PUBLIC

Agenda Item 5

DERBYSHIRE HEALTH AND WELLBEING BOARD

19 April 2018

Report of the Strategic Director for Children's Services

Report regarding the key issues and themes identified in Derbyshire Safeguarding Children Annual Report

1. Purpose of the report

To update the Health and Wellbeing Board regarding the key themes and issues in the Derbyshire Safeguarding Children Board (DSCB) 2016-2017 Annual Report.

2. Information and analysis

The DSCB produces an annual report detailing the work which is undertaken by the DSCB over the preceding year. The report details the aims and strategy for the Board and also looks at the key performance data and achievements of the Board during this period. The Board strategic priorities during this team were the following:-

1. Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children and young people across the child's journey
2. Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice with assurance that safeguarding is everyone's responsibility.
3. To evidence the impact of the DSCB

These aims were taken forward by Chris Cook, DSCB Independent Chair in his first full year in post. One of the key ways in which these aims were driven forward was by a regime of multi- agency auditing modelled on the themes of the Joint Targeted Area Inspection. By looking at examples of practice from the perspective of all agencies it has been possible to identify cross agency areas for improvement. Action plans have been created following on from these audits and these are being monitored across the partnership as each action plan has been allocated to a DSCB sub group. In addition to the priority areas a more detailed work plan sets out the actions of the Board during the year.

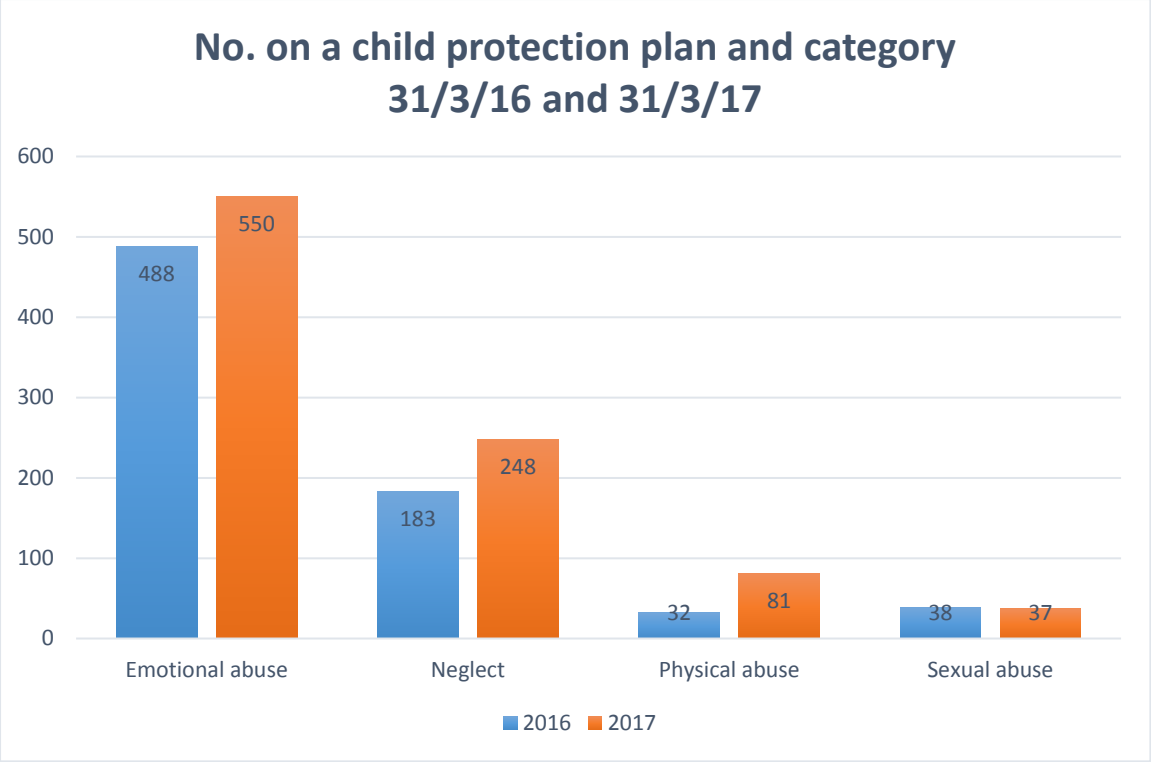
Annual Work Plan

1. Keep children and young people safe from harm, including those affected by Child Sexual Exploitation (CSE) and children missing from education, home or care.
2. To complete robust Serious Case Reviews (SCR's) and share and embed the learning from these.
3. The board is aware of the financial implications on its ability to deliver its statutory duties and is planning for the coming years due to the continuing programme of austerity.
4. To ensure that the Board operating model is fit for purpose and adapted in accordance with new guidance and requirements (including the Wood review)
5. We will revise our performance framework to ensure we are clear about the impact of board related activity.
6. We want to ensure that our engagement strategy (with both the public and partner agencies) maximises the opportunities for promoting important messages about how to keep children and young people safe and ensures feedback informs the work of the board.
7. The DSCB has clear strategies and comprehensive approaches to ensuring young people are supported to be safe on-line.

In relation to the annual work plan the report highlights the work which has been undertaken in relation to Serious Case Reviews. The ADS14 SCR was published on 5th September 2017, but the preparation of this report and the actions identified in the comprehensive action plan were ongoing during the period covered by the report. The publication was appropriately delayed pending the conclusion of related litigation. The report is published on the DSCB website along with an executive summary, briefing note and action plan. The action plan continues to be regularly monitored and reviewed. It is noted that all key actions have been completed.

The DSCB also introduced a new website as part of the engagement strategy with both the public and professionals.

The DSCB has introduced a new performance report and this is presented at each DSCB meeting highlighting statistical information which relates to key areas of DSCB activity. The high level of child protection activity as demonstrated in the numbers of children subject to child protection plans. The below diagram highlights the continuing increase in Child Protection (CP) plans over the period of the report.



The DSCB continues to support partner agencies in ensuring that the child protection process is highly effective.

The report notes the continuing specific aims for current year.

1. Continue to promote on-line safety initiatives, including the involvement of young people within the scoping and development of this aim.
2. To improve the response to situations of neglect.
3. Ensure the extensive use of early help assessments across all agencies.
4. Explore the potential benefits of a Public Protection Board.

3. Links to the Health and Wellbeing Strategy

Derbyshire's Health and Wellbeing Strategy focusses on four priority areas, these are:

- Keep people healthy and independent in their own home.
- Build social capital.
- Create healthy communities.
- Support the emotional health and wellbeing of children and young people.

The work of the DSCB links closely with the priority of supporting the emotional health and wellbeing of children and young people. Given the changes that will take place in the future in terms of the abolition of Children's Safeguarding Boards and the creation of multi-agency safeguarding arrangements, opportunities to work effectively with other existing structures is

to be fully explored. The new arrangements are required to be in place in 2019.

RECOMMENDATION

The Health and Wellbeing Board is asked to:

- Note the information provided.

Jane Parfrement
Strategic Director for Children's Services
Derbyshire County Council

Derbyshire Safeguarding Children Board

Annual Report 2016 – 2017

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1. Chair's Foreword and Introduction

I would like to take this opportunity to welcome you to the Derbyshire Safeguarding Children Board (DSCB) Annual report for the period 2016-2017. This represents my first full year as Chair of the Derbyshire Safeguarding Children Board.

I have continued to be impressed by the strength of the partnership working arrangements in Derbyshire and have witnessed this first hand during a visit to 'Starting Point' where colleagues from health, social care and police work together to safeguard and protect children and young people, responding quickly and effectively to referrals. This effective multi- agency practice is evident across all areas of the board's work, from the main board meetings to the board's sub-groups. All constituent agencies ensure that the board's work impacts positively on children's wellbeing.

The Board has maintained as its core objectives for 2016 - 2018:

- Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children and young people across the child's journey.
- Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice with assurance that safeguarding is everyone's responsibility.
- To evidence the impact of DSCB.

These core objectives have been taken forward by a regime of multi-agency auditing where senior representatives of each agency have critically evaluated the services provided to safeguard children and young people. The input of all the respective agencies ensures that future service provision will be the most effective it can be. I would like to thank agencies for their commitment to this valuable process.

The work of the DSCB has continued to take forward the following priority areas:

- Keeping children and young people safe from harm, including CSE and missing children. The programme of auditing above included a specific focus on this area.
- To complete robust Serious Case Reviews and share and embed the learning from these. The DSCB published ADS14 and the associated action plan following on from this on the 5th September 2017. We have continued to monitor carefully the implementation of this plan.
- The DSCB has clear strategies and comprehensive approaches to ensuring young people are supported to be safe online. The DSCB has monitored the development and effectiveness of policies and procedures regarding this and has involved young people in the development of these.

- Improving the response to situations of neglect. The DSCB has ensured the effective introduction of the Graded Care Profile to ensure the impact of neglect can be fully quantified and understood across agencies to enable the appropriate intervention to be put in place.
- Ensure the extensive use of early help assessments across all agencies to identify safeguarding concerns at the earliest opportunity and to offer effective and timely intervention.

The Children and Social Work Act was given royal assent in April 2017 and the impact of this on future multi agency safeguarding arrangements will be considerable. The priority for the DSCB will be ensuring that effective arrangements remain in place both during the transitional phase and once the new Multi-Agency Safeguarding Arrangements (MASA) have been established. These are fundamental changes to safeguarding arrangements but the core objective of ensuring children and young people's safety remains unchanged and I am confident that agencies in Derbyshire will continue to be committed to and successful in achieving this.

C. J. Cook.

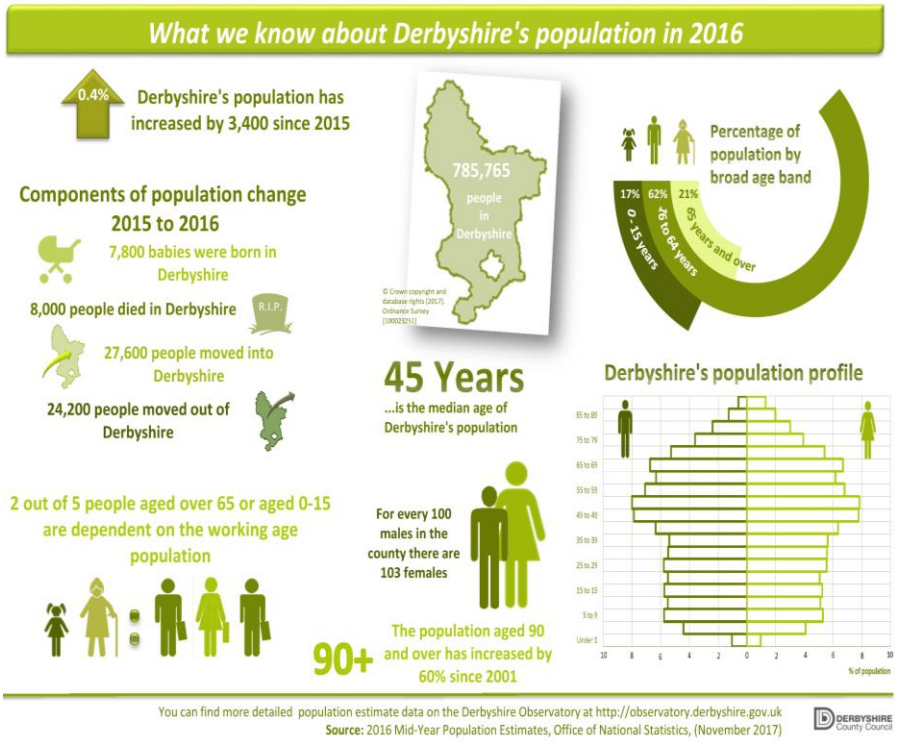
Chris Cook
Independent Chair – Derbyshire Safeguarding Children Board

2. Characteristics of Derbyshire and the demographic context of the DSCB

2.1. Derbyshire is a large diverse county with a number of heavily built up towns alongside large sparsely populated rural areas. A large part of the North and West of the county falls within the Peak District National Park. In 2014 the population of the county stood at 779,804 people and is projected to rise to 858,852 people by 2039, a 10% increase. Overall Derbyshire has an increasingly ageing population, particularly in Derbyshire Dales.

2.2. Derbyshire has a two tier local authority structure, comprising of the county council and eight district and borough councils. During the period the report covers there were five clinical commissioning groups (CCGs), two of which also cover areas outside the Derbyshire boundaries due to their locality. A number of key agencies work in partnership across both Derbyshire and Derby City areas, including the Police, Community Rehabilitation Services and some Health providers. Therefore strong links exist between Derbyshire Safeguarding Children Board (DSCB) and Derby Safeguarding Children Board, including the sharing of certain Board sub-committees. There is one Police and Crime Commissioner covering Derbyshire (including Derby City).

2.3. The demographic information (obtained from the Public Health Child Health Profiles) highlights the number of children and young people aged 0-19 years as being 170,500 and comprising 21.8% of the population of Derbyshire.



https://observatory.derbyshire.gov.uk/IAS/Custom/Resources/infographics/2016MYEInfographic.pdf

2.4. The above diagram reflects an increase in the median age of Derbyshire's population, from 42 years (in 2015) to 45 years in 2016. The number of babies who were born in Derbyshire in 2016 is 7,800 which was the same figure for 2015.

About the DSCB, the statutory and legislative context.

2.5. Derbyshire Safeguarding Children Board (DSCB) was formally established in April 2006 in response to the requirements of the Children Act 2004 and its accompanying guidance at the time, 'Working Together to Safeguard Children' (2006). DSCB has a range of roles and statutory functions, details of which are below.

2.6. The Derbyshire Safeguarding Children Board will:

- 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; and
- ensure the effectiveness of what is done by each person or body for those purposes (Section 14 Children Act 2004)

2.7. Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 as follows:

1(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) co-operation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB serious case review function and regulation 6 which relates to the LSCB child death functions are covered later in this report.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

Working Together 2015 (Chapter 3:16) states that the Independent Chair of an LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

2.8. This report is the annual review of the work of DSCB for the business year 2016-2017 and a reflection of how our priorities have been progressed. It is a rigorous and transparent assessment of the performance and effectiveness of safeguarding in Derbyshire. The report will demonstrate the contributions made by DSCB partner agencies toward the work of DSCB and most importantly what difference has been made to the lives of children and young people within the county.

2.9. It will provide the public, practitioners and main stakeholders with an overview of how well children in Derbyshire are protected, and identify any gaps in service development and challenges ahead for the coming year.

2.10. The DSCB business plan is reviewed regularly by the DSCB Core Business Group. The plan contains details of progress against priorities, which DSCB sub-group is responsible for actions, and impact and outcomes as a result of completed work.

2.11. The Derbyshire Child Health Profile published by Public Health England provides background information concerning child health in Derbyshire. The number of households with dependent children is slowly decreasing as detailed below.

27% of Derbyshire's households had dependent children in 2014 this will fall to 25% by 2039

Key Findings

- Children and young people under the age of 20 years make up 21.8% of the population of Derbyshire.
- 6.3% of school children are from a minority ethnic group, compared with 30% for England
- Life expectancy at birth (2013-2015) for boys is 79.2 years compared to 79.5 for England; and 82.2 years for girls, compared to 83.1 for England.
- 9.4% of children aged 4-5 and 17.9% of children aged 10-11 are classified as obese

2.12. Where Outcomes for Derbyshire Children are performing well in comparison to England:-

- The health and wellbeing of children in Derbyshire is generally better than the England average.
- Infant and child mortality rates are similar to the England average.
- The level of child poverty is better than the England average with 16.8% of children aged under 16 years living in poverty, compared with 20.1% for England

- The rate of family homelessness is better than the England average
- Childhood obesity aged 10-11 is 17.9%, comparing significantly better than the England average of 19.8%
- The area has a lower teenage conception rate compared with the England average

2.13. However, it should be recognised that whilst Derbyshire compares better than England for these specific outcomes, they each remain important as influential determinants which adversely impact health outcomes throughout childhood and the whole life-course, and therefore remain important for targeted interventions towards vulnerable populations, communities, groups, families and individuals. For example, smoking in pregnancy is a known risk-factor for infant mortality infant where targeted support for families to stop smoking remains an important intervention.

2.14. Where outcomes for Derbyshire children are of concern:

- The under 18s hospital admission rate for alcohol specific conditions is higher than the England average
- The hospital admission rate for substance misuse is higher than the England average for 15-24 year olds
- In 2015/16 there was an increase in children being admitted in to hospital for mental health conditions at a similar rate to that in England, which is increasing as a whole
- In 2015/16 the rate of in-patient admissions for self-harm was higher than the England average (15-24 years)
- In 2015, the chlamydia detection rate of 1,541 per 100,000 population was lower than the minimum recommended rate of at least 2,300 per 100,000 population
- The percentage of infants being breastfed at 6-8 weeks (40.7%) is lower than the national average (43.2%)
- By the age of five, only 91% of children have received their second dose of MMR immunisation
- The percentage of children achieving 5 GCSEs A*-C (including English and maths) at 54.8% is significantly worse than the England average of 57.8%

2.15. Derbyshire Public Health commissions specialist services and works in partnership to address the harm caused by substance misuse to children, families and communities:

2.16. Derbyshire Safeguarding Children Board has commissioned a learning review in relation to the alcohol misuse in young people. The recommendations from this will be recorded shortly and an action plan developed arising from this.

