Vulnerable Children and Young People
JSNA

Derby City Council

Version 9 – April 2016
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Priorities:

**Working together to close the gap**

Working together to target services effectively towards vulnerable groups including; children in care and children living in poverty to increase their opportunities, reduce inequalities and improve outcomes against the Boards' three priority outcomes...

- Children and young people are safe
- Better educational attainment
- Improved health and well-being for children and young people

The key priorities identified throughout the JSNA for Derby City relating to early intervention, early help and improved health and well-being prevention outcomes:

- Responding to the changing population needs and ensuring access to appropriate services
- Ensuring voice of service user helps shape commissioning decisions
- Recruitment and retention of a skilled workforce
- Building community resilience; empowering families and communities
- Improved accessibility to services
- Managing current and future demand within current service provision
- Improve the emotional resilience and mental health of children and young people
- Children and young people are safeguarded and protected from harm
- Children and young people are supported to achieve and attain
- Partnership approach to working with families ‘Think Family’
- Early help and prevention services improve outcomes for children, young people and families
- Negative risk taking behaviour is reduced
- The key priorities identified throughout the JSNA for Derby City relating to early intervention, early help and improved health and well-being prevention outcomes:
Executive Summary

This is what we’ve learnt:

- Increasing demand for services across all tiers of support
- Changing population and demography trends
- Deprivation and high levels of inequalities across wards
- Increasing emphasis on the emotional health and well-being of children and young people

How our delivery model has responded:

- The Children and Young People’s Department is committed to ensuring early help is available to vulnerable young people and their families in order to prevent them from requiring (more costly and socially damaging) higher tariff services in the future.
- We are supporting 2110 families with complex needs over the next five years (2015-20) through the Priority Families Programme, following the launch of the expanded programme.
- The demand for Children’s Social Care is continually reviewed and resources are allocated from other locality teams when demand meets the thresholds.
- A new family support scheme is due to be introduced in locality 3 during August 2015 to address high levels of Child Protection and Children In Care from this locality.

More to do:

- Gather intelligence from service users to ensure that can help us to continually improve the services we offer.
- Use learning from transformation programmes to inform the development of a local delivery model for lower level needs.
- Compliance with statutory visiting requirements is a key priority improvement area in 2016/17.
- Moving forward there is increasing priority to engage and recognise the value of fathers to children.
- A key priority is to address the emotional health and well-being of Looked after Children by creating a merged service as part of the transformation plan for Future In Minds.
Executive Summary - Introduction

Introduction:

The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of the local population.

The purpose of the JSNA and the Health and Wellbeing Strategy, is to improve the health and wellbeing of the local community and reduce inequalities for all ages.

One of the principle aims of the JSNA is to support the development of evidence-based priorities for local commissioning plans and activity which will improve the public’s health and reduce inequalities; developing the whole health and social care response so it more closely meets the wants and needs of local people.

This JSNA presents a range of information on local vulnerable children and young people showing their journey through our services, identifying their needs and concluding with our priorities and plans.

Further supporting information on the broader health and wellbeing of children and young people within the city can be found in the appendices at the end of the document.

The Derby City approach

The JSNA is an on-going process that provides a comprehensive analysis of current and future needs of children and young people within Derby City to inform commissioning of services that will improve outcomes and reduce inequalities. To do this, needs assessments gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice.

A steering group has taken responsibility for the JSNA, key decisions regarding the development and maintenance of our JSNA are made by this group and this is implemented by a dedicated coordinator and a larger group across the local authority, involved in producing the content. Our JSNA is published online and is designed to be user friendly, publicly accessible and interactive.

We use a standard template for our chapters to ensure quality and consistency across the JSNA. We have a rolling update programme in Derby City and aim for all chapters to be updated within a yearly cycle as latest data becomes available. Please reference ‘Derby City JSNA’ if making use of any of our content.
Executive Summary - Demography

Derby is a small, culturally diverse city with a population of 251,423 representing 182 nationalities, speaking 71 languages and 83 distinct dialects. It lies upon the banks of the River Derwent and is located in the south of the county of Derbyshire. It is an internationally renowned centre for advanced transport manufacturing, encompassing Rolls-Royce, Bombardier Transportation and Toyota Manufacturing.

Approximately 25% of Derby's population are from BME communities, with its largest ethnic group comprised of the Asian/Asian British community. Derby's ethnic diversity is mirrored by its great variations in levels of deprivation.

Overall, the city is within the 25% most deprived areas in the country. Pockets of deprivation are mainly concentrated within Arboretum, Normanton, Sinfin and Alvaston, all within the top 10% most deprived areas in England. These wards are characterised by high rates of unemployment and households with a lower than average annual income. Conversely, Allestree and Mickleover are amongst the least deprived 10% of wards in the country.

This translates into vast health inequalities between Derby's wards. For example, a child born in Allestree could expect to live up to 12 years longer than a child born in Arboretum.

Derby is served by one upper-tier local authority, Derby City Council and one clinical commissioning group – Southern Derbyshire CCG (which also covers the south of the county). The city has 17 electoral wards. NHS Southern Derbyshire CCG is organised into four localities, two of which are within Derby City. The CCG localities are formed of groups of interested practices rather than being based on specific geographies.

Derby is home to more than 250,500 residents living in 103,000 households, 8,000 single parents, 357 couples in a same-sex relationship, 335 British Sign Language (BSL) users, 3,500 people without central heating, 20% of the population with a long-term illness, over 180 nationalities, 29% of households without a motor vehicle, 30% of households being home to a sole person and a population that will increase to 275,000 by 2021.

