significant, in an effort to fully support the young people. Improvements in the treatment of and arrangements for young witnesses in Court are much needed.

23.19 Judge Jonathan Gosling the trial judge commended the police for a very thorough and well managed investigation and praised the young people involved. He said: “The young people have showed extreme courage and fortitude, this case has gone back many months and against that background, there is the ordeal they had to go through giving evidence"

23.20 The progress that has been made by agencies in dealing with complex cases demonstrates an improvement in systemic partnership work in Derby. It also clearly shows the value of working together to improve outcomes for children and young people and means they better protected as a result.

23.21 Despite this being a very successful outcome, there remains concern about the complex needs of the individual young people, some of whom are now adults. The successful action taken by agencies needs to be balanced with the recognition that in terms of outcomes for the young people, the impact of what they have gone through has been so significant that some of them continue to be vulnerable and the longer term outcomes for them remain unclear. For that reason individual young people need a very strong transition plan and information about what support can be offered in adulthood.

23.22 The young people and parents/carers offered some very profound and powerful insights into their experiences through court and these informed the recommendations to improve practice locally and to support national plans to improve the victim journey through court.

23.23 The added value to Learning Improvement Framework arising from the involvement and views of children, their families and practitioners is an area that will be extended in the quality assurance work of the Derby Safeguarding Children Board. ***This will be an action for the coming year:***

Extend learning arising from local reviews and the work of the Board and establish effective arrangements (including priority areas) for consultation with Children, Young People, Parents/Carers and Practitioners.

24 Child Death Overview

24.1 The Child Death Overview Panel (CDOP) covers Derbyshire County and Derby City. CDOP reported to the Derby Safeguarding Children Board on a quarterly basis during the year and has continued to have multi-agency representation.

24.2 The panel has three main functions:

- To maintain and report on a database of all deaths of children and young people aged 0 to 17 years (inclusive).
- To oversee the investigations into these deaths.
- To learn lessons from these investigations, identify where there may be preventable causes and disseminate those lessons to Safeguarding Boards and other relevant stakeholders in Derbyshire County and Derby City.

24.3 CDOP provides an annual report to the Derby Safeguarding Children Board that illustrates actions that have been taken. (The time period for reporting is up to those cases that arose in 2012)

24.4 In Derby and Derbyshire, 13 cases resulted in specific recommendations and of these eight children became subject to a serious case review and one child was subject to a serious untoward incident enquiry. Of the remaining seven cases CDOP identified areas for improvement related to practice and care pathways.

24.5 Examples of some of the actions taken in response to recommendations identified by CDOP include:

- New leaflets for parents on particular medical conditions being provided in the
- Children's Emergency Department and advice about breast feeding for all pregnant mothers who have diabetes is being developed.
- Unsafe sleeping was a factor in a number of cases. The majority of cot deaths now involve a parent who smokes co-sleeping with their baby. The Safe Sleeping Campaign's advice emphasises this area and includes additional information that babies are not to be left to sleep in their car seats for a long period of time. The progress is being monitored via the Safe Sleeping Group.
- Physiotherapy Services on Neonatal Intensive Care Unit (NICU) have now been introduced and work is being undertaken to help the transition from Neonatal Intensive Care Unit wards to wards in the Children's Hospital.
- CDOP are completing a self-assessment of the effectiveness of the arrangements and the report and action plan is due to be presented to the Board in December 2014.

25 Impact of Inter Agency Derby Safeguarding Children Board Safeguarding Training

25.1 The Derby Safeguarding Children Board completed a project working with individual agencies to explore the learning need of staff so that clearly defined pathways for safeguarding and child protection development and training could be developed. The pathways will be linked to the roles and responsibilities of key staff who work with or provide support/ supervision and have a designated child protection role in the organisation.

25.2 Following the completion of the project and publication of new national guidance the Derby Safeguarding Children Board was able to publish the training pathways for education sector organisations. The remaining training pathways will be published in the coming year.

25.3 The impact of Inter Agency Derby Safeguarding Children Board safeguarding training was audited during the year and reported on in detail in the annual training report.

25.4 The audit selected randomly 59 participants to complete structured telephone interviews 6 months after completing 10 different training courses. The following summary sets out the main points that indicate how well Derby Safeguarding Children Board training helps practitioners improve their practice.

- *What has been the most important thing you remember from the course?* 91% (54/59) identified positive elements of the course, whilst 5 attendees could not recall anything specific or were negative about the course material.
- *Have you been able to share your learning in any way?* 78% (46/59) confirmed they had shared in some way including recommending the course to others, sharing information with colleagues and cascading information to the team.
- *Have you been able to put your learning into practice?* 79% (47/59) stated that their learning was influencing their practice whilst 20% (12/59) stated they were unable to identify something particular that they had taken into their work.
- *Overall comments:* Generally there was a sense that attendees were positive about the training and the impact it had on their practice in different ways. 71% made additional positive comments (42/59)

25.5 The scrutiny of the impact of the courses on practice demonstrated that there was a consistent significant impact on practice arising from attendance at Derby Safeguarding Children Board safeguarding training. It was very encouraging that 79% of attendees could talk about how the training had helped their practice and that 91% were remained positive about the training.

25.6 Of the small number of reports that indicated that the training had less impact, it was apparent that systemic shortcomings were contributory factors. IT was apparent that in some cases managers and staff had not been able to take on board the information in the training programme to help them chose the right course for them. Consequently people attended courses that they had repeated before or that were not appropriate to the individual's role and responsibilities.

25.7 The Derby Safeguarding Children Board will continue to promote clarity about which courses should be attended by which staff through the programme and over the coming year will reiterate which training and development pathways should be followed by staff with key roles and responsibilities

26 Partner Agency Safeguarding Reports (S11) Audit and Analysis

26.1 The Derby Safeguarding Children Board received audit reports carried out using section 11 of the Children Act 2004 from the following agencies: Children's Social Care; Youth Offending Service; Police; Probation; The Derby Hospitals Foundation Trust and Derbyshire Healthcare Foundation Trust submitted the *Markers of Good Practice* self audit tool that is comparable with the section 11 audit. Additionally Education settings completed an equivalent self-audit of their arrangements.

26.2 The following sets out examples of some of the areas individual agencies identified for improvement:

Derby City Council: Children and Young People's Department

- Work is on-going to collate views of children and young people in order to evaluate services and inform service planning. There is an engagement strategy under development but not yet fully implemented.
- Safeguarding is integral to the work of CYPD and is incorporated into all service business plans and other developmental plans such as the Keeping Families Together strategy. Safeguarding is a priority in the current difficult spending decisions but the Derby Safeguarding Children Board will require evidence of the assessment of the potential impact on safeguarding when organisational changes are made in the coming year.
- The Council keeps records in relation to all CYP staff training and managers keep records relating to their own teams but there is not a reliable, consistent approach. The Council has introduced a new HR system which will capture centrally information relating to induction and training of all staff; this will improve on the local inconsistencies.
- The current CYP workforce development plan needs to be up-dated and incorporate revised pathways for the existing Newly Qualified Social Worker programme, residential staff programme and a new pathway for Multi-Agency Team staff.
- Staff would benefit from refresher training/e-learning options in SCR / Learning Reviews due to the infrequent nature that this work takes place.
- Low numbers and referral rates in respect of private fostering from all staff groups and other agencies suggest case are being missed and/or there is less awareness amongst others. Further awareness raising, challenge and audit is still required.
- There are ongoing challenges to ensure the teams remain abreast of the various language and communication differences in the city, with specific focus in one locality on a burgeoning range of languages that are spoken in that area. There have been issues with interpretation services and action has been taken to improve these.

Youth Offending Service

- The details for Head of Service posts do not include any reference to safeguarding and this needs updating.

- There is a need to evidence the assessment of the potential impact on safeguarding when organisational changes are made.
- Training in respect of domestic violence and perpetrators remains undeveloped though it is included in the plans for commissioning of training by April 2014.
- Service learning from the analysis of the use of interpreters needs to be undertaken to help improve their use.