2.17. The DSCB is commissioning a task and finish group to consider how risk assessments undertaken in respect of young people moving placements can be improved. During the period covered by this report two serious incident learning reviews were completed regarding the deaths of young people. The learning from which has been disseminated across agencies to assist those working with the above cohort.

3. Executive Summary

3.1. This annual report provides an overall assessment of the work of the Derbyshire Safeguarding Children Board. As the detail within the report highlights the partnership have continued to work through the board and the sub-groups to ensure that children and young people are effectively safeguarded in Derbyshire.

3.2. This year has seen an expansion in the multi-agency audit activity undertaken by the board which is one of the key ways by which the board is able to provide assurance that it is monitoring the effectiveness of partnership arrangements for safeguarding children and young people. The co-operation of partners within these audits is a testament to the strength of the partnership relationship. The board has undertaken multi-agency self-evaluation to identify those areas where improvement in practice could be achieved and implemented an action plan to achieve such changes. These will then continue to be evaluated as part of the multi-agency audit programme.

3.3. The Board continues to operate against a landscape of change and the commitment to partnership working has remained strong notwithstanding the anticipated changes which will be brought about by the Children and Social Work Act 2017. The numbers of children who are subject to child protection plans continues to increase from 741 as at 31/03/16 to 916 as at 31/03/2017, suggesting an overall increase in child protection activity across the partnership.

3.4. The Board's Strategic Priorities for 2016 – 2018 are to:

1. Promote, monitor, coordinate and evaluate multi-agency effectiveness in safeguarding children and young people across the child's journey;
2. Strengthen and support a competent and equipped workforce that is committed to learning and developing safeguarding practice with assurance that safeguarding is everyone's responsibility;
3. Evidence the impact of DSCB and thereby build upon the areas of greatest effectiveness;
4. Continue to promote online safety initiatives, including the involvement of young people within the scoping and development of this aim;
5. Improve the response to situations of neglect;
6. Ensure the extensive use of early help assessments across all agencies;
7. Explore the potential benefits of a Public Protection Board.

3.5. The DSCB also agreed an annual work plan which includes specific work in the following areas:

- Keeping children and young people safe from harm, including CSE and missing children;
- to complete robust serious case reviews and share and embed the learning from these;
- to ensure that the Board operating model is fit for purpose and adapted in accordance with new guidance, legislation and research;
- the revision of the performance framework to ensure that this contains performance data form across the partnership to effectively measure the impact of the actions taken;
- ensure that our engagement strategy (with both the public and partner agencies) maximises the opportunities for the promotion of important messages about how to keep children and young people safe and ensures feedback informs the work of the board;
- the DSCB has clear strategies and comprehensive approaches to ensuring young people are supported to be safe online.

3.6. The details of the work undertaken by the sub groups demonstrates how these objectives have been taken forward. The range of agencies contributing to this work and their commitment is evident in the description of the work undertaken by the board and subgroups.

4. Membership of the Derbyshire Safeguarding Children Board and subgroups

4.1. The DSCB regularly reviews those agencies who are represented on the main board and also those who attend the DSCB sub-groups. This ensures that the correct agencies who can bring about effective change are represented at all key meetings. In addition to the meetings which take place the DSCB also seeks to engage with partner agencies through large scale training and development events and through the DSCB newsletter and bulletins. This information is then spread across all agencies comprised with the DSCB membership. For full details of the material please view the DSCB website www.derbyshirescb.org.uk. The full DSCB membership is detailed at Appendix 1.

4.2. In addition to the professional agencies who are represented, the DSCB is fortunate to have two lay members who are highly committed to the activities of the board, attending both the main board meetings and also DSCB sub-groups fulfilling a ‘critical friend’ role and assisting the development of links between the DSCB and the Derbyshire community.

4.3. A recent review of the board’s activities highlighted the benefits of a sub-group comprising safeguarding representatives from the Borough Councils and this commenced in July 2017, ensuring that key safeguarding information was shared effectively across the Boroughs.

4.4. The report details the key activities of the sub groups and the priorities of the board to provide an understanding of its work and the impact of this work.

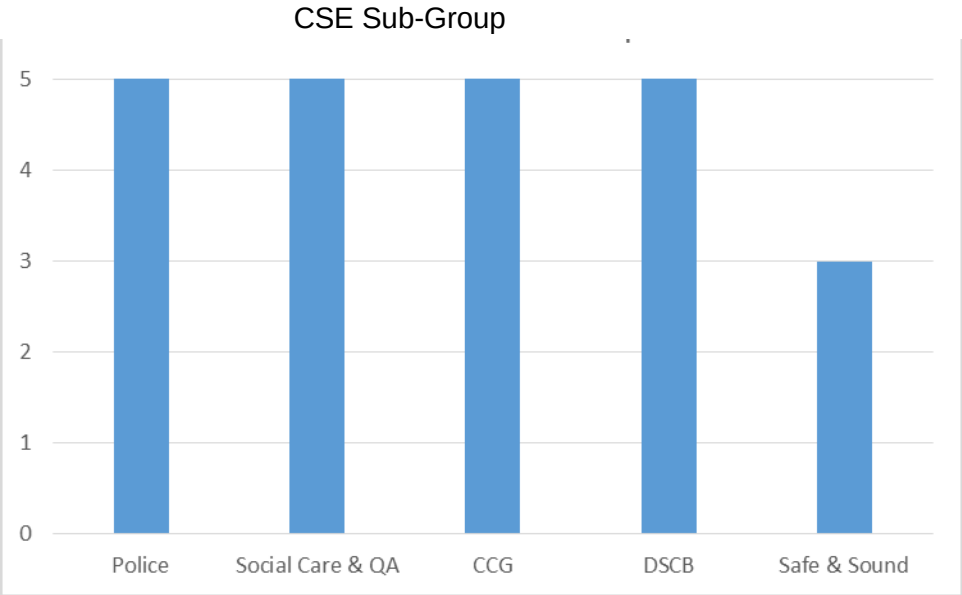
5. Child Sexual Exploitation Sub-Group

5.1. This sub-group provides strategic direction in relation to protecting children and young people from child sexual exploitation. The membership of the group includes representatives from Children's Social Care, The Community Safety Partnership, and the police and health agencies along with specialist sexual health agencies. The sub-group has latterly expanded its terms of reference (February 2017) to include the increased range of vulnerabilities for young people and is now the DSCB CSE and Vulnerable Young People Sub-Group. For the majority of the period covered by this report the focus of the group was child sexual exploitation

5.2. The work of the group has included:

- Developing and ensuring the implementation of a comprehensive action plan to ensure the implementation of recommendations. These recommendations were the result of a previously commissioned independent audit of CSE cases and a review undertaken by the Scrutiny Committee within Derbyshire County Council.
- To establish learning from the programme of Joint Targeted Area Inspection which focussed on Child Sexual Exploitation between February and August 2016, including multi–agency auditing with partner agencies. The sub-group considered a comprehensive multi-agency self-evaluation form to establish where areas of improvement across the partnership may exist.
- Reviewing available material to assist practitioners, e.g. The Brook Traffic Light Tool and CSE Toolkit, ensuring this was made widely available to practitioners and that it was being used.
- Reviewing the CSE training provision to ensure this was being effectively used.
- Considering regional information regarding CSE to ensure effective cross boundary work was being undertaken and continuing to contributing to the development of an East Midlands CSE framework.
- Ensuring effective arrangements are in place to conduct interview with children who have been missing within 72 hours of their return.

5.3. The membership of the group was revised following the expansion of the terms of reference for the group. The chart below details the membership of the group as it was prior to this changes. The attendance of some agencies/groups may not have been required for a particular meeting dependent upon the matters being considered.



6. Serious Case Review Sub-Committee

6.1. The Local Safeguarding Children Boards Regulations 2006 includes the requirement for LSCBs to "undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews (SCRs), namely:

5(1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either:- (i) the child has died; or (ii) the 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 worked together to safeguard the child.

6.2. Working Together 2015 states LSCBs should also consider conducting reviews on cases which do not meet the SCR criteria. The DSCB refers to these cases as serious incident learning reviews (SILRs). Working Together 2015 is clear that the LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

6.3. The DSCB SCR Sub-committee meets bi-monthly unless an additional extraordinary meeting is required to consider an urgent new case. The sub-committee is independently chaired by a Service Director from Derby City Council under a reciprocal arrangement. A sub-group of the SCR Sub-Committee is the SCR Action Plans group, which has responsibility for the oversight and monitoring of recommendations and actions from all SCRs and SILRs in which DSCB is involved.

6.4. The membership is comprised of a multi-agency group of professionals from the

SCR Sub-Committee alongside representatives who deliver training on behalf of the DSCB. The group meets bi-monthly to scrutinise progress and evidence on recommendations, and sign off recommendations when agreed as complete. The SCR Action Plan sub-group reports regularly to the SCR Sub-Committee. The SCR Sub-Committee has regularly reviewed its membership and terms of reference during the period of this report and expanded its membership to include a Deputy Assistant Director from the Education Improvement Service. This will ensure that the group has the benefit of an educational specialist in making decisions and recommendations.

6.5. The DSCB published the SCR, ADS14 on 5TH September 2017. The commissioning of this report took place during the time period covered by this report and was therefore considered by this sub group. The SCR, ADS13, was also prepared during this period, although not published until 2018, pending the conclusion of associated litigation. Both reports are available to view on the DSCB website.

6.6. The group also oversaw the preparation of two learning reviews relating to the deaths of young people, one as a result of hanging and one following the ingestion of drugs purchased utilising the 'dark web.' In relation to both these reports and the aforementioned SCRs, the authors were greatly assisted by the co-operation of the young persons' families and would wish to extend their gratitude to them for this. The learning from these reports has been taken forward by individual agencies and shared at multi-agency learning events.

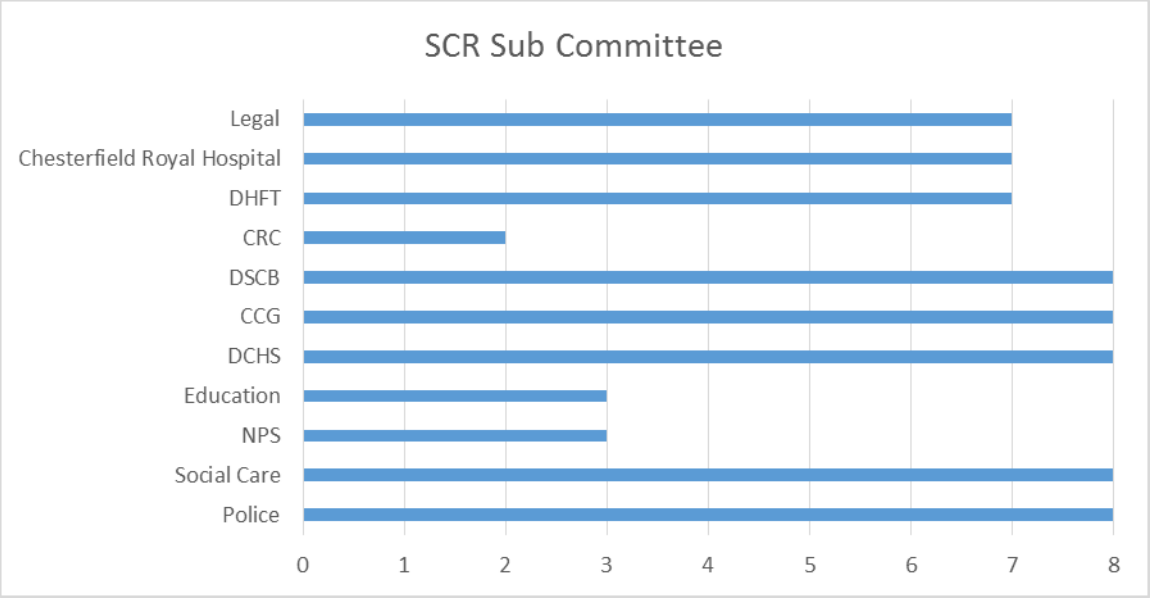
6.7. The sub-committee also co-ordinated the contribution from Derbyshire agencies to learning reviews which were being conducted by Local Safeguarding Children Boards in other areas.

6.8. A single agency learning review examined by the sub-committee produced a recommendation that a pathway should be sought to enable certain findings within family court proceedings to be included in medical records. This recommendation is being taken forward locally and interest has been expressed nationally by other LSCB looking to adopt this model. The Family Court Judge or the Lay Justices considering a case may be invited direct that an alert should be included on an adult's medical records requiring a referral to Children's Social Care if the treating doctor receives information suggesting that the adult concerned may be involved in the care of a child now or in the future (e.g. current pregnancy).

6.9. The sub-committee also considered a matter relating to historical abuse and referred the matter to the National Panel of Experts who supported a decision not to conduct a serious case review regarding this matter. An assurance report has however been commissioned to provide assurance to the DSCB that events such as those detailed by former residents could not happen today within the current framework of protection and regulation. The DSCB has also sought assurance as part of this process that victim support is available for those affected by these events. The report and any recommendations arising from this report will be

carefully scrutinised by the sub-committee.

6.10. The attendance at the group is carefully monitored to ensure that the appropriate agencies are represented and able to contribute and hold themselves and others to account. Not all agencies may be required at each meeting, dependent upon the area in which the matter under review occurred or the agencies who were involved with a particular child. This is reflected in the attendance chart below. The key agencies have maintained a complete attendance record (100%) reflective of the pivotal importance of this area of the board's work. The below diagram illustrates the attendance over the eight meetings held during this period.



6B. Serious Case Review Action Plan Sub-Group

6.11. This group of professionals focus on seeking to ensure that the action plans arising from the serious case reviews are fully implemented. Although not published until 5th September 2017, the group spent a great deal of time during this period scrutinising the implementation of the actions arising from this review. The detailed action plan full report and executive summary for ADS14 can be viewed at : *https://www.derbyshirescb.org.uk/serious-case-reviews/serious-case-review-ads14/default.asp*

An example of the material produced by the group is the poster below which summarises some of the key recommendations which are being taken forward by the group and the agencies they represent.

6.12. The below learning material was produced following discussions within the action plan sub-group to ensure that a summary of key learning points was readily available and displayed in working environments and public areas. It is is also recoomended that these could be included in supervision files to ensure these

issues are considered and highlighted during supervision sessions.

6.13. The action plan sub-group has expanded its composition to include represenatives from within the Derbyshire Children's Services, Derbyshire County Council training team and legal services. This ensures that learning identified within any learning reviews will be incorporated into Derbyshire Children's Services training programmes and also taken forward with the local judiciary. The DSCB Manager chairs the Local Family Justice Board Training sub-group which ensures that learning from serious case reviews is brought to the attention of the LFJB and taken forward as appropriate. The 2017 Local Family Justice Board annual development day focussed on the ' Voice of the Child' and included training on the lessons from serious case reviews. The sub-group also co-ordinated a large scale multi-agency training event on 20th June 2017 regarding the learning from local and national serious case reviews. Practitoner feedback from the two events indicated that they would take forward learning; two examples given included:

- the need to consider a child protection plan alongside a supervision order in circumstances where children were returning to parents/carers from whom there had been concerns leading to the care proceedings.
- recording children's missed medical appointments as 'was not brought' rather than 'did not attend' to capture the possibility of parental neglect and to protect children who are unable to attend appointments when an adult will not accompany them.

6.14. The action plan sub-group also looks to identify learning from local domestic homicide reviews and learning from serious case reviews conducted by other LSCBs. The 're-thinking' around missed medical appointments was learning form a serious case review in Nottingham City. This resulted in the production of a short animated film which is now shown at the conclusion of all DSCB training events to ensure this point is embedded and acted upon by practitioners.

Derbyshire Safeguarding Children Board

Serious Case Reviews (SCRs) and Serious Incident Learning Reviews (SILRs) 2014-17

The Child Protection Plan is key. Reflect all possible risks in the Plan, including parental mental health or drug misuse.

Show that authoritative social work practice leads your child protection planning.

Be alert to and understand the signs of disguised compliance and do not be unduly optimistic about outcomes.

Ensure robust arrangements are in place to support children with Supervision Orders.

When a child subject to a Supervision Order returns to a carer who presents safeguarding concerns, consider a Child Protection Plan rather than a Child In Need Plan for the first six months.

This consideration should be recorded.

Where there are safeguarding concerns for children, fathers or male partners must be consulted, supported and assessed, even if they are not the primary carer.

Record a child's missed medical appointment as *'was not brought'* rather than *'did not attend'* so parental neglect is considered as a factor.

Medical staff must always consider abuse or neglect within their differential diagnosis.

Ensure new parents view the film 'Shaking Your Baby Is just Not the Deal', on DVD or on YouTube

Ensure the child's voice is clearly heard and use chronologies to record the child's *'lived experience'*.

All professionals should consider the need for an Early Help Assessment.

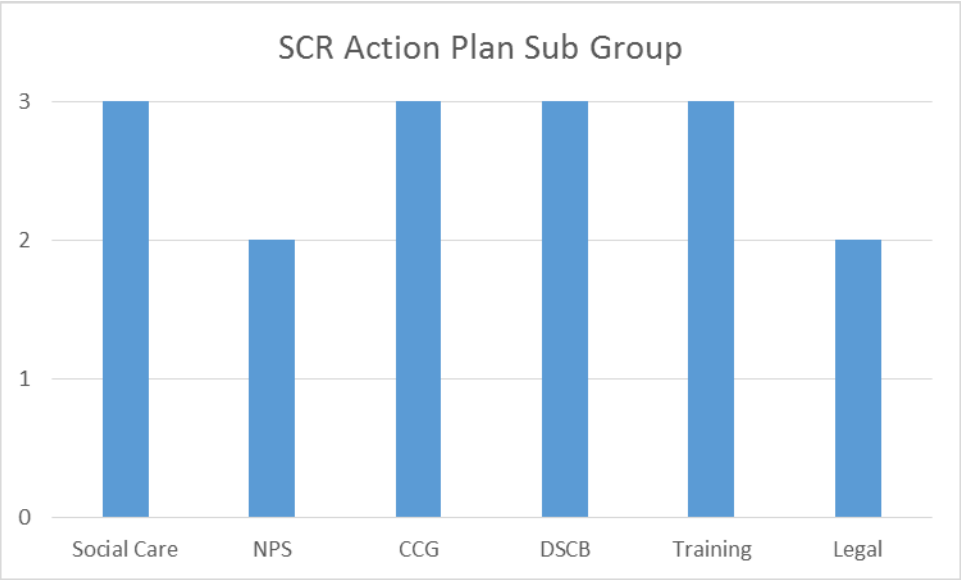
Seek leave to include relevant Family Court findings in the adult's medical records.

Undertake robust assessments of housing provision for vulnerable young mothers.

Key themes of Derbyshire SCRs and SILRs:

- The importance of authoritative practice
- Be alert to disguised compliance
- The importance of professional curiosity
- Be alert to the possibility of abuse
- All professionals to consider the need for an Early Help Assessment
- Hear the voice of the child
- Understand and record the child's lived experience
- Refer to www.derbyshirescb.org.uk/policies-and-procedures.asp to guide practice

6.15. Attendance at the group is monitored to ensure both regular attendance and also to ensure that the correct agencies are involved in the key decision making. Attendance may vary slightly for each meeting as particular organisations or agencies may be asked to attend to consider particular points contained within action plans. As would be expected health, social care and training partners consistently attend all meetings providing valuable insights and direction to ensure the progress of the actions identified within action plans.



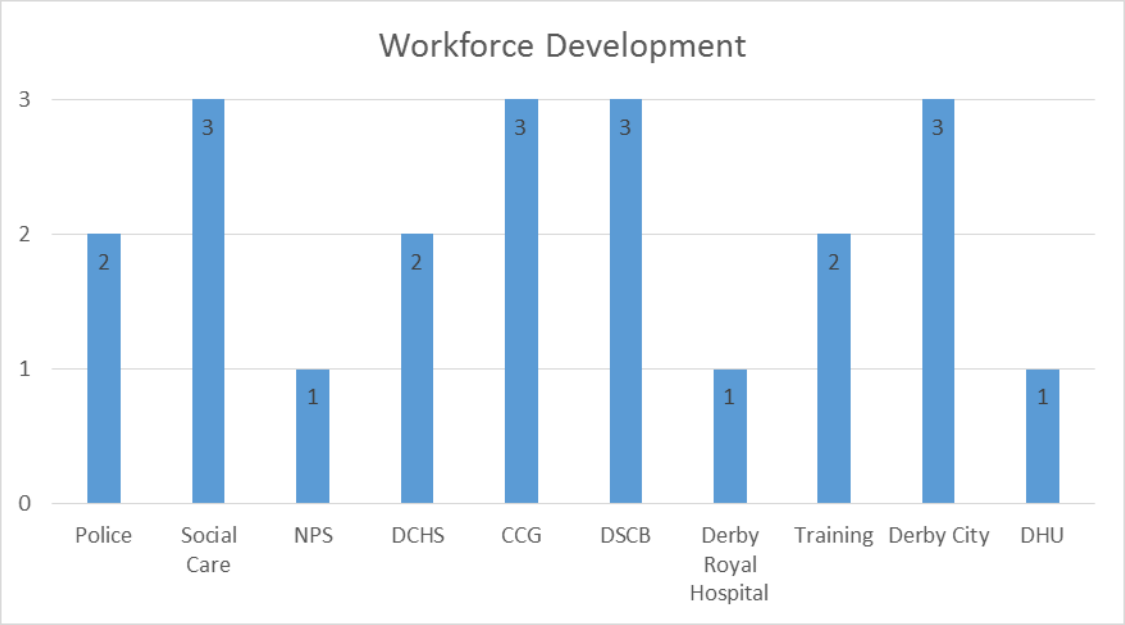
7. Workforce Sub-Group

7.1. This joint Derbyshire and Derby LSCB sub-group carries out the requirement of the DSCB to scrutinise arrangements for maintaining a safe, sufficient and effective workforce. The Workforce sub-group commissioned capacity reports in respect of key front line roles including front-line social workers, police officers (Public Protection Unit), community midwives, school nurses, health visitors.

7.2. The following areas were progressed by the group:

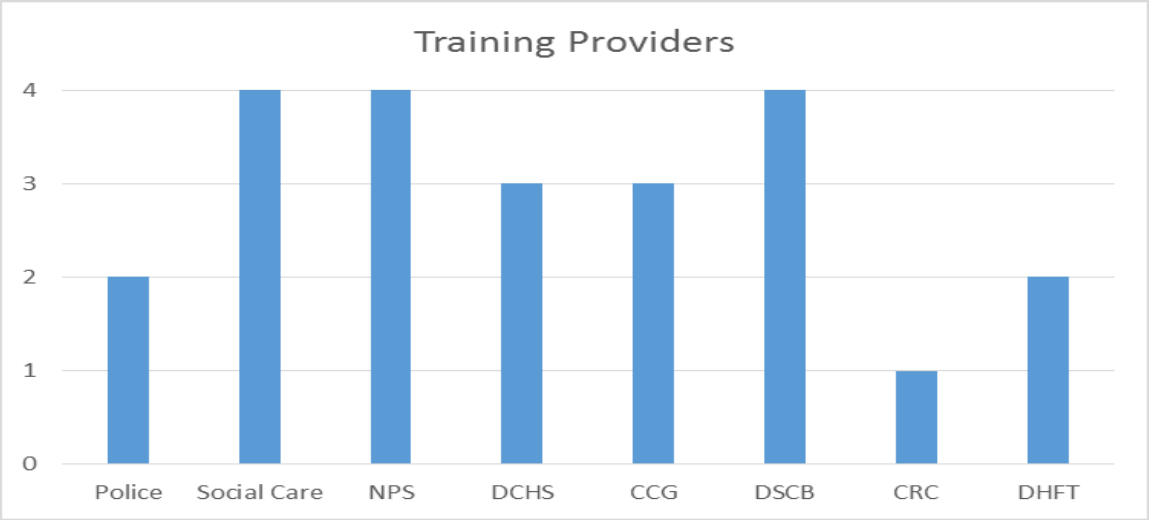
- workforce capacity scrutinised across the partnership;
- LADO (Local Authority Designated Officer) information reviewed in order to consider any important themes or issues rising form this;
- training needs evaluated by reference to the identified workforce. This then ensures that there is appropriate directed training available for the workforce.

7.3. Attendance at the Workforce Development group has been organised so that only those representatives who are contributing to the particular issue being evaluated attend that particular meeting.



8. Training Providers Sub-Group

8.1. The Training Providers Sub-group is a joint sub-group with the Derby LSCB. The group comprises representatives from the two local authorities and key DSCB agencies. The chart below details attendance at the sub group. The quarterly meeting enable DSCB training to be planned, delivered and implemented with agency input.



8.2. During the period of the report the DSCB training team have endeavoured to deliver high quality training that is relevant, accessible and at the appropriate level for professionals and volunteers who work with children and families in Derbyshire.

8.3. In line with the Training Strategy, the DSCB training programme aims to give agencies the training they need to carry out their roles and responsibilities for

safeguarding children. The team ensures that different types of learning are available and that learning is evaluated and promotes good safeguarding practice.

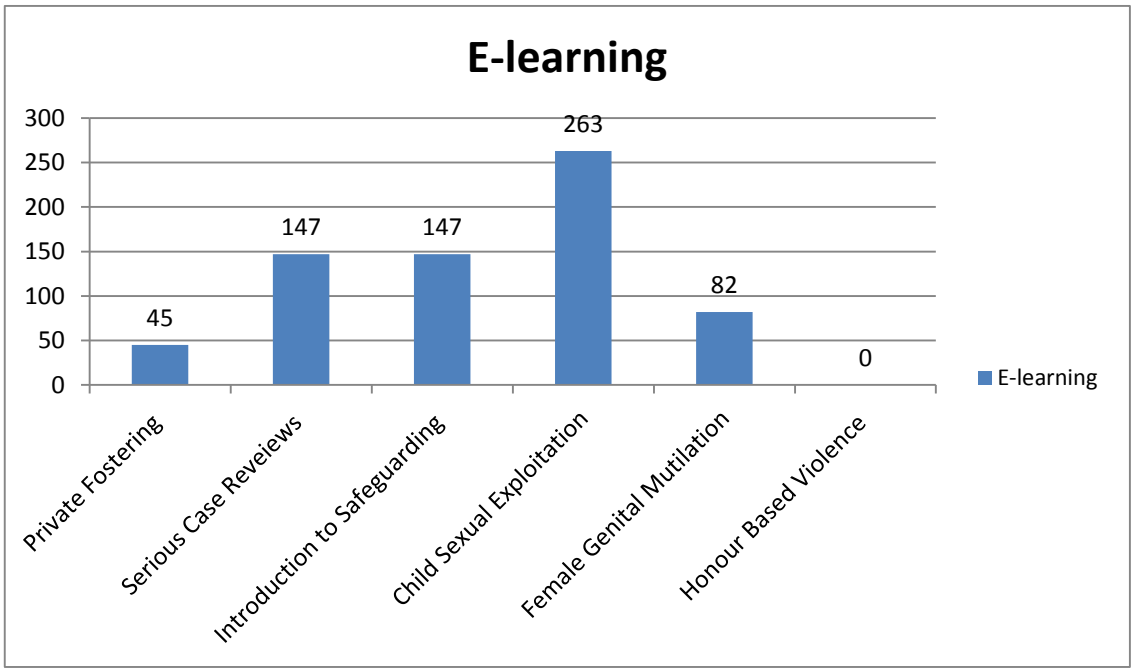
8.4. In the period covered by the report there have been changes in staff who deliver safeguarding training. The DSCB is currently exploring introducing a programme of training provided with the support of professionals from other key agencies to assist in ensuring the delivery of training and enhancing the quality of this training. This will also assist the training team to adapt to any internal staff changes without a reduction in the nature and frequency of training courses provided.

Delivery of training

8.5. Seventeen different topics/key development areas have been covered in the face to face training with a total of 89 courses being delivered. The majority of courses are one day courses with two courses being of a half day duration. Wherever possible, the training has been delivered by or with trainers from a variety of agencies to increase the relevance of depth of knowledge available to participants. The trainers from partner agencies have included:

- A DCC Social Inclusion team manager
- A Named Nurse
- Community Safety Officers
- Family Support workers
- Child in Care Drugs Worker
- Social Workers
- A LADO (Local Authority Designated Officer)
- A Multi Agency Team Manager
- A Safeguarding Adviser – Derby Diocese

8.6. Derbyshire County Council introduced an e-learning platform this year (Learning Pool) where the suite of e-learning packages is now based. The offer of e-learning available topics has been extended this year to include Female Genital Mutilation and Honour-Based Violence and Forced Marriage. The figures in table 1 are based on the number of users via Learning Pool; the figures for the Introduction to Safeguarding may actually be higher as the DSCB website directed people to the Derby SCB website to complete this package. The Introduction to CSE has been the most used e-learning course this year. The diagram below highlights the e – learning courses which have been introduced and number of people who have accessed and completed that particular training topic.



Course attendance

8.7. Total programme attendance has increased in 2016/17 to 1,810 from 1,498 in 2015/16. In addition to the programme of courses, the training team have delivered a number of courses to single agencies and services within Derbyshire. These include a Private Children's Home, a Housing Association, Chaperones (transport), Independent Advocates, Multi Agency Team Workers and Youth Workers.

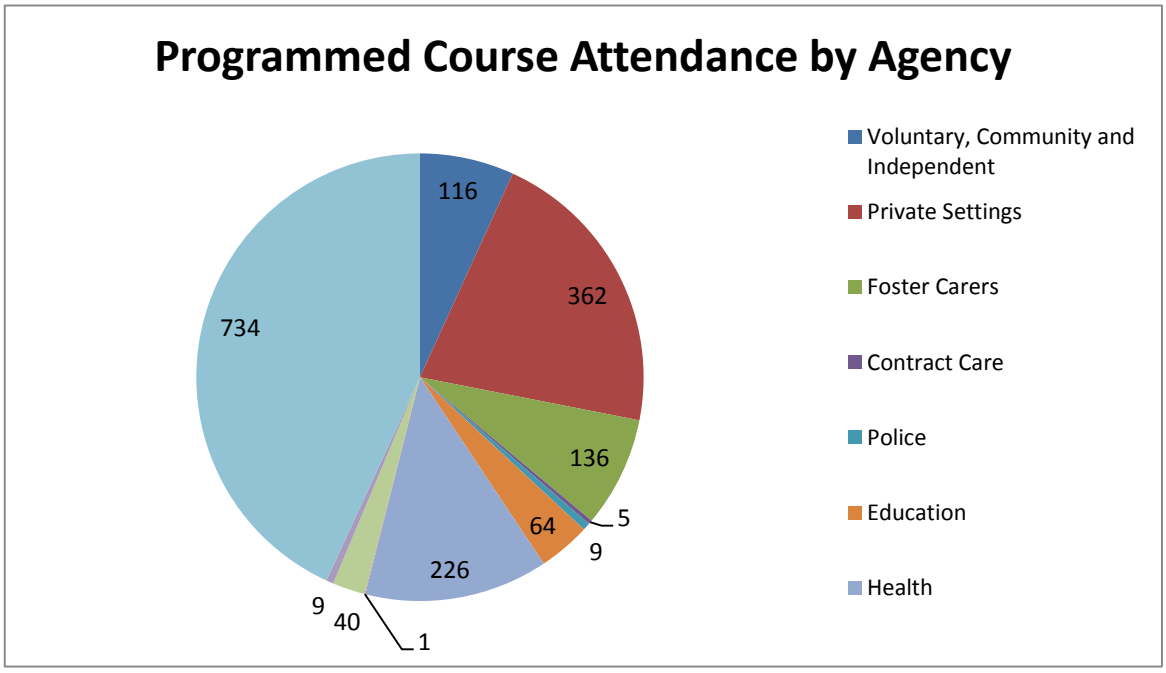
8.8. The Workforce Development Team also provides safeguarding training to Childminders and Early Years settings under the direction of the training team. Eight 'Introduction to Safeguarding' courses have run and nine refresher courses have been delivered to this cohort.

8.9. Safeguarding for Schools courses have been well attended again this year with 81 whole school sessions, 13 Designated Safeguarding Lead (DSL) courses, 14 DSL Refreshers, 11 Safer Recruitment and 2 Governor sessions :-

- programme total Attendance = 1,810
- single agency training = 255
- schools training = 3,507
- childminders and early years workers =389
- **Total attendance on and participation in DSCB courses = 5,961**

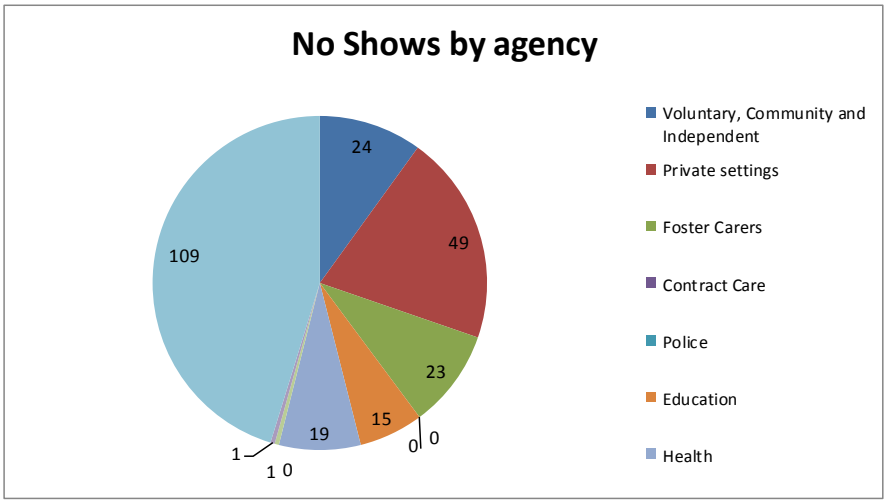
8.10. Derbyshire County Council staff continues to make up the biggest group attending training with private settings the next highest and then health settings. Derbyshire

County Council staff make up the largest proportion of those attending DSCB courses and this is also reflected in the percentage of DCC staff who are unable to attend training once booked on. The percentage of those professionals unable to attend from DCC is 14%, however private settings are close with 13.5% but the Voluntary, Community and Independent sector have the largest percentage of non-attendance on previously booked courses at 20%.



Those professionals unable to attend on the day of training.

8.11. There has been a very slight decrease in the number of people failing to attend training without prior notice from 246 in 2015/16 to 241 in 2016/17. In terms of percentage no shows, this year there have been 13% no shows compared to 16% last year.