Police

- Child Abuse Policy is reviewed every 12 months by the Detective Inspector responsible for Child Abuse Investigation Unit. Child Abuse Policy has been reviewed and updated May 2014 although particular areas of Police Policy will be reviewed against Authorised Police Practice and Home Office Guidance when it is published.

Probation

- The Derby Safeguarding Children Board has received confirmation that on completion of the changes to the probations service a self-audit will be completed by the two new provider services.

CAFCASS

- No self-audit was submitted by CAFCASS. The first national inspection of CAFCASS was carried out by Ofsted and included inspection of the service area which covers the areas of Nottingham, Nottinghamshire, Leicester, Leicestershire and Rutland, Derby, Derbyshire, Lincolnshire, Peterborough and Cambridgeshire. The leadership and management of local services this area was judged to be good and no actions were required to meet regulatory standards.

Markers of Good Practice Report from Health Partners

Derbyshire Healthcare Foundation Trust

- Following completion of the serious case reviews workshops and information sheets will be organised to disseminate learning within the organisation.
- Human resources will update the job descriptions of all staff working with children and add a clause to identify their responsibility to safeguard all children.
- The new safeguarding children training programme is to be finalised and implemented across staff identified as requiring training.
- Repeat audit of employees' awareness of advice system during the 2014 audit cycle.
- Update, amend and implement the *Think Family Action Plan* throughout the organisation.
- All designated areas where children are seen or cared for must be safe and suitable for children. Future health and safety audits will further focus on consistency of the assessments and the strength of controls in place.

Derby Hospitals Foundation Trust

- Professionals working on a day to day basis with children and families should have child protection supervision available to them in order to promote good standards of practice. Safeguarding supervision to be made available when team staffing issues resolved.
- Ensure organisational policy is consistent with the domestic abuse and serious sexual violence strategy and staff guidelines developed by the Derby Hospitals Foundation Trust
- Ensure that the policy to safeguard children in whom illness is fabricated is reviewed.

Education Sector

26.3 The Board is working with Children's Services and head teacher groups to improve the level of assurance from schools that they are meeting their safeguarding obligations.

26.4 A total of 104 education settings within the city, including nurseries, schools, colleges and external education providers, were requested to confirm that the Derby Safeguarding Children Board Safeguarding Audit tool (or equivalent) had been completed. At the time of writing 72/104 (69%) feedback forms had been received.

26.5 Providers were asked to provide comment about action that could be taken to improve safeguarding arrangements across the partnership. More than half of the schools that had completed the feedback form made comments regarding improvements to multi-agency working arrangements.

26.6 More than quarter of them felt the process had been useful to them with some indicating how the audit was informing their activity. Others wanted to share ideas about improving working dynamics between agencies and comment on resource issues.

26.7 E-safety appears to be an issue on several establishments' radar; whilst it is a encouraging that the issue is being given attention and consideration, it is of concern that resources for responding to the issue and raising awareness of risks with young people and their parents/carers are a concern for some settings.

26.8 Communication between agencies, the level of information being shared and an understanding of agency roles and thresholds remain a concern for some settings though the numbers raising the issue suggests it is not a consistent problem across the city. Individual issues were immediately discussed with the settings concerned and concerns about difficulties accessing social care will remain an issue for monitoring by the Education Hub.

26.9 Education settings raised concerns about no longer being routinely informed when their pupils' families have been involved in domestic violence incidents; this issue was also raised in a Derby Safeguarding Children Board

survey of practitioners during the year. Initial action has been taken to raise issues about the notification of Bail Conditions and domestic violence with the police. This is a complex area and further action will be taken to consider how information can be shared about domestic violence with education settings when the new safeguarding arrangements are put in place jointly with the police and social care in the coming year.

26.10 Some education establishments feel their time and resources are in more demand as a result of other resources being removed due to the recent and current financial constraints on public spending. They have questioned whether these cuts are having an impact on other agencies' practice and communication leading to greater demand on them.

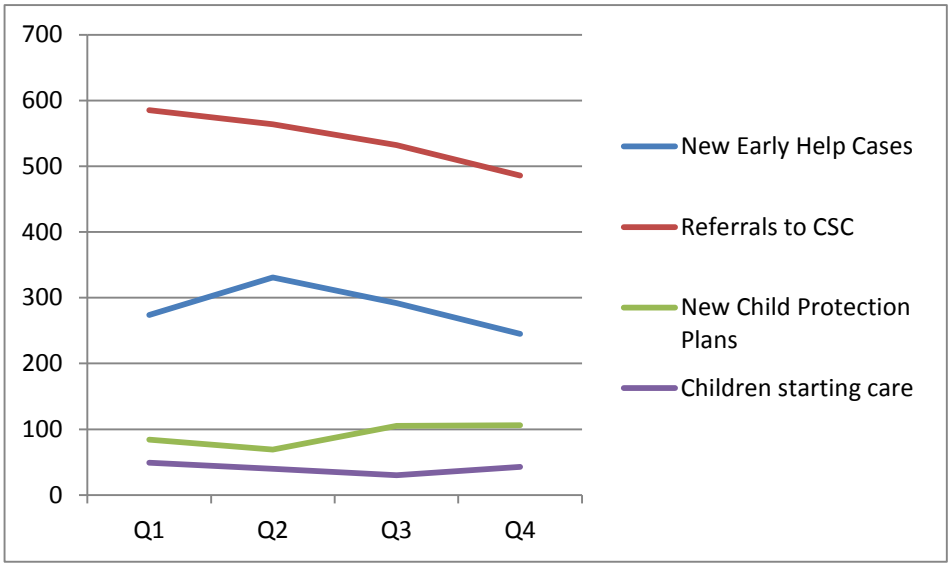
26.11 Some settings have identified that they do not know the services that may be available to families and suggest a directory of agencies and groups; some settings consider Vulnerable Children Meetings (held in locality services) as a place where this information may be found, and seek representation at them especially when their referrals are being considered.

26.12 The completed report that include the views of all settings will be presented to the Education Hub in October 2014 to establish an action plan and response to the findings of the safeguarding audit that will be shared across all settings.

27 Derby Safeguarding Children Board Performance and Outcome Measures

27.1 Requests for services

Requests for service each quarter illustrate the new cases identified at an early help level, those cases that are referred to Children's Social Care and those that require child protection plans or the child needs to be in local authority care. This baseline data will be compared with next year's figures to provide trend analysis.



New Cases 2013 – 2014 per Quarter	Q1	Q2	Q3	Q4
New Early Help Cases	274	331	292	245
Referrals to Children's Social Care	585	564	532	486
New Child Protection Plans	84	69	105	106
Children starting care	49	40	30	43

Referrals	2011-2012	2012-2013	2013-2014
Referrals to Children Social Care	3842	2509	2766
Rate of referral per 10,000 population	570	440	484
Number of Section 47 Enquiries	327	379	414

Derby had 2766 referrals during 2013-2014 and a rate of referral 484 per 10,000 population which is below the 2012-2013 national rate of 521 and the comparator authority average rate of 602. The work undertaken to audit practitioners' views indicated no significant concern about decisions around thresholds. This helps assure the Derby Safeguarding Children Board that the

referral rates do not indicate undue pressure is being applied to keep referral rates below both comparator and national averages.

27.2 Section 47 Child Protection Enquiries

The current local authority computer system records when child protection enquiries are carried out in response to concerns about significant harm remains predominantly linked to those cases which are subsequently considered at a child protection conference. Never the less, the same tracking of data over a three year period indicates a continuing trend upwards.

A new local authority computer system is due for implementation in the coming year and this will improve data on Section 47 enquiries.

27.3 Children in Need

2012-2013	Q1	Q2	Q3	Q4
Total Children in Need	2115	1832	1916	1946

Children in need figures provide a proxy indicator as to the effectiveness of early help interventions. In isolation of other factors it would be expected that effective early help would impact on the numbers of children in need. However factors such as economic pressure and deprivation on the local population may cause increasing demand for services. Therefore in the trend illustrated should be considered in this context.