8.12. The DSCB continues to monitor very closely the number of people who are unable to take up the opportunity which their place on a course provides. Consideration

was given at the DSCB meeting in September 2016 to charging those persons who were unable to attend. Analysis of training returns suggested that often the places are often allocated to colleagues, preventing the place on the course being wasted. In addition, the DSCB wishes to encourage participation in training and acknowledges that the nature of child protection and safeguarding work may mean that professionals have urgent professional commitments to attend to. The DSCB does not wish to deter participants from booking on to important training courses.

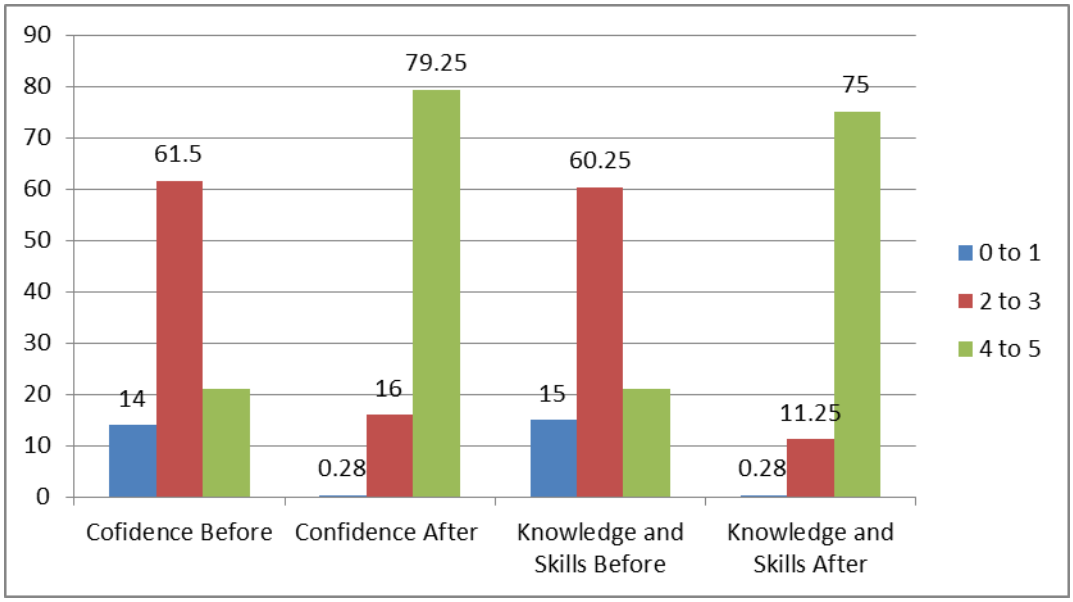
Cancellations

8.13. There has been a slight reduction in the number of people cancelling prior to a course - 279 in 2015/16 and 257 in 2016/17. In percentage terms this is a decrease from 18% to 14%.

8.14. People attending without pre-booking has remained similar at 143 in 205/16 and 154 in 2016/17. This has meant a number of cancelled places have been fully utilised.

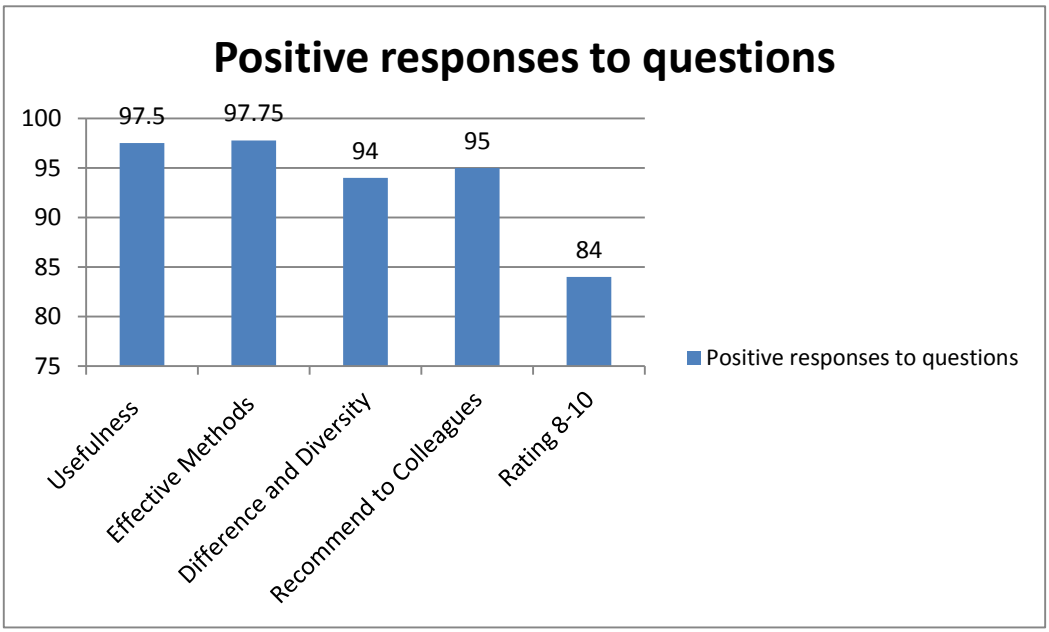
Evaluation of training

8.15. The 'on the day' evaluation provides a 0-5 scaled self-assessment of the participants' learning in terms of knowledge and skills (KS) and level of confidence in the subject before and after the training. This helps to develop the content and assess whether learning has taken place.



8.16. Five questions are asked about the usefulness of the course: whether effective methods have been used, if difference and diversity have been addressed and whether they would recommend the course to colleagues. There is also a rating of the overall course from 1-10. This helps to measure whether the content is satisfactory and sufficient and helps when we review courses. It is noted that

confidence and skills increased greatly for participants as a result of attending the courses.



8.17. Participants are asked to identify key learning points and how the training will change their practice. There is also the opportunity to provide other comments which invites suggestions for improvements or compliments about the training. The majority of comments are complimentary about the content, methods, and the trainer. Some comments express dissatisfaction with the location or quality of the venues which are addressed if possible within the budget available. It is acknowledged that there are both geographical and budgetary challenges in locating course venues across a large county such as Derbyshire.

8.18. Overall, courses have been evaluated positively, with suggestions for improvements; for example:

"Really informative and enjoyable. The trainer obviously has a lot of experience and shared where appropriate. Good use of different resources helped keep involvement and interest" (from the course 'Safeguarding - Child and Adolescent').

"It is such an in-depth subject that I feel one day is not enough to cover everything in great detail as ever brilliantly delivered by the trainer" (from 'Domestic Abuse' training).

"Many different agencies lead to good discussion although some professionals used jargon and acronyms that were specific to them and I found it difficult to understand the flow of conversation" (from the course 'Safeguarding for Managers').

"The course was thorough and covered all areas to broaden knowledge/skills and confidence to apply these within my job role" (from CSE Recognising and Reporting).

8.19. Wherever possible the recommended suggestion for the improvement of courses

has been implemented.

Validation Scheme

8.20. A validation scheme has been introduced by the sub-group.

8.21. The validation panel has met regularly to quality assure independent safeguarding training companies to ensure they meet rigorous quality standards for content and are organisations who use suitably qualified and knowledgeable trainers. To date the following training providers have been validated:

- Traci Goode – Online safety
- Safe and Sound
- Linda Rickets
- Ann Cruickshank
- John Gordon, Turquoise Training
- A&G Training

8.22. Training materials' have also been approved for

- Southern Derbyshire Clinical Commissioning Group
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire Community Health Services Foundation Trust

8.23. This offers assurance for both the training team and participants regarding the quality and content of the course.

Plans for 2017/18

8.24. To charge profit making organisations to attend DSCB training. This will enhance the funding available and enable more courses to be delivered and for additional venues to be sourced to undertake courses in.

8.25. To develop half-day workshop provision to increase availability and accessibility of face to face training. This will enable participants to more efficiently manage their professional obligations alongside their training requirements.

8.26. To update and extend the range of e-learning packages available on Learning Pool. The response to the introduction of the e–learning courses has been very positive and the DSCB training team would like to build on this efficient means of disseminating knowledge and information.

8.27. To improve the identification of additional and/ or alternative courses that are required as a result of audits, serious case reviews and the priorities of the Board. A senior training officer attends the action plan sub-group to ensure that key learning points are incorporated into training programmes. A theme which will be incorporated across the training programme following on from the ADS14 SCR is the development of authoritative practice amongst all professionals. In addition,

the short film produced by Nottingham LSCB highlighting the need to 'rethink did not attend' is shown after all face to face courses to embed this learning.

8.28. To identify a sustainable method of evaluation that measures the impact that training has on the practice of participants and the lives of children and families. Evaluation has been conducted by a variety of methods thus far including post training telephone calls and feedback forms. The DSCB also seeks detailed evidence from practitioners regarding how their practice has changed as a result of the training which they have undertaken.

8.29. To develop a pool of trainers from across agencies. This not only ensures a comprehensive training programme can be maintained but brings added knowledge and experience to the subject area being addressed.

9. Quality and Performance Sub-Group

9.1. Representatives from a wide range of partner agencies attend this quarterly meeting which seeks to provide assurance that the work of the partnership is effective. The work of the group has included the following:

- consideration of the audit capability of the partnership and the specific audits which have been undertaken. The group has latterly taken ownership of the neglect action plan which arose following on from audits focussing upon this area;
- dissents from case conferences. The group has monitored the revised dissent and escalation policy created by the Child Protection Service within the local authority;
- S11 Audits. (These are detailed at section 18 below);
- consideration of the challenge day audits undertaken by Derbyshire Children's Services;
- the group also considers in detail the performance report which is presented to the board in March and September and the DSCB risk register, prior to their consideration by the full board;
- the group considered the use of secure accommodation in Derbyshire to identify areas of learning here;
- the group sought to assure themselves around the programme of work for suicide prevention.

9.2. The DSCB independent chair also represents DSCB as a member of the Derbyshire County Council Children's Services Performance Board, which meets regularly to scrutinise management information relating to the provision of Services on all aspects of safeguarding performance and request assurance and action when necessary services for children. This provides an opportunity for the

DSCB to challenge senior representatives of Derbyshire Children's Services.

9.3. Attendance is secured at the meeting form all key agencies. Some agencies will be invited to attend specific meetings to assist in informing discussions around specific areas. The chart below highlights the attendance, by agency, at the meetings.

10. Education Sub-Group

10.1. This group brings together a wide range of representatives from across the Derbyshire education estate. The representatives also have a clear pathway through their cluster groups for collating and disseminating information. The information gathered also informs decision making by the group. The group reviewed their effectiveness in June 2016 and their self-assessment highlighted the benefits of a neutral and effective Chair and also the positive environment which the group created where schools had been able to share concerns on best practice and highlight issues across the county and undertake action to address these. The key impact areas for the group during the period covered by this report include the following:

The S175 School Safeguarding Audit.

10.2. The school safeguarding audit was revised and updated in 2017 and reissued to all schools, including private schools, independent schools, support centres and colleges. It is now an expectation that all schools in Derbyshire will undertake this audit activity and produce a working action plan and submit a copy to safeguarding services. The DSCB is grateful to Debbie Peacock, Derbyshire Children's Service Child Protection Manager Schools and Education, Performance, Quality Partnerships, for collating the audit responses below.

10.3. In the period 2015/16, 254 audit returns were received (a significantly higher figure than in 2014/15). In the period covered by this report, 2016/17, 237 returns were received. The reason for this fall in response has been carefully considered and the view taken, following consultation with schools, is that the method of completion is a deterrent and that designated safeguarding leads and headteachers would prefer to complete the audit ' on-line' rather than a paper completion. The Education Sub-Group has conveyed this view to the DSCB and the DSCB is researching the cost effectiveness of a virtual audit capability. Further random sampling of schools highlighted that the forms had been completed and were available for inspection but had not been submitted. Primary schools remain the largest proportion of schools to respond and the response rate remained high, but this, of course, reflects the fact that there are a significantly greater number of primary schools within the educational estate. A slight fall in returns from secondary, special and support centres was noted.

10.4. An important and positive development in this period was the rise of completed action plans accompanying the audit returns. The message had been given to schools via school forums that the action plan is a critical piece of evidence of safeguarding activity and a tool for highlighting the activity and progress made against safeguarding objectives. The action plan process also necessitates regular review and evaluation of safeguarding risks which in itself is a positive protective activity undertaken by schools. It appears from the returns received during this period that headteachers and designated safeguarding leads have embraced this advice.

10.5. A snapshot analysis of the 2016-17 returns highlighted:

- schools' confidence in having and implementing a comprehensive safeguarding policy and procedures;
- increased staff awareness and training and staff effectively trained to undertake safeguarding activity within their role;
- ability to implement safer recruitment and manage allegations against staff;
- able to embed safeguarding in the curriculum and in classroom and within whole school activity;
- robust anti-bullying reporting and responses;
- increased confidence in tackling on-line safety, cybercrime and online grooming;
- increased confidence, awareness and usage of protocols for children missing education (CME) and early help assessments.

10.6. It is also identifying the following:-

- less confidence around emerging specific safeguarding issues:female genital mutilation (FGM), child sexual exploitation,issues related to gangs;
- gaps in having a fit for purpose sex and relationship education programme in schools; and
- when having a programme as detailed above, confidence in the delivery of this.

10.7. Following consideration of the audits and action plans the following actions have

been promoted:

- flag and escalate schools who are not providing designated lead details and/or not submitting an audit and/or not attending schools forums and/or not using the safeguarding services on offer;
- determine any fall in returns during 2017 from individual schools to identity potential risks and to engage them in discussion around this and provide appropriate advice and guidance;
- correlate the findings of the audit into current Derbyshire Children Services actions with a focus on CME, CSE and gangs;
- work with workforce development/safeguarding training to plug any deficits in training for schools and connected partners;
- escalate the need for a school self-assessment tool to more accurately capture and record the school audit and action plan. This has been discussed at board subgroups in order to progress this.

Record keeping and transfer

10.8. The group has developed and implemented an agreed procedure for ensuring that information regarding children and young people is transferred when a child moves school. It is of course recognised that families' move across borders and the process of seeking wider adoption of this protocol has begun. It is understood that Derby LSCB has confirmed their adoption of this protocol.

The use of information regarding domestic violence notifications

10.9. The group has continued to promote the positive benefits of ensuring that information regarding domestic violence notifications is made available to schools. The group would like to see an 'Operation Encompass' type model operate in Derbyshire. This is the reporting to schools before 9am on a school day when a child or young person has been involved or exposed to a domestic abuse incident the previous evening. This enable schools to effectively respond to the needs of their pupils. The group continues to promote this objective.

The promotion and use of Kayleigh's Love Story within secondary schools.

10.10. The group has been instrumental in ensuring that children and young people are educated in relation to online dangers. The DSCB has arranged for Kayleigh's Love Story to be shown to in secondary schools across Derbyshire (directed at year 7 pupils).

10.11. This film been shown to in excess of 7,000 children and the questionnaires given to the children following these showings indicate that 78% of these young people have increased their knowledge and understanding of the internet and online safety. The questionnaires were developed following discussions with the Derbyshire Youth Council and young people from a Derbyshire CSE support group and youth participation officers.

- total questionnaires sent: 7,145

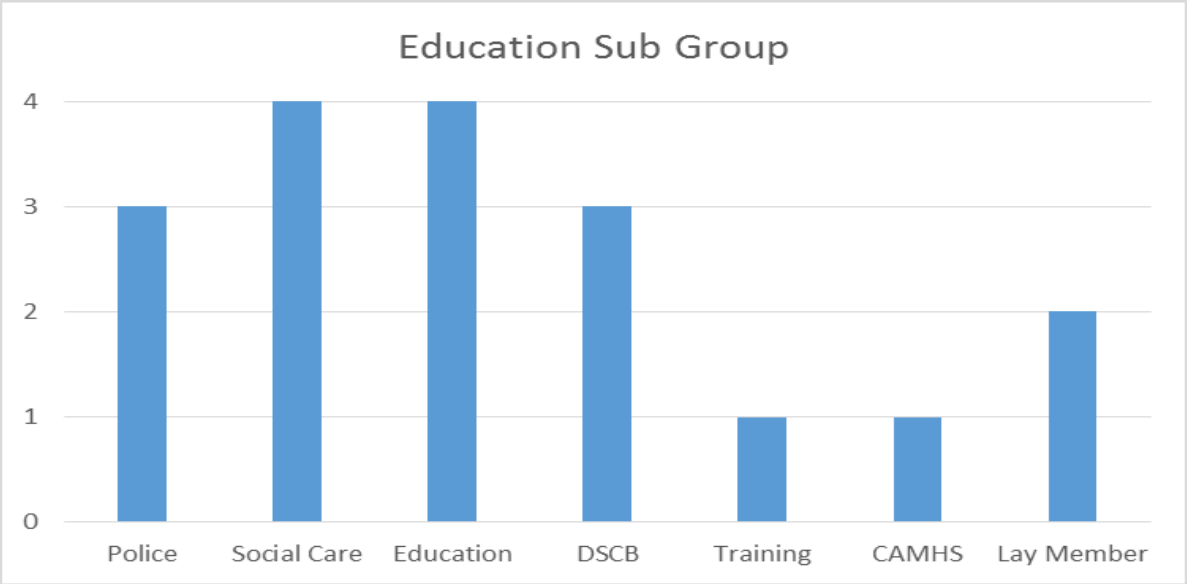
- total received back: 2,330 (33%)

10.12. An evaluation report was received by the DSCB main board meeting in September 2017. 78% of the children who completed the questionnaire indicated that it will make a difference to what they post online and who they talk to online. Over 1,200 children indicated that it had increased their knowledge about online grooming and the danger of not knowing who you may be talking to online.

School Holiday Protocols

10.13. The group were instrumental in ensuring that a school holiday protocol was in place to enable schools to be contacted during holiday periods to address any urgent safeguarding concerns. This has resulted in better child protection information being available at key points.

10.14. The Group has also contributed to the development of an induction pack for head teachers and Designated Safeguarding Leads in schools.



11. Policies and Procedures Sub-Group

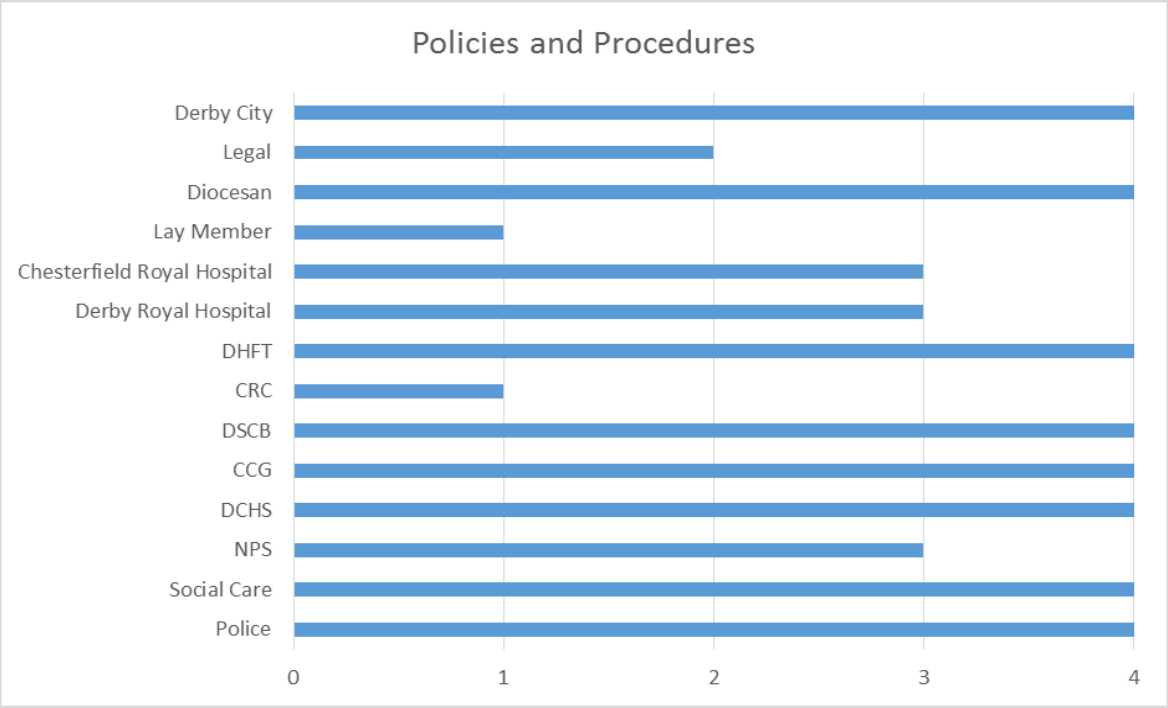
11.1. The Policy and Procedures Sub-group is a joint group of both the Derby and Derbyshire LSCB. The involvement of both LSCB ensures that the policies are consistent across Derbyshire. Representatives from a wide range of partner agencies attend this quarterly meeting which ensures that the policies governing the work of the agencies are fully effective and have been revised in accordance with a rolling programme to ensure all content is current, relevant and implemented. The work of the group has included the following:

- regular revisions and updates of all policies as required reflecting changes in practice and knowledge. The two LSCB work closely with Tri-x in ensuring that

there is a comprehensive suite of both policies and briefings avaialble to all professionals working in the field. The involvement of Tri-x ensures that the procedures reflect legislation, statutory guidance and best practice; it also provides an additional link with boards across the country;

- the preparation of multi-agency and self-harm and suicide guidance, self-harm pathway and action plan. The Board also produced posters and 'Z fold cards' for professionals to ensure that key elements of the policy were immediately and readily avaialble to them;
- ensuring policies and procedures are consistent with Working Together 2015. Once the revised 2018 Working Together has been issued the DSCB will repeat this procees in respect of the new statutory guidance;
- updating the policy for adults who disclose non-recent abuse to reflect feedback from a survivors group regarding the response to their disclosures;
- the group also notes and links in the learning from serious case reviews to ensure that this is reflected within policies;
- the group has raised awareness of Deprivation of Liberty Safeguards (DOLs) amongst professionals and included this within a policy with has evolved with the changes in case law;
- the group explored the merits of a policy providing specific advice to professionals regarding children who were abused and the circumstances in which this may be a safeguarding issue. This issue is to be further reviewed upon the completion of an associated piece of work regarding this topic.

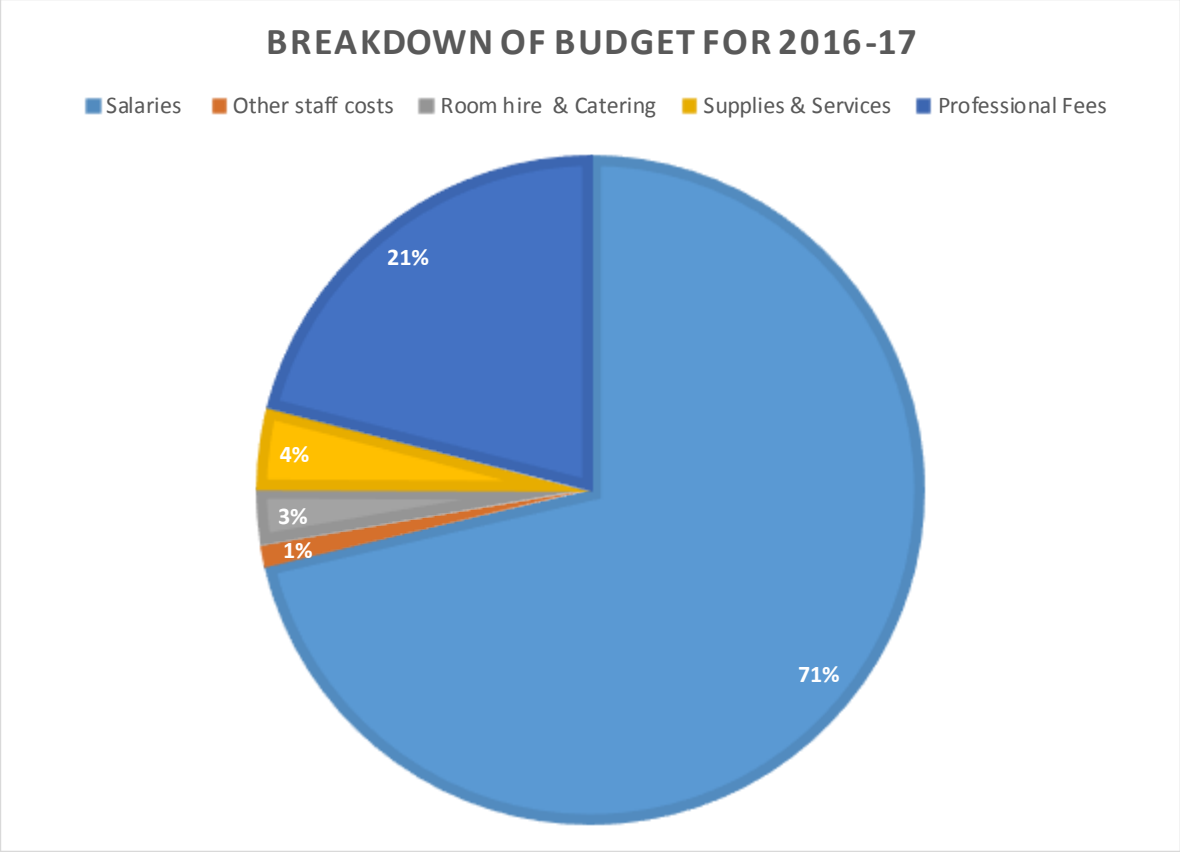
11.2. Attendance at the group is monitored to ensure that the correct representatives are present to ensure the policies and procedures are as effective as they can be and also to ensure that the policies are applied within partner organisations. The group has the benefit of an independent chair, a Safeguarding Advisor from the Derby Diocese who is well placed to resolve any conflicting aims between agencies regarding the content of policies. During this year the DSCB also appointed an Audit and Policy Officer who is able to ensure awareness and usage of the policies across the safeguarding partnership. The chart below highlights the consistent attendance of the key agencies. As with other sub-groups, attendance by a specific agency may be requested at particular meetings where a policy or piece of guidance is being discussed.



12. Budget

12.1. The DSCB is funded to undertake its statutory functions by a number of agencies. These agencies, along with the sums provided are detailed below. The importance of this area of work is reflected in the fact that agencies have continued to make the requested contributions notwithstanding other budgetary pressures which are ongoing. The DSCB budget is monitored at each board meeting and through the multi-agency core business group which meets between board meetings to ensure that actions identified at the board are progressing and that sufficient funds are in place to support this activity. The board underspend has been retained to ensure that funds are available to robustly conduct learning and improvement activity in the form of serious case reviews of serious incident learning reviews. An independent author may for example be instructed to ensure that there is public and professional confidence in any recommendations which follow from the review. It will be noted from the table below that a number of independent experts have been utilised by the board and this is reflected in the expenditure on professional fees.

	16-17 (£)	16-17 (%)
Local Authority (Derbyshire Children's Services)	154,813	46.38%
Derbyshire Police	22,033	6.60%
North Derbyshire Clinical Commissioning Group (on behalf of all Derbyshire CCG, except Tameside and Glossop CCG)	145,850	43.68%
Probation	1,765	0.53%
CAFCASS	534	0.16%
Tameside and Glossop CCG	7,069	2.12%
DLNR CRC (Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company)	1,765	0.53%
Total contributions	£333,829	100%



Category	£
Salaries	214,091
Other staff costs	3,127
Room hire & Catering	7,920
Supplies & Services	11,792
Professional Fees	62,984
Total Spend	**299,913**

13. Participation of children and young people in safeguarding arrangements

13.1. The DSCB continues to promote greater engagement by children and young people in their safeguarding arrangements. The DSCB Manager has met with the Youth Council to discuss the role and priorities of the DSCB and to seek their input in the development of the on-line safety strategy. The DSCB Chair met with the Derbyshire Children's Services participation team to explore options for the engagement of young people with the board. The DSCB Manager and Ruth Peat, Derbyshire Children's Service's Participation Officer, met with a group of young people to discuss the development of an online safety strategy. The group highlighted the wide range of sites which were being routinely accessed by young people and the areas where they considered adults and care givers were unaware that information could be shared. The information provided by the young people helped to scope the questionnaire which was given out to the cohort of young people who watched the film 'Kayleigh's Love Story' as detailed at paragraphs 11.10- 11.12 above.

13.2. Children and young people were assisted and supported in contributing their experiences to the child protection conference process by indirect and direct means. The suite of leaflets available for child protection conferences includes material specifically to assist children and young people in this respect.

13.3. The below table details the methods which are used to ensure children are enabled to participate in their 'child in care' reviews. 99.7% of children are enabled to participate within their own reviews.

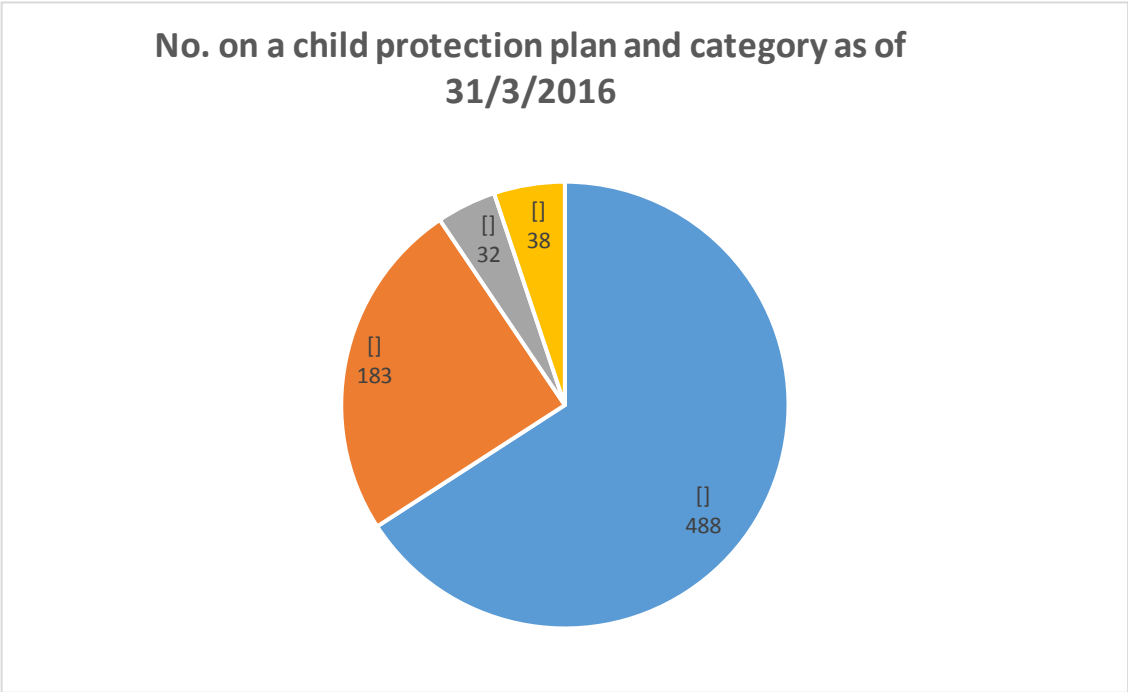
Participation Method	2016/17 Outcome (%)
Child physically attends and speaks for his/herself	72.50
Child physically attends and an advocate speaks on their behalf	1.80
Child attends and conveys his or her views symbolically	1.20
Child does not attend physically but briefs an advocate to speak for them	0.20
Child does not attend but conveys their feelings and wishes to the review by a facilitative medium	24.00

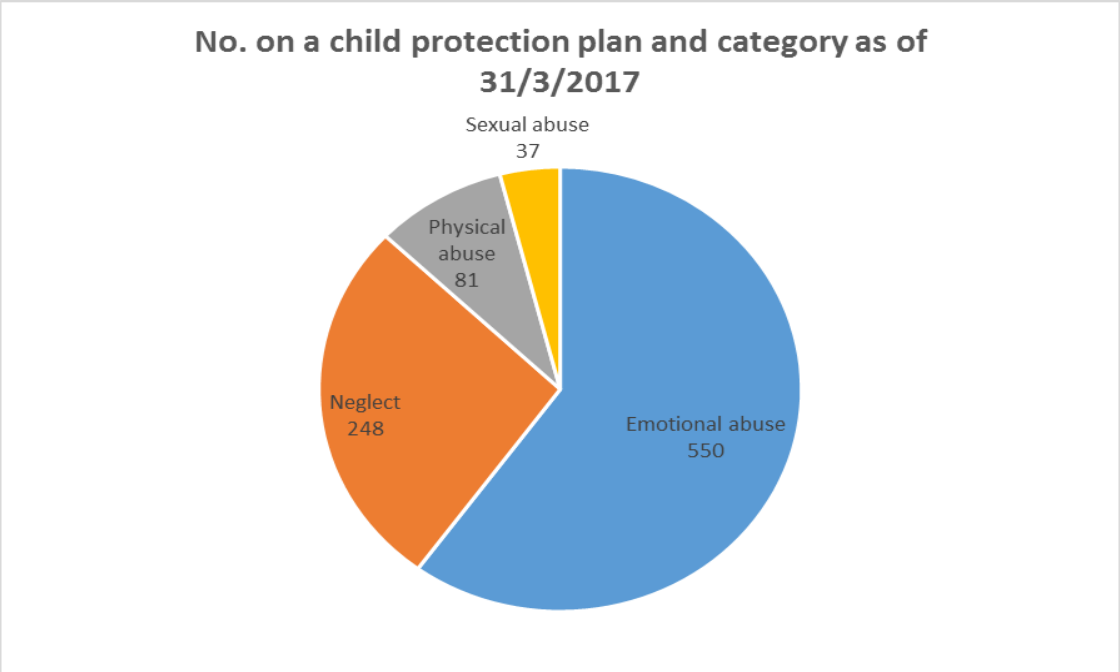
14. Child Protection

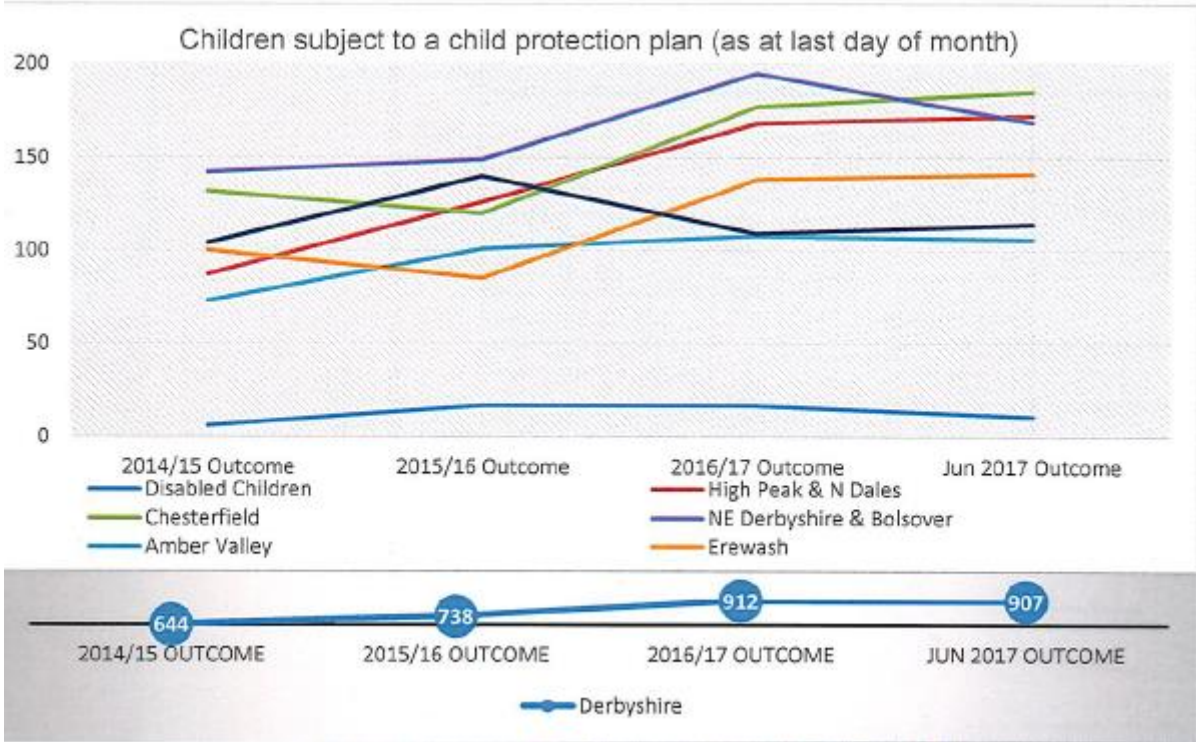
14.1. The numbers of children and young people who are subject to child protection plans has continued to rise during the course of the year. The DSCB has commissioned an independent social care expert to review the operation of child protection conferences to ensure that these are as effective as they can be and the plans developed for children provide the most effective protection for them. 81.9% of initial case conferences held resulted in a CP plan which

would suggest that in the majority of cases the decision to progress to conference from S47 is correct.