CIN Rate per 10,000	2010-2011	2011-2012	2012-2013	2013-2014
Derby	464	412	375	341
Comparator Authority	377	353	371	Not available
National	346	325	332	Not available

At 31st March 2014 the Derby rate for CIN would indicate a sustained trend downwards which may indicate the impact of early help arrangements.

27.4 Priority Families Programme

The Priority Families programme spans both the early help and specialist service fields, with nine staff (Intensive Family Support Workers) based in the multi-agency teams and three staff in the Youth Offending Service. The year-end Priority Families total for 2013/14 was 604, which represents 91% of the target of 660 families

Effective work with priority families should contribute to a reduction of children in need. Further analysis will be available to consider the impact of the programme in the coming year.

27.5 Child Protection Planning Processes

Total at end of quarter	Q1	Q2	Q3	Q4
New Child Protection Plans (CPP)	84	69	105	106
New CPPs with DV Significant Factor	19	26	58	33
Total Ceased CP Plans	100	57	42	21
Total CP Plans over 2 years	0	0	0	3
Total Child Protection Plans	**188**	**200**	**263**	**299**
Total DV Significant Factor at Qtr End	62 (33%)	77 (38%)	99 (37%)	102 (34%)

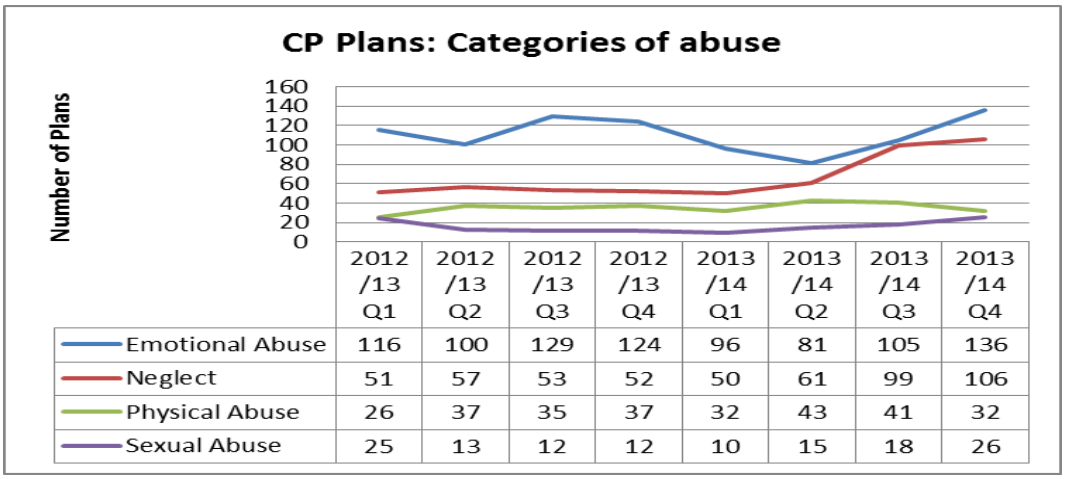
Child Protection plans are required where there is an ongoing risk of abuse to the child. In Derby, 299 children had a child protection plan as at 31st March 2014, this equates to a rate of 52.5 per 10,000 children. Derby's figures continue to be in line with the national average (52.7) and below comparator authority figures (61.8) (2012-2013). Although there has been a significant increase over the four quarters, it is noted that historically there has been notable variation. For example the last 10 quarter figures illustrate this variation.

2011-2012		2012-2013				2013-2014			
Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
302	228	217	208	229	225	188	200	263	299

During the year one family of three children were subject of a plan for more than 2 years (1%). This compares to 3.2% nationally and 4.5% for our comparator authority average.

The quality of the data indicating the number of plans where domestic violence is a significant factor has improved and is now available over two years. The data indicates a range over this period of between 26% and 38% of plans have a significant domestic violence factor and average at 35%.

Category of abuse



	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4
Emotional Abuse	116	100	129	124	96	81	105	136
Neglect	51	57	53	52	50	61	99	106
Physical Abuse	26	37	35	37	32	43	41	32
Sexual Abuse	25	13	12	12	10	15	18	26

The categories of abuse over the last two years indicate that there has been an increase in plans for Emotional abuse and this is consistent with an increasing awareness and rigour in the assessment of the impact of domestic violence on children.

The implementation of the use of the Graded Care Profile over the last two years to assess in a systematic way concerns about Neglect at an early stage has led to greater clarity about what needs to change to improve outcomes for children. This may account for a gradual and sustained increase in plans for neglect as practitioners are more able to identify a lack of progress and are able to evidence this in a clearer manner and avoid “drift”.

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

There are 12 children who have disabilities and are subject of child protection plans (as of 31st March 2013). This is consistent with the previous year (noting that the numbers have changed during the year).

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

Family Attendance at CP Conferences / ACYP Meetings:

Total 'Chaired Sessions': 524
('Chaired Session' may be in respect of just one Child Protection Conference or Abuse by Child or Young Person (ACYP) Meeting, but may include siblings)

Family Present: 465 (88.7%) compared to previous year 434 (87.1%).

Attendance by Young People and Children 4 years and over: 59 (8.5%) compared to 40 attending in the previous year.

Attendance by Advocates on behalf of Young People and Children
Advocates attended on behalf of **74** young people and children compared to 36 children in the previous year.

There has been an increase in family attendance and a more significant increase in both the attendance of children and young people. The attendance of advocates has more than doubled during the year and is indicative of a positive trend, alongside numbers of children and young people attending in person. This demonstrates improvements in the way in which children and young people are involved in the arrangements to keep them safe and will continue to monitored and developed in the coming year.

27.6 Care Proceedings

The figures for care proceedings will be included in the quarterly monitoring arrangements by the Derby Safeguarding Children Board starting in April 2014. This will ensure that comparator data can be evaluated following implementation of changes to family law.

Derby City Council's target is to complete 90% of care proceedings within 26 weeks. For the period July 2013 to end of June 2014 there was some slippage in that 83% were completed within 26 weeks.

The target was not achieved mainly as a result of 2 issues the council had to contend with:
1) The increase in cases that have an international element in light of the number of Eastern European families in Derby
2) Case law (Re BS and Re B) which has impacted on the extent to which the Court must consider extended family members as alternative carers for the children and also the number of extended family members that have come forward at a late stage in the proceedings.

A further cause of delay has been potential fathers putting themselves forward at a late stage in proceedings.

It is difficult to prevent delay for the cases with an international element as such cases involve the Central Authorities becoming involved, legal argument about habitual residence and also on occasions for the case to be transferred to the High Court, which in itself is a lengthier process.

However, in terms of assessment of extended family members and issues re paternity, a local practice direction has been issued by the Court in an attempt to air issues regarding extended family members and paternity at the very outset of proceedings. This should assist in the prevention of delay beyond the 26 weeks.

27.7 New Entrants to Care

2012-2013	**Q1**	**Q2**	**Q3**	**Q4**
Children starting care	49	40	30	43
Children leaving care	53	41	33	47
Total Looked After Children	462	462	458	458

Evaluation of the rates over the last 3 years indicate that the Derby figure has decreased for the second year in a row in comparison with comparator figures that have increased consistently over the last six years. Up to the end of March 2013 the national figure had increased by almost 15% since 2008.

CLA Rate per 10,000	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
Derby	461	480	465	458
Comparator Authority	549	559	564	Not available

27.8 Crime where victim is a child

Recorded Crime (Derby City)	2011-2012	2012-2013	2013-2014
Crime Type	Crimes with Victim aged under 18	Crimes with Victim aged under 18	Crimes with Victim aged under 18
Rape	31	29	40
Other Sexual Offences	106	63	90
Violence with Injury	347	286	271
Violence without Injury	267	212	162

2013 – 2014 figures show an increase in the recording of both rape and other sexual offences when compared to the previous time periods. Much of the increase is due to historic reporting of sexual offences and the increased awareness following recent high profile cases. The increased reporting may also be due to increased confidence in the police and that victims may feel more likely to be believed and that offences will be taken seriously and investigated.