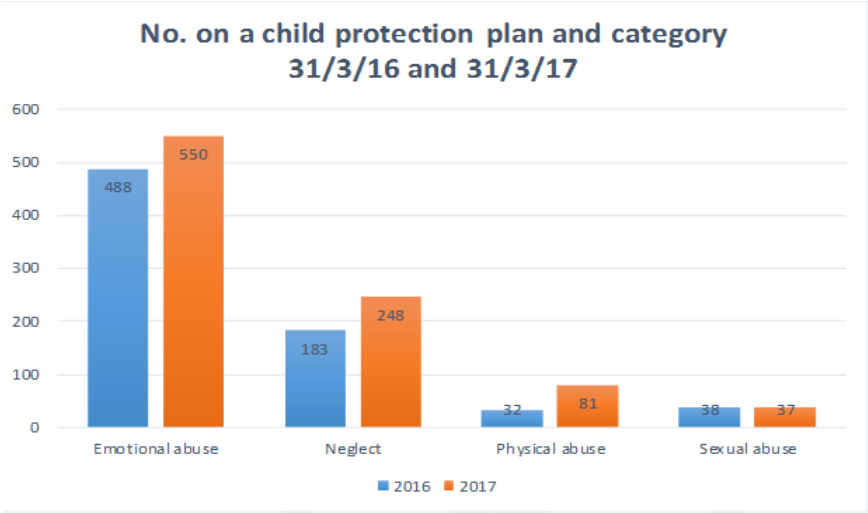
14.2. The below figures illustrate the number of children who were subject to plans and the categories of these plans as at 31/03/16 (741) and again as at 31/03/2017 (916).



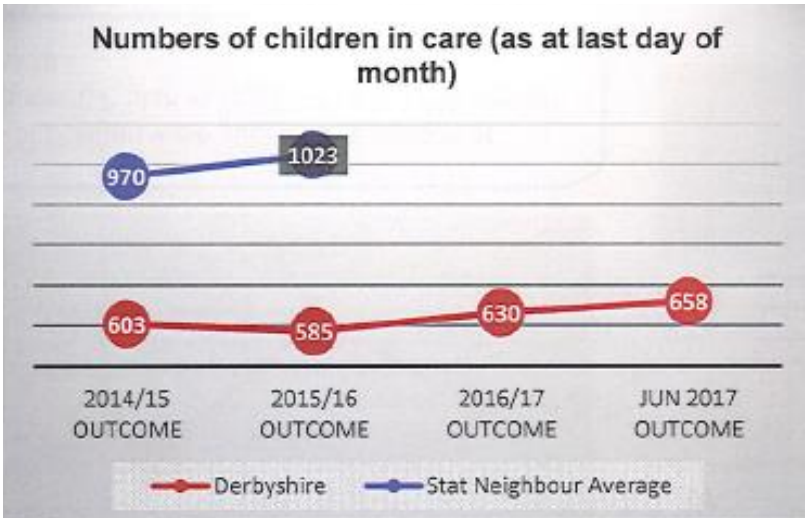




14.3. The graphics demonstrate the comparable categories of plans across the two periods. Emotional abuse is the most common reason for a child protection plan and has been since 2015. Neglect has been noted to be a steadily increasing category over this period, with 31.8% of child protection plans in 2017 being related to neglect. The work which is being undertaken around child protection plans will seek to provide assurance for the DSCB that the child protection process is effectively protecting those children and young people who need a child protection plan. The work is due to be completed in 2018. The effective identification of the risk of the abuse is one of the areas that is being actioned through this programme.

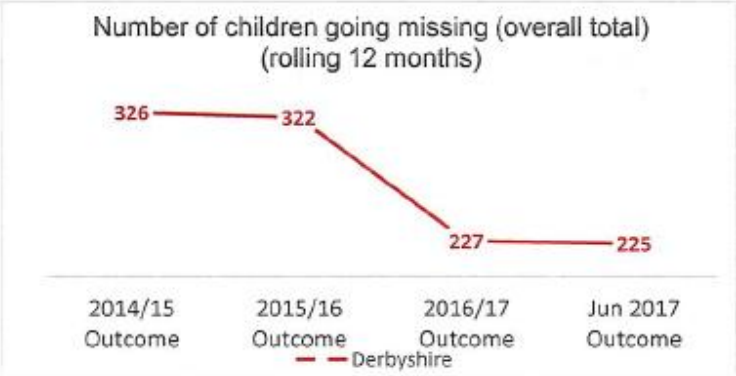


14.4. The DSCB monitors the numbers of children who are in care as part of the performance report received by the Board. It is noted that the number of children who are in the care of the local authority is increasing, although remains relatively low in comparison to the statistical neighbour average.



15. **Children who are missing**

15.1. The number of children who are going missing from home or care overnight is currently on a downward trend. In November 2016, the number of overnight missing episodes was 264. In June 2017, the number of missing episodes was 225. There has been an increase in the number of return interviews which have been conducted within 72 hours from 65% in November 2016 to 69.4 % in June 2017. This is a continuing rising trend from 57% in 2015. The DSCB monitors this figure and supports the increasing figure in prompt return interviews as this ensures that children and young people can be better protected. Their reasons for going missing and the risks they are exposed to when they go missing are identified and addressed. The DSCB is also involved in supporting the development of a regional protocol for the undertaking of return interviews, where children may be placed in neighbouring authorities.



16. Child Death Overview Panel (CDOP)

16.1. The CDOP Panel, which was established in 2008, is a statutory body and is a sub-group of both the Derby and Derbyshire Local Safeguarding Children Boards.

16.2. CDOP Statutory Functions are as follows:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether a Serious Case Review (SCR) is required;
- agreeing local procedures for responding to unexpected deaths of children;
- co-operating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths;

16.3. Derby and Derbyshire CDOP consists of two separate panels, a Neo-Natal Panel and an Older Children panel which bring together appropriate experts from a range of agencies. Both the panels are chaired by a Consultant in Public Health. The DSCB is grateful to CDOP and in particular the Chair and Vice Chair for the preparation of the CDOP annual report which was considered by the DSCB on 8th December 2017. The information contained in this section of the DSCB annual report is derived from the aforementioned report.

16.4. The Child Death Overview Panel meets regularly to review the child deaths and to ensure that respectful analysis is undertaken of any learning arising from these deaths to ensure this can contribute to increased safety for children.

16.5. In the period April 2016 to March 2017, 51 cases were considered by the panel. In addition to reviewing individual cases, the panel also discusses emerging safety messages and broader themes, and panel members are engaged in related pieces of work outside the panel. Some important work flows have included:

- further work supporting national work regarding safer manufacture and retail of nappy sacks;
- building on work undertaken in relation to consanguinity as a local risk factor including a genetic literacy training programme;
- supporting the local implementation of a new national review process for reviewing deaths of all people aged 4 and above who have a learning

disability (LeDeR);
- engaging with DH/NHS England's national review of CDOPs.

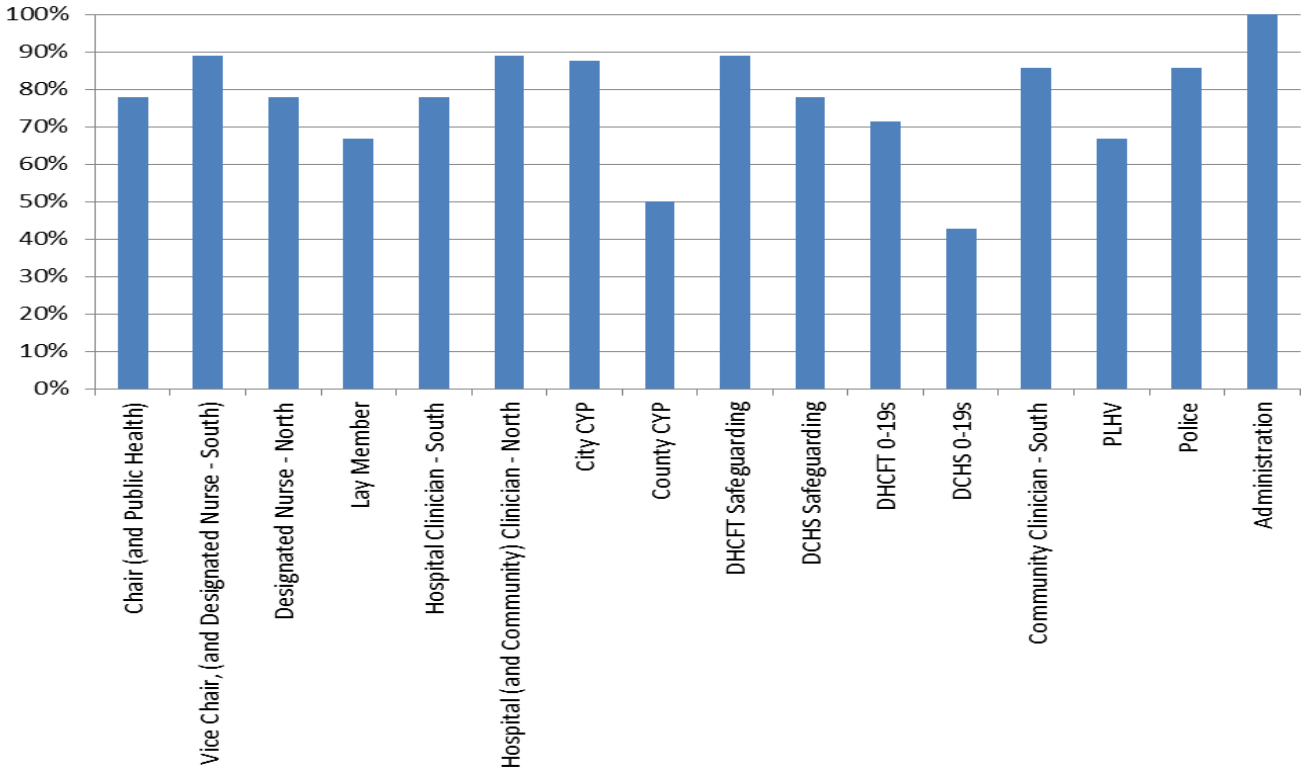
16.6. One very welcome proposed innovation is the establishment of a National Child Mortality Database (NCMD), for which a specification has been developed by the National Perinatal Epidemiology Unit (NPEU). Commissioning of the database has commenced.

16.7. It is hoped that this will lead to greater standardisation of the process of reviewing deaths in those under 18. In the meantime, every effort is made to ensure processes are robust, up to date and able to absorb any change. CDOP has measured its current processes against the 2016 revision to the guidelines for responding to sudden unexpected deaths in infants and children (SUDIC), and included this topic within the annual CDOP seminar in June 2017. The group has engaged proactively with establishing Derbyshire's implementation of the new national Learning Disability Mortality Review programme (LeDeR), which commenced operating locally in April 2017.

16.8. It is acknowledged that it is a hive of change for all organisations involved within the safeguarding arrangements for children. CDOP was included in the review of the effectiveness of the Derby Safeguarding Children Board. Ofsted judged the Derby Safeguarding Children Board to be 'Outstanding', and specifically said this about CDOP: "The child death overview panel is appropriately constituted and carries out its function well. It links to the SCR sub-group when necessary, oversees rapid response arrangements for when children die unexpectedly and promotes public health messages about relevant issues such as safer sleeping, the use of smoke alarms and nappy sack safety. This means that the board is doing all that it can to ensure the awareness is raised in the local community in the hope of prevent further deaths." CDOP is looking to continuously improve and create a forward plan for CDOP. This is itself a direct response to the above inspection, as is an ongoing review of bereavement support processes, particularly for families of children who die suddenly and unexpectedly.

16.9. The review of all child deaths involves the collation of information about the circumstances of the death, categorising the cause of death in accordance with the national dataset, determining if there are any modifiable factors that may have prevented the death and agreeing if there are any lessons to be learned in order to reduce future deaths. The Panel is highly committed to learning from any such death where possible in order to identify preventable factors at both national and local level and inform action that can be taken to reduce the number of child deaths in the future.

16.10. The death of any child is tragic, but CDOP ensures all cases discussed are sensitively and thoroughly reviewed; CDOP actively seek the views of all parents and responds to them in a timely manner. A wide range of agencies are represented on the panel. This enables an in-depth analysis to be undertaken and for learning to be derived from this.



16.11. The attendance at the Panel is monitored and consideration is given as to how the representations from relevant agencies can be most effectively made to the group and thereby contribute to the learning. The attendance has remained comparable to proceeding years.

16.12. The numbers of child deaths which have been considered by the Panel are detailed below : -

Table 1: Number and proportion of deaths reviewed grouped by local authority of residence

Local authority of residence	Number of deaths	Proportion of deaths
Derby City	**22**	**43.1%**
Amber Valley	<5	*
Bolsover	<5	*
Chesterfield	5	9.8%
Derbyshire Dales	5	9.8%
Erewash	<5	*
High Peak	<5	*
Glossop*	<5	*
North East Derbyshire	<5	*
South Derbyshire	<5	*
Derbyshire County Total	**26**	**51.0%**
North West Leicestershire	<5	*
No data	<5	*
Total	**51**	**100.0%**

*Although Glossop is part of High Peak, the areas have been separated for the purposes of this report.

16.13. The causation of the deaths has been categorised as follows:

Category of death	Number of deaths	Percentage of deaths
Perinatal/neonatal event	18	35.3%
Chromosomal, genetic and congenital anomalies	10	19.6%
Malignancy	5	9.8%
Chronic medical condition	5	9.8%
Acute medical or surgical condition	<5	*
Suicide or deliberate self-inflicted harm	<5	*
Infection	<5	*
Sudden unexpected unexplained death	<5	*
Sudden Infant Death Syndrome	<5	*
Known life limiting condition	<5	*
No data	<5	*
Grand Total	**51**	**100.0%**

These figures highlight that the majority of deaths are a consequence of a perinatal or a neo-natal event. This is therefore reflected in the age range of the children who are considered by CDOP; the highest proportion of children considered by CDOP were under 28 days of age.

16.14. The gender of those children who were considered by the Panel is reflective of the child population of Derbyshire as illustrated in the table below :-

Gender	Number of cases	Proportion of reviewed cases	Proportion of 0-17 population
Male	26	51.0%	51.1%
Female	24	47.1%	48.9%
Total	**51**	**100.0%**	**100.0%**

16.15. CDOP considers and records the contributory factors in relation to a child's death and these are illustrated in the table below:

Contributory factor	Number of reviewed cases	Proportion of all reviewed cases (51)
Acute/sudden onset illness	42	82.4%
Other chronic illness	13	25.5%
Prior medical intervention	12	23.5%
Prior surgical intervention	9	17.6%
Motor impairment	8	15.7%
Smoking by parent/carer in household	8	15.7%
Access to health care	7	13.7%
Domestic violence	6	11.8%
Smoking by mother during pregnancy	5	9.8%
Housing issues	5	9.8%
Other disability or impairment	<5	62.8%
Emotional/behavioural/mental health condition in child	<5	
Alcohol/substance misuse by a parent/carer	<5	
Poor parenting/supervision	<5	
Epilepsy	<5	
Learning disabilities	<5	
Consanguinity	<5	
Child abuse/neglect	<5	
Sensory impairment	<5	
Alcohol/substance misuse by child	<5	
Co-sleeping	<5	
Bulling	<5	
Gang/knife crime	<5	
Total number of contributory factors	**131**	

16.16. The most common contributory factors which were noted in the analysis of cases were acute/sudden onset illness and other chronic illness, both of which are intrinsic to the child. This was followed by factors relating to service provision i.e. prior medical or surgical intervention. Smoking by a parent or carer (15.7% of all cases reviewed) and domestic violence (present in 11.8% of all cases reviewed).

16.17. A key issue for CDOP is the identification of modifiable factors where potentially their work could have maximum impact in the prevention of other child deaths. The table below illustrates where modifiable factors have been identified.

Modifiability	Number of cases	Proportion of cases
No modifiable factors identified	39	76.5%
Modifiable factors identified	5	9.8%
No data (blank)	7	13.7%
Total	**51**	**100.0%**

16.18. The combination of the review of modifiable factors along with all the information gathered has enabled CDOP to develop a forward plan of actions to take forward the key learning points which have emerged.

16.19. These include the following:

- Obesity in children and young people– developing a fuller awareness and understanding of this issue and the development of guidelines to manage and improve this. This would include the mapping and signposting of relevant services. CDOP has linked in with work which is being undertaken around this issue by the Serious Case Review Sub-Committee.

- The work undertaken by CDOP has highlighted the need for bereavement support, particularly in the circumstances of a sudden unexpected child death. CDOP propose to map the availability of support and consider whether a unified information resource would be of assistance.

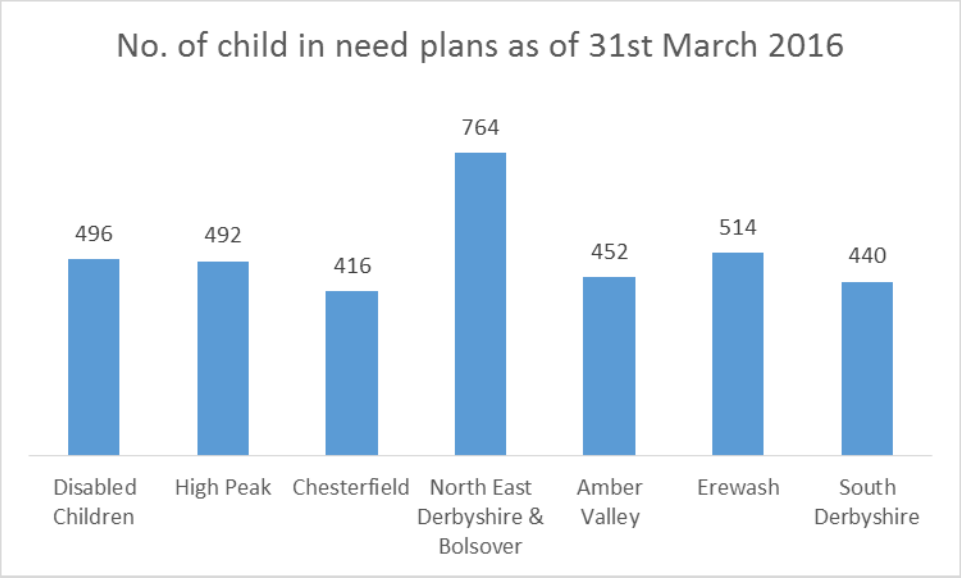
- Consanguinity – following the presentation on consanguinity at the CDOP 2016 seminar funding was secured to provide genetic literacy training to front line staff working within target communities. The production of a leaflet regarding cousin marriage is being considered.

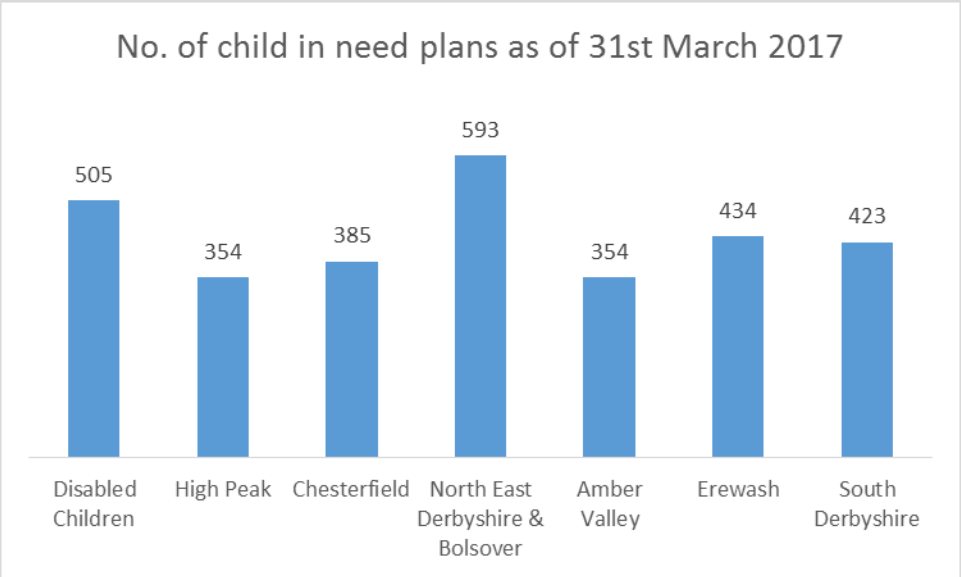
- Accident prevention - CDOP will continue to work very closely with RoSPA in order to reduce accidents within the home and also to continue to promote the safe sleeping message.

16.20. CDOP will continue to contribute to the ongoing discussions regarding the organisation of multi-agency safeguarding arrangements to ensure that the most effective role can be undertaken.

17. Children In Need

17.1. The numbers of children in need for the periods ending 31/03/16 and 31/0/17 are illustrated below. The figures demonstrate that as at the 31st March 2016 there were 3,574 children deemed to be in need and then at 31st March 2017 there was 3,048. Taken in conjunction with the increasing child protection figures it would suggest that the circumstances of more children are meeting the threshold for child protection intervention. The contributory factors to this might include greater awareness and identification of child protection issues (as reflected in the increasing numbers within this cohort) and/or it could be a reflection that an increasing number of children are being effectively assisted prior to reaching the threshold for child in need. The DSCB will continue to monitor the data for this area alongside the detailed work being undertaken in relation to child protection.





18. Partner Agency Safeguarding Reports, (S11) Audit and Analysis

18.1. Section 11 (Children Act 2004) requires DSCB partner agencies to undertake an audit to provide evidence to the Board that they are meeting their legal requirements in terms of safeguarding arrangements. This year a different approach has been initiated for the Section 11 audits using a combined audit tool with Derby Safeguarding Children Board. The Derby and Derbyshire Safeguarding Children Boards strengthened the Section 11 process that is completed by agencies, including updating the audit forms and guidance documentation to ensure that agencies provide consistent and clearly illustrated feedback and analysis of whether standards are being met. Agencies were individually audited by representatives from the Derbyshire/Derby City Boards, and relevant representatives from health organisations, to assure compliance of each agencies self-assessment with the agreed standards. The face to face meetings also

provided an opportunity to gather additional evidence of compliance and impact and to test whether suitable arrangements were in place.

18.2. The Quality & Performance sub-group will obtain updates from agencies to demonstrate the changes that had been brought about by activity arising from the Section 11 self-assessments that had been carried out in the previous year. A report summarising the updates will be presented to the Quality Assurance sub-group. This report will describe how agencies have demonstrated the action taken as a result of previous audits. As a result of the updated process partner agencies were able to provide a greater level of detail, demonstrating those issues that have changed or emerged, linked to the S11 standards, over the last year and what has been done to improve safeguarding arrangements.

18.3. Examples of the additional evidence gathered as part of this process has included the following :

- Derbyshire Community Healthcare Foundation Trust detailed a virtual platform that has been created to support whistleblowing and referrals to the Local Authority Designated Officer and which hosts numerous documents to signpost and support employees.

- East Midlands Ambulance Service have created an information booklet for paramedic and staff for use with patients who don't communicate in the English language. To assist in helping the patient communicate where and what level of pain they are experiencing. A link is contained within the booklet to enable prompt access to a vast list of translators. This will ensure that appropriate medical treatment is secured promptly and children and young people would be assisted in reporting any safeguarding concerns.

- Derbyshire Health United demonstrated an open door policy encouraging staff to discuss any safeguarding concerns prior to them being formally referred. This ensure that concerns were identified and reacted to at the earliest opportunity.

19. Allegations against staff, carers and volunteers (LADO)

19.1. The Local Authority Designated Officer service considers and advises in relation to allegations against staff, carers and volunteers. The following information relates to the period 01/04/16–31/03/17. The information was scrutinised on this occasion by multi-agency representatives of the DSCB.

Allegations referred to the LADO

19.2. There were 388 referrals submitted to the LADO for consideration between 1st April 2016 and 31st March 2017 compared with 362 for the same period 2015/2016 and 349 for 2014/2015. Again, the figures indicate a continual rise in the numbers of referrals year on year. This no doubt reflects a growing awareness and alertness to safeguarding issues.

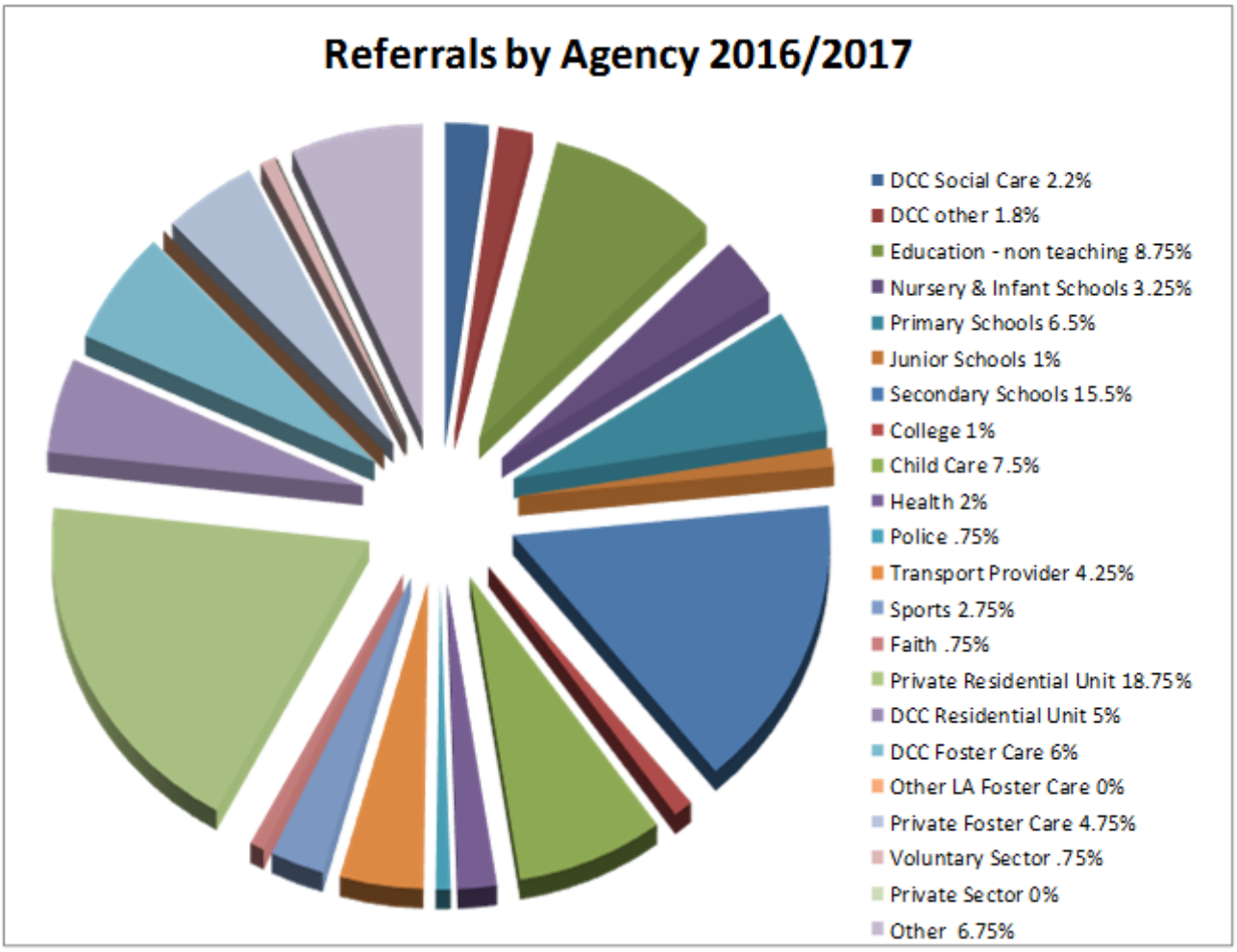
19.3. Of the 388 referrals received 84 resulted in an Initial Strategy meeting being

convened and 16 of those required a further review.

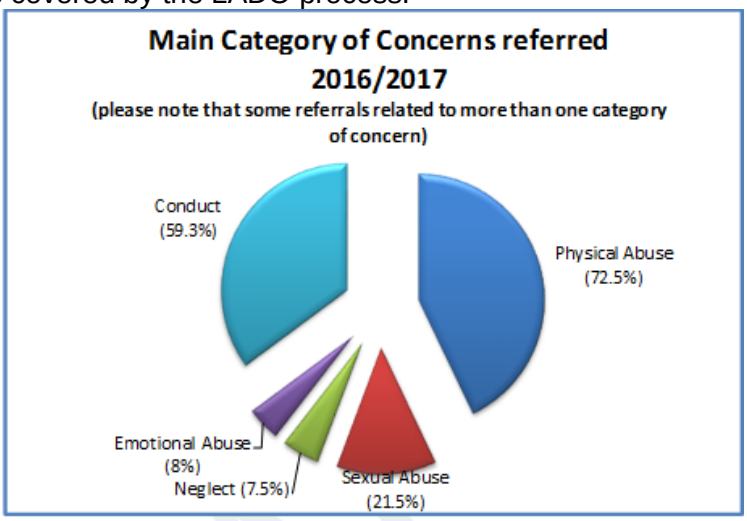
Category of concern by agency

AGENCY	2013/2014	2014/2015	2015/2016	2016/2017
DCC Social Care	6	6	5	9
DCC other			3	7
Education teaching staff	92	97	*	
Education other	20	20	*	34
Education (Teaching) – Nursery & Infants			*	13
Education (Teaching) – Primary School			*	25
Education (Teaching) Junior School			53	4
Education (Teaching) Secondary School			52	60
(College) Further/High education	3	2	3	4
Child Care	9	19	20	29
Health	4	10	14	8
Police	3	2	5	3
Transport Provider			14	16
Sports			14	11
Faith Group			**6**	3
Private Residential Unit	47	54	44	73
DCC Residential Unit	12	26	16	19
DCC Foster Care	18	22	19	23
Other LA Foster Care	3	0	2	0
Private Foster Care	13	15	17	18
Voluntary Sector	18	4	7	3
Private Sector			22	0
Other	50	72	46	26
Total	298	349	362	388

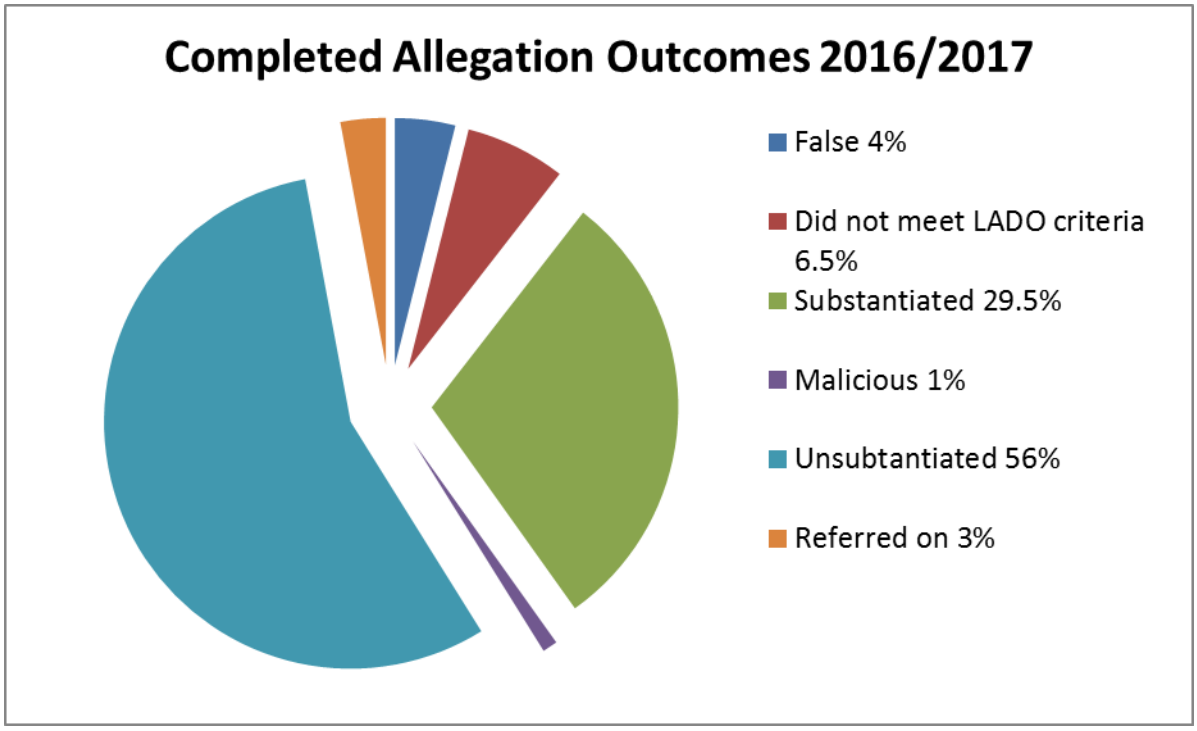
*in 2015-2016 the reporting methodology used did not differentiate across the education sector (from 2016 onwards reporting has fallen in line with Derby City to indicate which level of establishment referrals came from).