The figures show a continued reduction in the numbers of both 'violence with' and 'without injury' for the under 18's. This reduction in violence is consistent across all age ranges and fits the national trend. There are likely to be a number of factors behind this including better partnership work in relation to the night time economy , this has included taxi marshalling, better trained door staff , the use of the think 25 campaigns and the robust tackling of licensing establishments that flout laws on alcohol consumption.

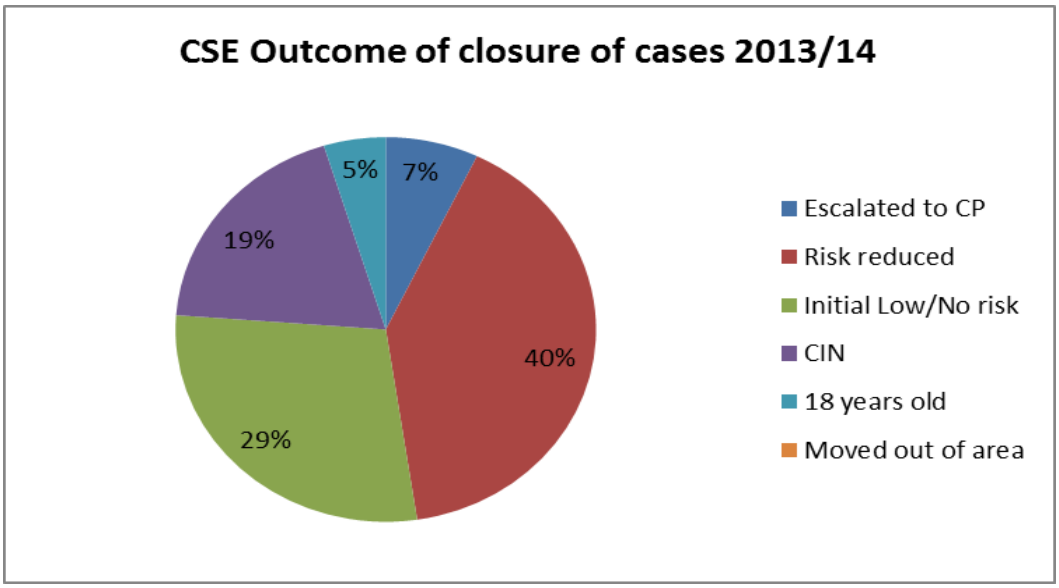
27.9 Child Sexual Exploitation

2013-2014	Q1	Q2	Q3	Q4
Number of referrals	21	10	9	8
Risk Level: None	0	0	0	1
Risk Level: Low	4	7	3	4
Risk Level: Medium	12	9	5	1
Risk Level: High	10	4	2	2
Attendance at meeting YP %	64%	63%	54%	53%
Attendance at meeting parent/carer %	73%	67%	77%	58%

Risk reduction

The analysis of the levels of risk to young people as a result of engagement to the strategy shows that there is a significant reduction of risk for the majority of young people. We measure the levels of risk and additional vulnerability factors at every meeting including network meetings. The official risk rating is

recorded at the CSE strategy meeting. Of the young people assessed as high risk at their initial meeting 85.7% have already had the risk removed or reduced within 3 months (54% in 2012-13, 45% in 2011-12). The remaining 14.2% are still to have their next meeting. This is a significant improvement on previous years and demonstrates increasing effective interventions with these young people.



7.10 Missing Children

2013 - 2014	**Total Missing**	Missing from **Home**	Missing from **DCC Homes**		Missing from **Independent Homes**		Missing from **Foster Care**		Missing from **Other Settings** (such as Hospital, YMCA)	
	Episodes	Episodes	Episodes	No of YP	Episodes	No of YP	Episodes	No of YP	Episodes	No of YP
Q 1	137 (180)	79	29	13	20	5	5	3	4	3
Q 2	162 (188)	84	47	19	25	7	6	3	0	0
Q 3	98 (162)	75	12	8	6	6	5	2	0	0
Q 4	121 (124)	100	12	8	2	2	7	2	0	0
TOTAL	518 (654)	338	100	48	53	20	23	10	4	3

(Last year figures in brackets)

The reduction in numbers of missing episodes for looked after children from Quarter 3 may, in part, be due to the more robust application of the updated 'missing' and 'absent' definitions. Numbers of children reported as missing

from home do not show a similar reduction – possibly because parents will not be applying the same criteria from the protocol that workers do.

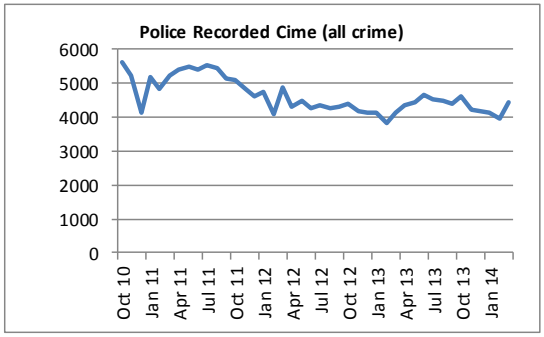
The Derby Safeguarding Children Board will continue to monitor the figures, be able to more clearly compare them over the coming year and provide suitable analysis.

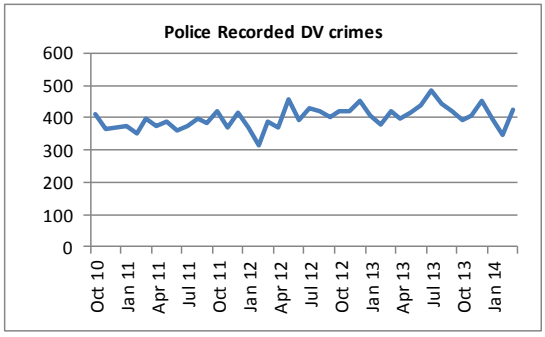
27.11 Domestic Violence

In the context of long-term reductions in crime recorded Domestic Violence flagged crimes continue to increase and now account for around 1 in 10 crimes (in 2007/08 it was 1 in 20). Although police recorded DV crime numbers are increasing, there is still a substantial gap between the number recorded and the expected victimisation rate. Improved recording and confidence in reporting are being helped by publicity campaigns and proactive work across all agencies and the voluntary sector.

The volume of recorded crimes in 2013/2014 has shown an increase (+1239, + 2.4%) on the previous 12 months, this being the first annual increase in many years. The volume of DV recorded crimes in 2013/2014 has shown an increase (+60, + 1.2%) on the previous 12 months.

The charts below detail the changes in the volume of recorded crime since October 2010.





Police recorded domestic violence victim data for Derby City by gender and age for 2013 - 2014.

The table below shows that 7% of recorded domestic violence victims were under the age of 18 and 82% of victims are female. This represents an increase from the previous two years that had total recorded figures of 5.2% (2012 – 2013) and 5.5% (2011 – 2012). This may reflect increased awareness and action taken to safeguard children and young people alongside the longer terms impact of changes to the definition of domestic violence to specifically recognise victims aged 16 and 17.

Over 18		16 to 18		13 to 16		11 to 13			Under 11		No age given
Female	Male	Female	Male	Female	Male	Female	Male	n/k	Female	Male	Female
1327	268	33	16	20	11	8	3	1	16	12	2

CAADA DASH Evaluation Forms - Children involved in DV Incidents
When a police officer attends a domestic violence incident they record whether there any children within the household.

Of the forms completed over the last two years there were between 51% and 55% stating there were children within the household. This proportion matches the estimates of around 50% of DV incidents having children either present or within the household based on Calls for Service and Record Crime analysis.

Prosecuted/Charged and Restorative Justice Suspect Data for Domestic Violence Offences on Derby City

Ages	Sum of Crime Count
Over 18	**964**
Female	133
Male	831
16 to 18	**42**
Female	16
Male	26
13 to 16	**48**
Female	7
Male	41
Under 13	**4**
Male	4
Grand Total	**1058**

Offences detected during 2013/14.

91% of offences are committed by adults and 85% of offenders are male.

There has been a significant increase in the total number of 1058 individuals held to account for domestic violence offences from 737 (2012 – 2013) and previously 628 (2011-2013).

Multi-Agency Risk Assessment Conference (MARAC)

Multi-Agency Risk Assessment Conferences are held for those cases where the victims are assessed at the highest level of risk. Of the 214 cases considered at MARAC during 2013 -2014 the following figures illustrate the numbers of children living in the household (48 (22%) had no children).

166 cases (78%) had children living in the household:

- 64 (30%) had one child
- 47 (22%) had two children
- 22 (10%) had three children, and
- 33 (15%) had 4 or more children.

(A similar breakdown of figures for the previous year is not available)

Initial figures, for this year, illustrate the high level of children (78%) living in households where the most serious incidents of domestic violence are reported.

Court Conviction rates (April 2013 to March 2014) for all age ranges.

Derbyshire remains slightly below the National and East Midlands conviction rates for Domestic Violence, Sexual Offences and Rape. However some progress has been made in the National conviction rate rankings (42 areas) for Domestic Violence and Rape.

- Domestic Violence

Year to date figures for Derbyshire show a conviction rate of **76.4%.** The National rate is 74.6% and the East Midlands rate 76%.
Derbyshire has fallen from 27 to **31** in the National rankings between the end of Quarter 1 and the end of Quarter 4.

- Sexual offences

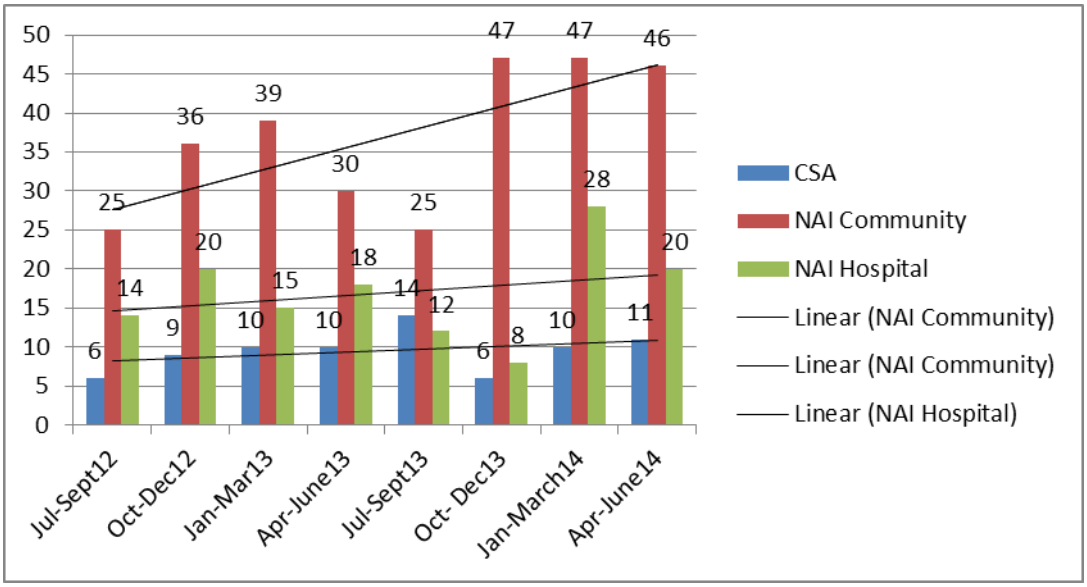
Year to date figures for Derbyshire show a conviction rate of **80.4%.** The National rate is 79% and the East Midlands rate is 80.8%
Derbyshire has advanced from 27 to **26** in the National rankings between the end of Quarter 1 and the end of Quarter 4.

- Rape

Year to date figures for Derbyshire show a conviction rate of **64.9%.** The National rate is 60.3% and the East Midlands rate is 69%
Derbyshire has advanced from 35 to **21** in the National rankings between the end of Quarter 1 and the end of Quarter 4.

Rates are currently not available for conviction of offences against children. The Derby Safeguarding Children Board will continue to consider the availability of information and analysis that is indicative of the effectiveness of action taken to hold individuals to account for the mistreatment of children. Whilst recorded crimes against children are known, the corresponding outcomes and conviction rates are yet to be available for analysis.

27.12 Child Protection Medicals



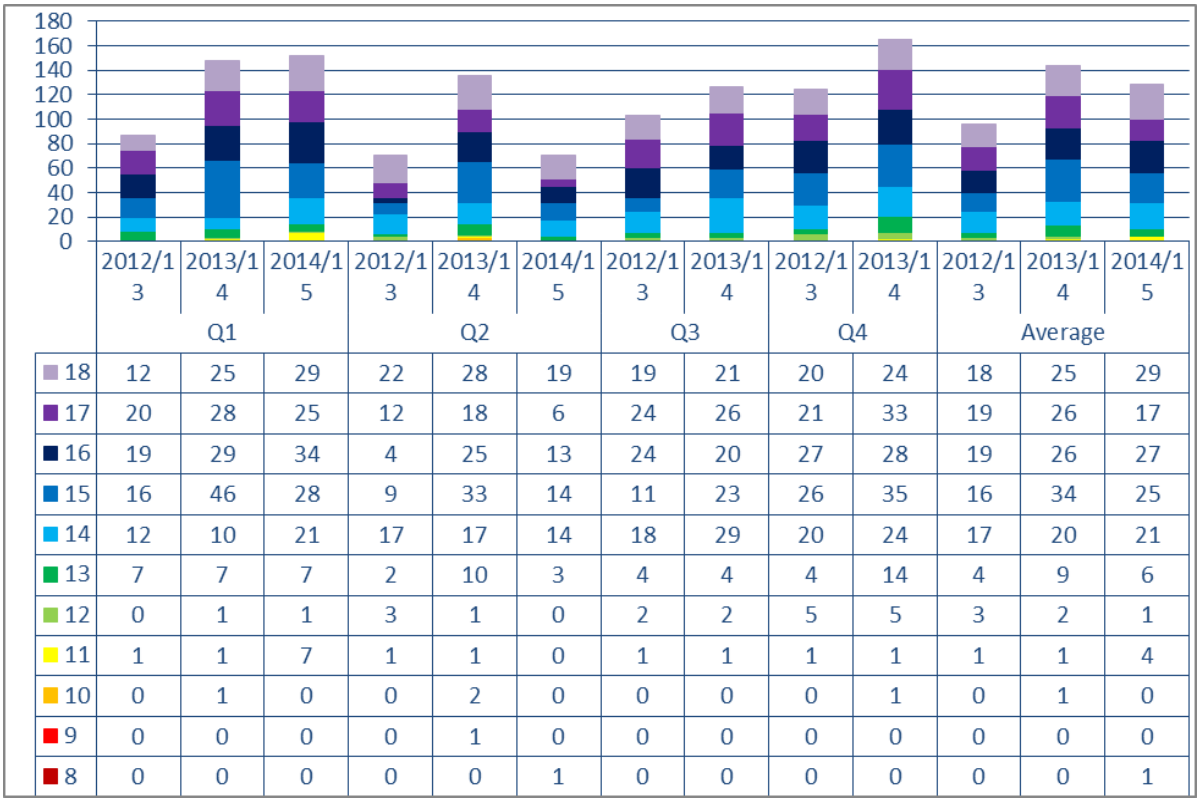
There has been a significant and continuing rise in the numbers of children and young people being medically examined for possible physical abuse. Although the current trend appears more marked in respect of community paediatric examinations (children over 18 months of age and with injuries not requiring immediate medical attention) it is of note that the hospital examinations increased sharply in the final quarter of 2013/14.

The data in the table above relate to the 8 quarters up to the end of 2013/14. The data for children requiring child protection plans for physical abuse over this period (see 27.5 above) do not show a similar increasing trend.

This apparent discrepancy is under further review; it the view of the paediatric services that referrals for physical examination are not being made unnecessarily. This will be monitored over the coming year.