19.4. Private residential units comprised the largest category for referrals. This would perhaps be anticipated given the 'round the clock' care role they have in a young person's life. Similarly, secondary schools comprise the second largest category reflecting the number of children and families who would have contact with staff members covered by the LADO process.

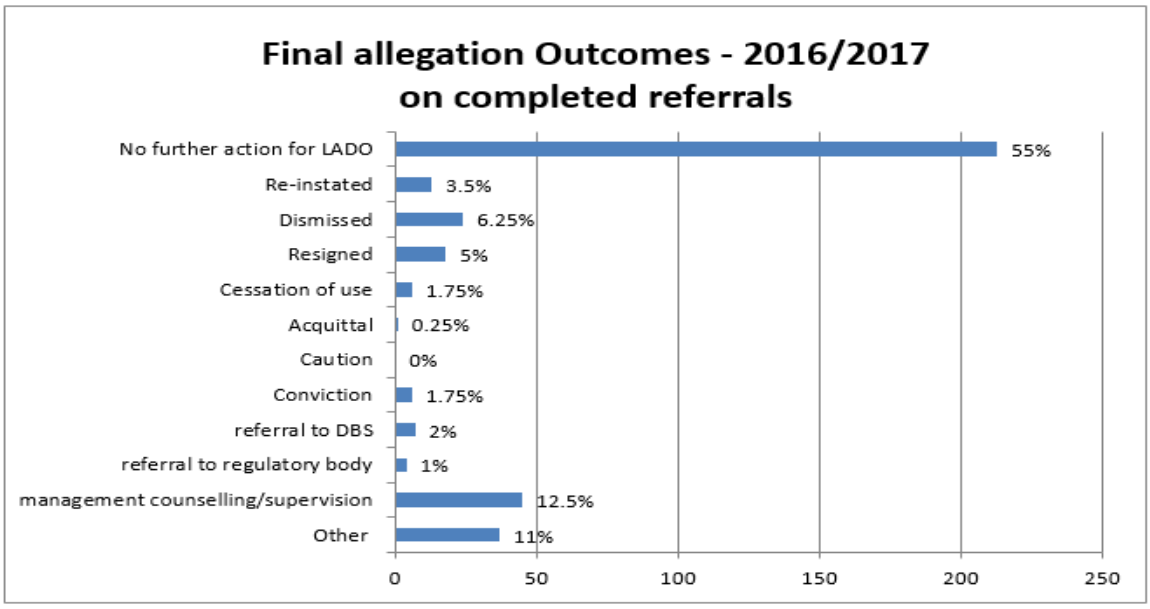


Investigation Action 2016/2017 – on completed referrals	
No Further Action	7.5
Disciplinary Procedures	4
Section 47	1.5
Police Enquiries	12.5
Criminal Investigation	8
Internal Investigation	42.5
Suspended During Investigation	7.5
Resigned During Investigation	4.5
Other	12



19.5. The outcome categories remain the same as stipulated by Government guidance.

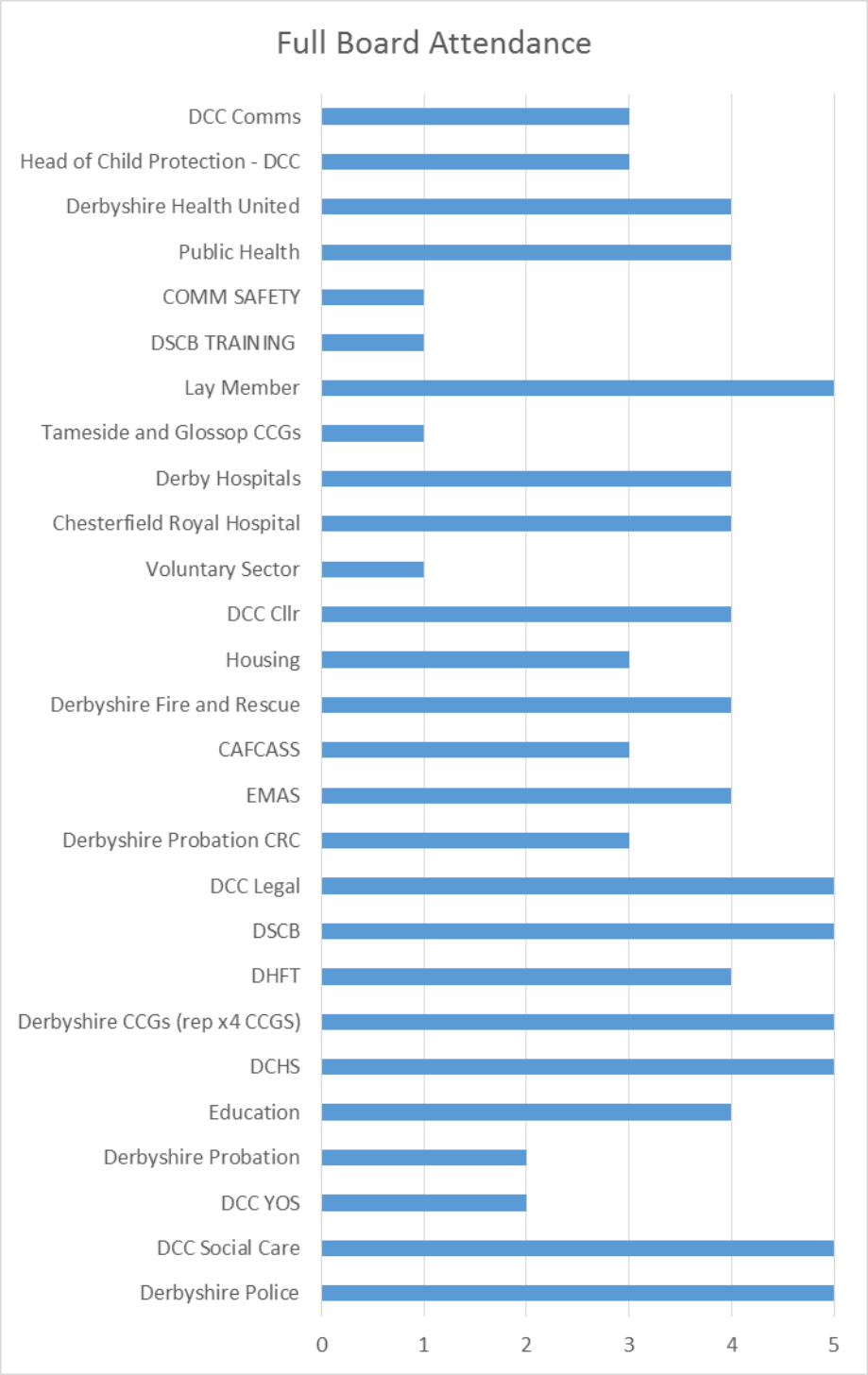
- **Substantiated:** There is sufficient identifiable evidence to prove or disprove the allegation.
- **False:** There is sufficient evidence to disprove the allegation.
- **Malicious:** There is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.
- **Unsubstantiated:** This is not the same as a false allegation. It simply means that there is insufficient identifiable evidence to prove the allegation. The term therefore does not imply guilt or innocence.



20. Attendance Monitoring and Membership

20.1. As detailed above at section 4 the DSCB reviews regularly the attendees of the DSCB and sub-groups to ensure that the representatives are best placed to make the key decisions which will impact positively on safeguarding arrangements in Derbyshire. The below chart illustrates the agencies who regularly attend the main board meetings. The attendance of some representatives may not be sought at all meetings dependent upon the topics for consideration. The three agencies (Children's Social Care, Health and the Police) who will be responsible for leading the new Multi-Agency Safeguarding Arrangements (MASA) as required by the Children and Social Work Act 2017 maintain a constant presence at all key meetings. In addition to the main board and sub-groups which have been detailed there the DSCB also co-ordinates a meeting of the Chief Officers of agencies to hold them to account as regards their safeguarding responsibilities. An example of this is that agencies have been asked to and have provided assurance that safeguarding will remain a priority not withstanding budgetary pressures or transitional activity.

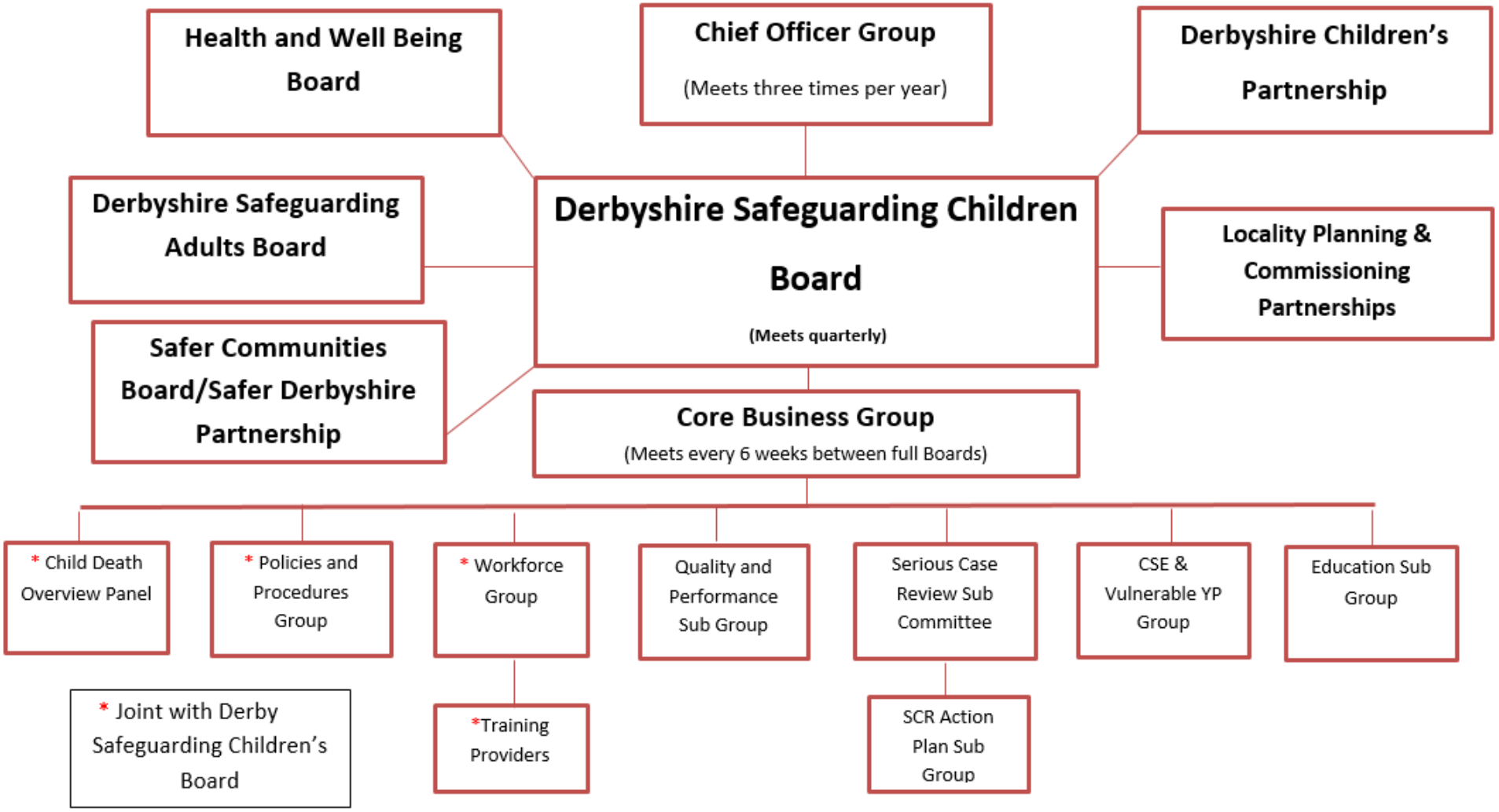
20.2. The DSCB would like to thank all the agencies which contribute to the work of the DSCB for their commitment to safeguarding the children and young people of Derbyshire.


Full Board Attendance
DCC Comms
Head of Child Protection - DCC
Derbyshire Health United
Public Health
COMM SAFETY
DSCB TRAINING
Lay Member
Tameside and Glossop CCGs
Derby Hospitals
Chesterfield Royal Hospital
Voluntary Sector
DCC Cllr
Housing
Derbyshire Fire and Rescue
CAFCASS
EMAS
Derbyshire Probation CRC
DCC Legal
DSCB
DHFT
Derbyshire CCGs (rep x4 CCGS)
DCHS
Education
Derbyshire Probation
DCC YOS
DCC Social Care
Derbyshire Police
0
1
2
3
4
5

DSCB Membership 2016- Appendix 1	
Member	Role
Chris Cook	Independent Chair Derbyshire
Jane Lakin	Interim Board Manager – DSCB
DS Mark Knibbs	Head of Public Protection, Derbyshire Constabulary
Heather Summers	Head of Housing Services - Rykneld Homes
Karen Barden	Acting DCC Children's Services Head of Child Protection
Lynne Greenhough	Headteacher (Secondary Education representative)
Carolyn White	Director of Quality/Chief Nurse, Derbyshire Community Health Services
Jane Parfrement	Strategic Director of Derbyshire Children's Services, Derbyshire County Council
Janice Ward	Service Manager - CAFCASS
Jayne Stringfellow	Chief Nurse and Quality Officer NHS North Derbyshire CCG
Jim Connolly	Chief Nurse, Hardwick CCG
Charlotte Dunkley	Head of National Probation Service Derbyshire LDUs
Grace Strong	Assistant Chief Executive of the DLNR Region, CRC
Kathy Webster (Vice Chair of the DSCB)	Consultant/Designated Nurse Safeguarding Children
Natalie Amey	Principal Solicitor, Derbyshire County Council Legal Services
Lynn Woods	Chief Nurse, Southern Derbyshire CCG
Ali Noble	Service Director for Early Help and Safeguarding, Derbyshire Children's Services.
Hazel Chamberlain	Lead Designated Nurse Safeguarding, Tameside and Glossop CCG
Munera Khan	Designated Doctor, Tameside and Glossop CCG
Patricia Field	Designated Doctor for Safeguarding Children Derbyshire
Peter Bainbridge	Derbyshire Representative EMAS
Dave Bond	Head of Youth Offending Service, Derbyshire County Council

DSCB Membership 2016	
Member	Role
Carolyn Green	Director of Nursing and Patient Experience, Derbyshire Healthcare NHS FT
Alex Johnson/ Davinder Johal	Head of Prevention & Inclusion, Derbyshire Fire and Rescue Service
Councillor Alex Dale	Cabinet Member for Young People, Derbyshire County Council
Cathy Winfield	Executive Director of Patient Experience and Chief Nurse, Derby Teaching Hospitals NHS Foundation Trust
Lynn Andrews	Director of Nursing & Patient Care, Chesterfield Royal NHS Foundation Trust
David Peet	Chief Executive, Office of the Derbyshire Police and Crime Commissioner
James Drury	Executive Director of Chesterfield Borough Council
Alison Pritchard	Public Health Consultant, Derbyshire County Council
Jenny Tilson	Executive Director Of Nursing & Quality, Derbyshire Health United
Lay Members	
Miry Gosling	Lay Member
Stephanie Marbrow	Lay Member

DSCB structure - August 2017



Glossary of terms and abbreviations

CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Children and Adolescent Mental Health Service
CCG	Clinical Commissioner Groups
CDOP	Child Death Overview Panel
CME	Children Missing Education
Comm Safety	Derbyshire County Council, Community Safety
CPC	Child Protection Plan
CSE	Child Sexual Exploitation
DCC Comms	Derbyshire County Council, Public Relations and Communication
DCC YOS	Derbyshire County Council, Youth Offending Service
DCHS	Derbyshire Community Health Services
DHFT	Derbyshire Healthcare Foundation Trust
DHU	Derbyshire Health United
DLNR CRC	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company
DoLS	Deprivation of Liberty Safeguards
DSCB	Derbyshire Safeguarding Children Board
EMAS	East Midlands Ambulance Service
FGM	Female Genital Mutilation
LADO	Local Authority Designated Officer
LeDeR	Learning Disability Mortality Review Programme
LFJB	Local Family Justice Board
LSCB	Local Safeguarding Children Board
NCMD	National Child Mortality Database
NPEU	National Perinatal Epidemiology Unit
NPS	National Probation Service

PCC	Police and Crime Commissioner
QA	Quality Assurance
Safe and Sound	http://safeandsoundgroup.org.uk/
SCR	Serious Case Review
SILR	Serious Incident Learning Review
SUDIC	Sudden Unexpected Deaths in Infants and Children