27.13 Self-Harm

Self-harm attendances to Children's Emergency Department / A&E by patients 18 and below April 12 to Aug 14: by quarter and by age (NB Q2 of 2014/5 is only two months; 2014/5 average is extrapolated)



	2012/13	2013/14	2014/15	2012/13	2013/14	2014/15	2012/13	2013/14	2012/13	2013/14	2012/13	2013/14	2014/15
	Q1			Q2			Q3		Q4		Average		
18	12	25	29	22	28	19	19	21	20	24	18	25	29
17	20	28	25	12	18	6	24	26	21	33	19	26	17
16	19	29	34	4	25	13	24	20	27	28	19	26	27
15	16	46	28	9	33	14	11	23	26	35	16	34	25
14	12	10	21	17	17	14	18	29	20	24	17	20	21
13	7	7	7	2	10	3	4	4	4	14	4	9	6
12	0	1	1	3	1	0	2	2	5	5	3	2	1
11	1	1	7	1	1	0	1	1	1	1	1	1	4
10	0	1	0	0	2	0	0	0	0	1	0	1	0
9	0	0	0	0	1	0	0	0	0	0	0	0	0
8	0	0	0	0	0	1	0	0	0	0	0	0	1

As a result of increased focus on self-harm additional data is being shared with the Derby Safeguarding Children Board. National comparator data and greater analysis will be included in the next annual report.

27.14 Children in Derby City diagnosed by Community Paediatricians with Attention Deficit Hyperactivity Disorder (ADHD) as a marker for emotional well-being of school age children

Research has shown that children who face difficult domestic environments are more likely to have poor concentration, poor impulse control and to respond to triggers in the environment that are not apparent to others. Research into the early development of the brain gives a pathological basis for this as neural networks and pathways will develop abnormally in children exposed to a threatening, uncertain, uncaring environment.

Previous local evidence demonstrated a significant association of ADHD diagnoses by community paediatricians with deprivation as measured by the Index of Multiple Deprivation (2007). New data is beginning to provide a more comprehensive assessment that included CAMHS diagnosis of ADHD.

Data will be collated to identify trends and to test the efficacy of this diagnostic information as a proxy indicator of neglect and reported on in the next annual report.

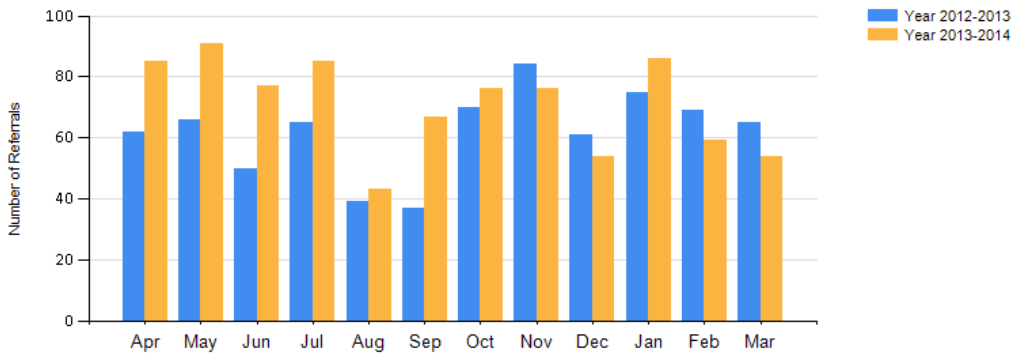
27.15 Children who are receiving School Action Plus specifically to address needs in relation to (a) Behaviour, Emotional and Social Difficulties and (b) Speech Language and Communication Needs

	January 2012	January 2013	January 2014
Behaviour, Emotional and Social Difficulties	628	677	611
Speech, Language and Communication Needs	499	447	465

The Derby Safeguarding Children Board will continue to explore the validity of trends in this data, alongside trends in ADHD diagnosis, as an indicator of the effectiveness of early help.

27.16 CAMHS services

Referral data indicates an overall increase in referrals over the year compared to the previous
year



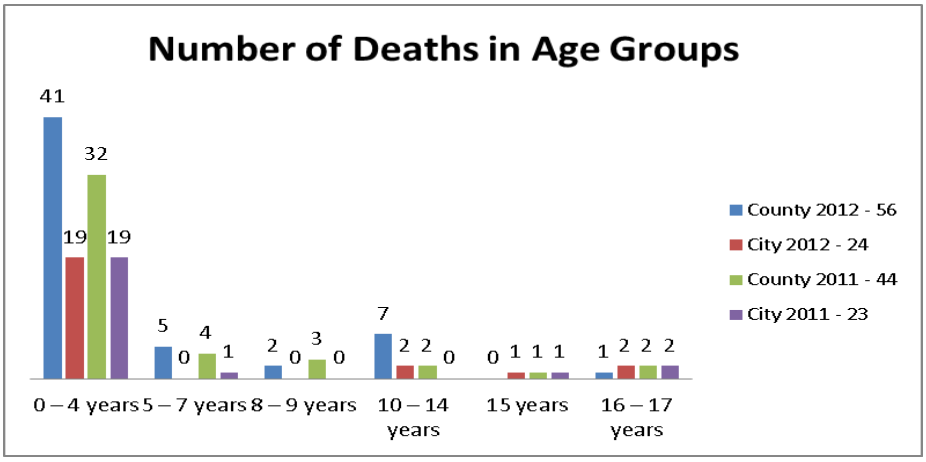
96.14% of young people are seen within 12 weeks for an assessment from the point of referral and overall 60.12% commenced treatment within 12 weeks.

The NHS CAMHS Benchmarking report (for the year 2012 - 2013) sets out analysis of CAMHS services against national standards. The target for an appointment for an assessment is 18 weeks. The mean national average is that 81% of referrals result in a pathway where the patient receives interventions from CAMHS. The CAMHS service in Derby and Derbyshire provided intervention for 80% during 2012-2013.

27.17 Child Deaths

There were 24 child deaths occurring to residents of Derby City during 2012 Two cases are still awaiting classification due to outstanding legal processes. These cases are included in the following data where possible, but are omitted from any reports requiring classification of the death. For this reason, some of the graphs are based on the 97.6% classified cases only.

Child deaths are thankfully relatively uncommon. The total numbers and, even more so, those in any particular sub-category, are very small. Therefore only very broad conclusions can be drawn from the charts and analysis below. The data will, however, become more robust and informative as it accumulates over longer periods of time. The data presented in the reports provides summary data for 2012, and where appropriate identifies trends in the data over recent years.



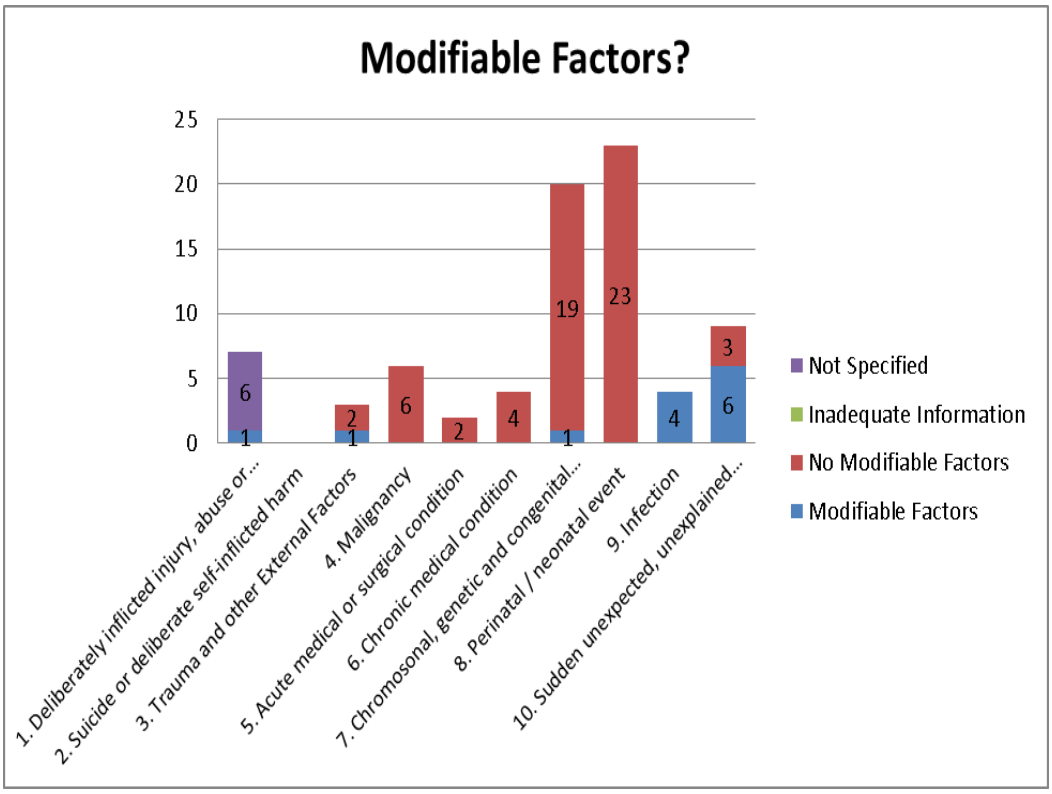
	2008	2009	2010	2011	2012
Total not classified	31%	4%	8%	5%	7%
Total no modifiable factors identified[2]	49%	70%	72%	81%	76%
Total modifiable factors identified[3]	20%	26%	20%	14%	17%

[2] **No Modifiable factors identified** The panel did not identify any potentially modifiable factors

[3] **Modifiable factors identified** The panel identified one or more factors, in any domain, 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.

The annual Child Death Overview Panel report (2012) identifies that there was a slight reduction in the number of deaths where one or more factors were present that could have modified or reduced the risk of future child deaths. This reduction may represent an improvement in action being taken to reduce child deaths.

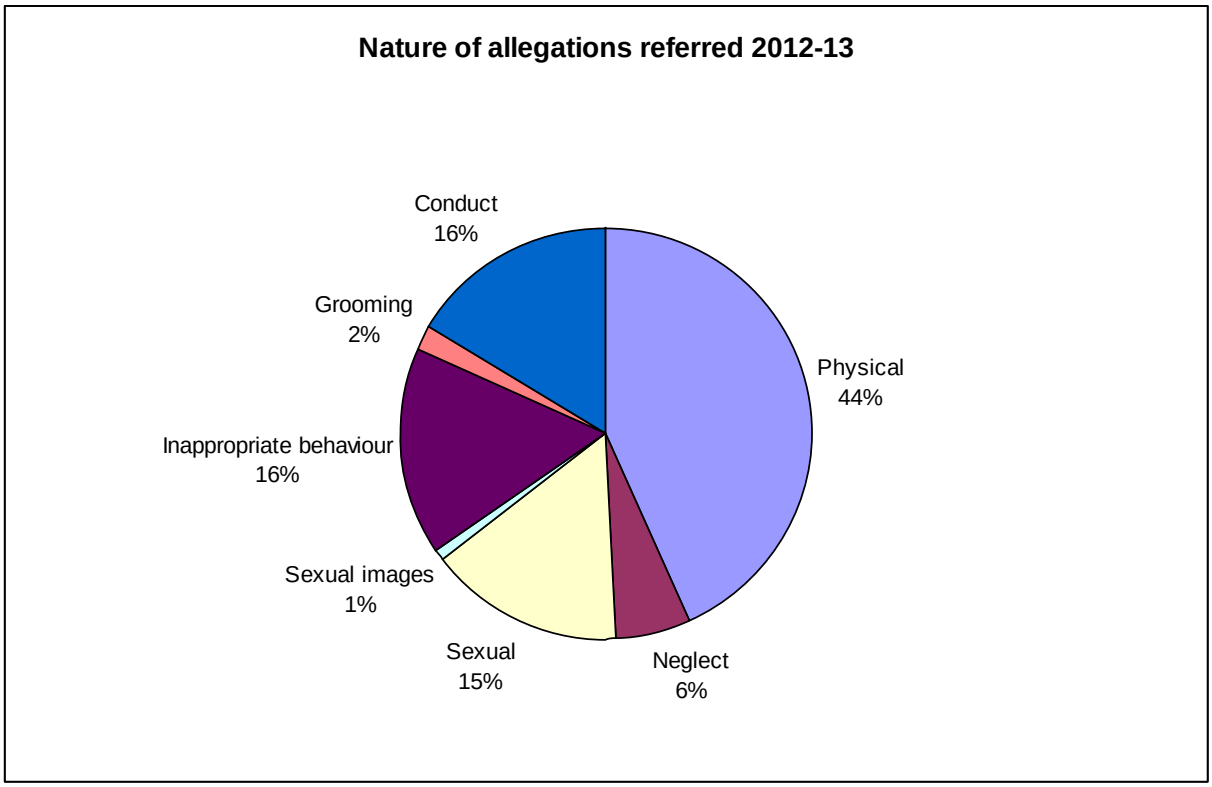
The main modifiable factors identified are related to safe sleeping in babies and sudden infant death syndrome. Other modifiable factors relate to the preventability of infection. This has changed from the previous year when it was the preventability of unintentional injuries



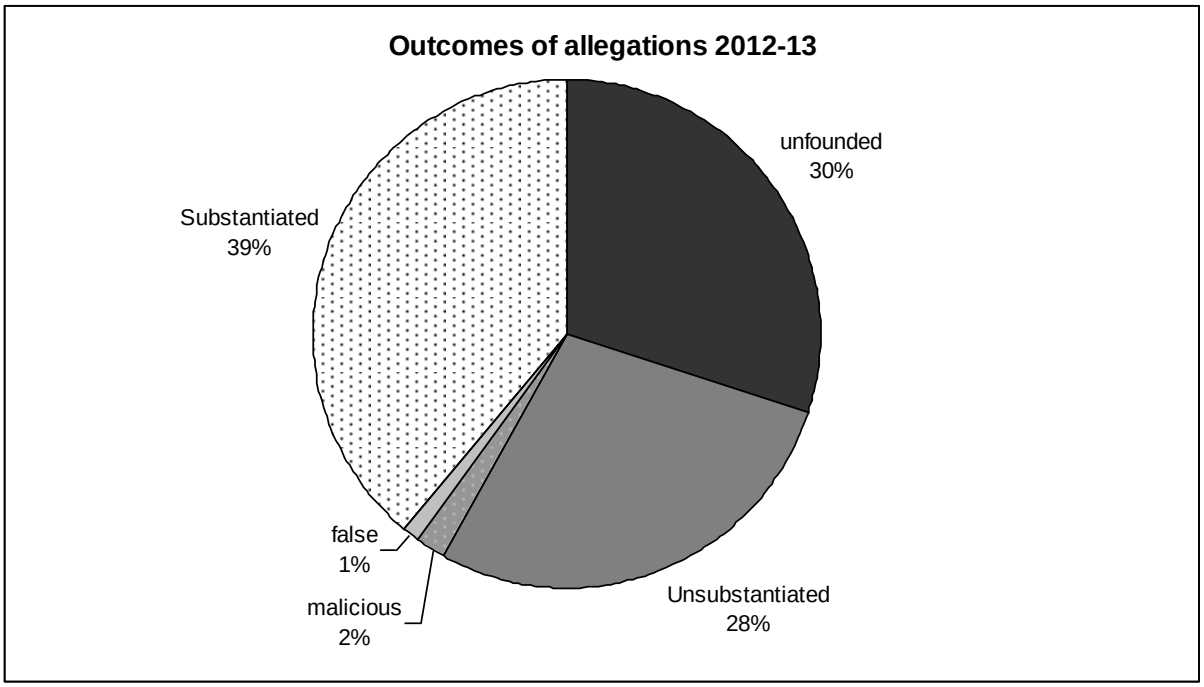
27.18 Allegations against staff

There were 104 referrals to the LADO in the specified time period compared with 102 last year and 82 in 2010-11. The distribution of referrals across agencies is broadly the same, though of note is an increase in allegations relating to school staff (from 26 to 40) – most likely related to improved reporting.

There has been a small reduction in allegations relating to DCC residential staff (from 11 to 6) and DCC fostering (from 11 to 7). This may reflect work undertaken by residential staff around more appropriate use of restraints. In some sectors referrals are very low, including the Police and Health, and these organisations were commissioned to check their internal processes to ensure any allegations relating to children are being responded to appropriately.



Resolution categories have been changed in 2012 in line with Government guidance, so cannot be directly compared with last year. The proportion of allegations which were substantiated, however, has dropped from 50% to 39%.



27.19 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%	5.7% (5.1 %)	10.3% (8.4 %)	2.4% (2.4 %)	9.2% (15.5 %)
Black or Black British	2.9%	2.2% (4.3 %)	3.4% (3.8 %)	3.7% (3.2 %)	3.1% (1.3 %)
Dual Heritage	2.9%	8.1% (6.6 %)	12.9% (12.0 %)	11.3% (11.3 %)	11.9% (9.9 %)
Not recorded	Nil	21.0% (6.8 %)	4.9% (5.1 %)	0.2% (0.2 %)	2.0% (3.9 %)
Other	1%	4.3% (4.8 %)	1.4% (2.3 %)	3.5% (2.2 %)	1.7% (4.3 %)
White British	75.3%	53.2% (63.4 %)	62.3% (65.2 %)	75.4% (79.2 %)	67.0% (62.1 %)
White Other	4.9%	5.6% (9.0 %)	4.7% (3.1 %)	3.5% (1.5 %)	5.1% (3.0 %)

(2012-2013 figures in brackets)

The data identifies some statistically significant difference in the proportional representation of children who have dual heritage being increasingly over represented as receiving services.

During the year increasing evidence has emerged as to the increasing numbers of Eastern European families (some of whom are Roma families) who have moved into Derby and are in receipt of services. This is likely to be contributing to the increase in figures of “white other” as an ethnicity recorded for people receiving children in need (including children in care and child protection services). This does however not account for the reduction in Early Help figures.

There has also been a rise of the Eastern European population that has had an impact upon the number of Court proceedings. There are 9 cases in proceedings where the children are Eastern European out of a total of 37 cases. This is a disproportionately high number of cases compared with the demographic population in Derby. The Local Authority is leading a multi-agency task group to look into the safeguarding arrangements in respect of Eastern European families.

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

The Derby Safeguarding Children Board has extended the evidence base upon which it is able to comment on the effectiveness of local arrangements and set priorities for the next year.

The annual report sets out the work that has been done and those areas where further development is required to improve arrangements. These are set out in full in the body of the report and the actions are listed in full in Section 29 of this report. These will inform the action plan developed by the Derby Safeguarding Children Board and be monitored on a quarterly basis.

The audits and supporting reports indicate that there are reasonably consistent views and decisions being made on the local thresholds of need.

Early Help arrangements are benefitting the children of Derby and the statistically analysis and evidence from the different services would indicate that these arrangements are helping to prevent unnecessary escalation of cases to Children's Social Care.

Further analysis of the outcomes of Early Help Services will become available in more detail in the coming year and ongoing scrutiny is appropriate of these arrangements and thresholds as organisations continue to face challenges arising from financial pressure and cuts.

The ability of the Derby Safeguarding Children Board to comment in depth about the impact of the Domestic Violence and Sexual Violence Strategy remains limited. Plans are in place for the coming year to address this, however this remains a priority.

The Derby Safeguarding Children Board will continue to co-ordinate multi-agency activity on CSE and to monitor the quality of both multi-agency and single agency work in this area. Whilst this report does reflect some very effective work in reducing the risks to young people locally, we are not complacent and look to improve further this area of safeguarding.

29 Action for the Derby Safeguarding Children Board 2014-2015

Ensure that robust arrangements are in place and consistent with Working Together 2013 and associated National Guidance, that Board approved guidance is embedded in partner agency practice and assess and monitor the impact of organisational change on safeguarding arrangements.

Assess and monitor the impact of organisational change on safeguarding arrangements.

Establish consistent and robust safeguarding training and development pathways within agencies and ensure that single and multi-agency training is quality assured.

Review the effectiveness of early intervention and child protection arrangements to safeguard children and young people.

Develop working arrangements with the Safeguarding Adults Board to ensure adult and children services are cooperating to promote effective safeguarding.

Monitor the impact of the local Domestic Violence and Sexual Violence Strategy and the implementation of the new Multi-Agency Safeguarding Arrangements.

Implement Learning Improvement Framework and collate findings of QA actions including reviewing the impact of the revised pre-birth multi agency arrangements to promote early help and the impact of the Preventing Suicide and Self Harm Strategy.

Extend learning arising from local reviews and the work of the Board and establish effective arrangements (including priority areas) for consultation with Children, Young People, Parents/Carers and Practitioners.

Coordinate agency responses to children and young people who are vulnerable to the risks of: Child Sexual Exploitation, Missing children and those missing from education, Online abuse, homelessness, radicalisation, substance misuse, self-harm and gangs.

Review the safeguarding arrangements of children in care living in Derby and in the care of other Local Authorities.

Review the safeguarding arrangements for

- *Young people from Derby who are Young Offenders.*
- *Children and young people from new communities in Derby.*
- *Children and young people at risk of Female Genital Mutilation.*

Appendix 1

Derby Safeguarding Children Board Membership 2013 - 2014

Member	Role	Agency
Christine Cassell	Independent Chair	**Derby Safeguarding Children Board**
Andrew Bunyan	Strategic Director for Children and Young People	**Derby City Council Children and Young People Directorate**
Liz Adamson (Vice Chair) *CDOP	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Councillor Martin Rawson	Lead Member	**Derby City Council Council Member**
Jane Parfrement	Director of 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**
Cathy Winfield	Deputy Director of Nursing	**Derby Hospitals NHS Foundation Trust**
Lynn Woods	Chief Nurse and Director of Quality	**Southern Derbyshire CCG**
Caroline Gilby (until December)	Chief Nurse and Executive Director of Nursing & Quality	**Derbyshire Healthcare NHS Foundation Trust**
Carolyn Green	Chief Nurse and Executive Director of Nursing & Quality	**Derbyshire Healthcare NHS Foundation Trust**
Ben Anderson	Consultant in Public Health (Lead for Child and Maternal Health)	**Derby City Council**
Judith Russ (until November 2013)	Service Manager Derby Cafcass	**CAFCASS**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Rosemary Plang / Sara Winwin Sein	Director of Probation	**Derbyshire Probation**
Dawn Robinson	Head of Service - Prevent	**City and Neighbourhood Partnerships**
Simon Emsley	Head teacher	**Schools - Primary**
Liz Coffey	Principal	**Schools Secondary**
Nathalie Walters (until	Representative for the	**Safe and Sound Derby**

June 2013)	Children and Young People's Network	
Mike Garner (from June 2013)	Representative for the Children and Young People's Network	**Safe Speak (Relate) Derby**
Phil Watson (from March 2014)	Principal Social Worker	**Derby City Council Children and Young Peoples Directorate**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**

***Liz Adamson represented the CDOP during the period of change of CDOP Chair**

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	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 (from September 2014)	Lead Member	**Derby City Council Council Member**
Maureen Darbon (from September 2014)	Director of 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	Principal Social Worker	**Derby City Council Children and Young Peoples Directorate**
Dawn Robinson	Head of Service - Prevent	**Derby City Council City and Neighbourhood Partnerships**
Cathy Winfield	Deputy Director of Nursing	**Derby 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**
Suzanne Meredith (until June 2014) Hamira Sultan (from September 2014)	Consultant in Public Health (Lead for Child and Maternal Health)	**Derby City Council Public Health**
Liz Adamson (Vice Chair until September 2014)	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Jenny Evennett	Designated Doctor	**Derbyshire Healthcare Foundation Trust**
Michelina Racioppi Designated Nurse	Designated Nurse	**Southern Derbyshire CCG**
Janie Berry Kaye Howells	Director of Legal and Democratic Services / Principal Lawyer	**Derby City Council Legal Services**
Neville Hall (from June)	Assistant Director Derby Cafcass	**CAFCASS**
Andrew Stokes	Detective Superintendent and Head of Public Protection	**Derbyshire Police**
Sara Winwin Sein	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**
Alfonzo Tramontano Danielle Burnett	Assistant Director of Nursing: Patient Experience / Quality and Safety Manager	**NHS England**
Mark Sobey	Board Manager	**Derby Safeguarding Children Board**