Source: Derby and Derbyshire Pharmaceutical Need Assessment 2015
Population Projections:

These projections show what population levels would result if assumptions about future migration, fertility and mortality were exactly realised. The assumptions underlying the calculation of the projections are based on recent demographic trends and do not reflect the impact of future policies:

- 3,300 more children aged 0-4 years;
- an additional 5,500 people aged 20-29;
- 2,900 more people aged 60 plus,
- including 1,200 more people aged 75 plus
- and 1,000 more people aged 85 plus.
- Our BME community has increased from 15.7% to almost 25%.
- Immigration is a key consideration for the city. In total, 34,600 individuals (14%) were born outside of the UK.

Source: Derby and Derbyshire Pharmaceutical Need Assessment 2015

Population Projections:

These projections show what population levels would result if assumptions about future migration, fertility and mortality were exactly realised. The assumptions underlying the calculation of the projections are based on recent demographic trends and do not reflect the impact of future policies:

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
<th>Change 2012-37 (number)</th>
<th>Change 2012-37 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>123,900</td>
<td>129,300</td>
<td>134,100</td>
<td>138,400</td>
<td>142,500</td>
<td>146,300</td>
<td>22,400</td>
<td>18.08%</td>
</tr>
<tr>
<td>Females</td>
<td>126,700</td>
<td>130,600</td>
<td>134,400</td>
<td>138,100</td>
<td>141,700</td>
<td>145,000</td>
<td>18,300</td>
<td>14.44%</td>
</tr>
<tr>
<td>Total</td>
<td>250,600</td>
<td>259,900</td>
<td>268,400</td>
<td>276,500</td>
<td>284,200</td>
<td>291,300</td>
<td>40,700</td>
<td>16.24%</td>
</tr>
</tbody>
</table>

The Derby City population is projected to increase by 25,900 to over 270,000 by 2027. This increase is equivalent to an average annual rate of growth of 0.6 per cent.

If past trends continue, the population will continue to grow, reaching over 290,000 by 2037. This is due to natural increase (more births than deaths) and because it is assumed there will be more immigrants than emigrants (a net inward flow of migrants).

Source: Office for National Statistics
Maternity and Infancy:

What happens in a baby’s first years has a big effect on how healthy he or she will be in the future. This section explores some of the key outcomes for our infants that will help us to ensure that we give them the best start in life.

• Almost 6 in every 1,000 babies born in Derby die before their 1st birthday.
• In Derby 92.6% of 2 year olds are vaccinated for MMR.
• 8.8% of new-borns in Derby are of a low birth weight.
• In Derby only 4 in 10 mothers continue to breastfeed at 8 weeks
• In Derby 15.2% of mothers smoke while pregnant.
• 2,350 children living in Derby are classed as being "in need".

Children:

This section explores their needs, including take-up of vital immunisation programmes, the lifestyle choices adopted by them and their parents, as well as their learning potential.

• In Derby 465 children are in care.
• 1 in 5 living in Derby claim free school meals
• 1 in 5 Year 6 children in Derby are obese.
• There are 10,000 young people living with a disability in Derby.
• In Derby 93.5% of young girls are immunised for HPV.

Young People:

To ensure that children develop well through their schooling and into adulthood, we need to first understand their behaviours and external influences on them at that age. This section looks at some of these influences on their lives.

• 1 in 20 young people aged 10 to 24 years are hospitalised for self-harm in Derby.
• 1,500 in every 100,000 people aged 15-24 years in Derby have a sexually transmitted infection.
• 307 children and young people living in Derby are the subject of a child protection plan
• 425 families in Derby were identified as ‘Priority Families’ during phase 1 of the programme.
• In Derby 1,038 per 100,000 children and young adults become first time entrants to the youth justice system.

Source: Derby and Derbyshire Pharmaceutical Need Assessment 2015
Deprivation:

32% of Derby’s under 18’s live in the most deprived wards compared to a ‘usual resident’ population of 26%. The most deprived wards in the City are:

- Derwent (Locality 1 and 5)
- Sinfin (Locality 2)
- Arboretum (Locality 3 / 4)
- Normanton (Locality 3 / 4)

All the above wards have a higher than average population of 0 – 17 years olds.

Over the last year (2013 – 2014) there has been a significant increase in the demand for social care services in Derby City.

In many instances the rises that have been seen over the last three years follows a decline in demand:

- Multi-Agency Team (MAT) / targeted cases – 39% increase
- Social Care referrals – 10% increase
- Children in Need (CIN) cases (all cases as per the CIN return) – 25% increase
- Children Protection Plans (CPP) – 33% increase
- Youth offending are working with 35% more young people
- Special Educational Needs (SEND) out of area have risen by 21% at the end of October 2014 from the end of March 2014
- The number of applications for primary school places have increased year on year; with over a 10% increase from 2010 to 2014

The overall demand for support services in relation to safeguarding is increasing nationally and has been rising in some areas since 2007/08 as illustrated by The Association of Directors of Children’s Services (ADCS) pressures published at the start of 2015, where 67% of authorities participated.

*See appendix 7 for Ward and Locality information*
The maps below highlight the variation in children in need, children in care and children with a child protection plan in place by Ward in Derby. It is apparent that children residing in the Normanton area have a consistently high need for support from the Local Authority and wider partner agencies. Other neighbourhood areas with a high proportion of vulnerable children include Arboretum, Sinfin and Derwent Wards.

**Children in Need:**

The greatest proportion of CIN can be found in Sinfin Ward (11.5%), followed by Arboretum (10%) and Normanton (9.6%) areas. The lowest proportion of CIN can be found in Allestree (1.1%). Derby is a multicultural city with varying health and care needs. The highest rate of alcohol-specific hospital admissions can be found in Sinfin, which is also home to the greatest proportion of those not in education, employment or training. Arboretum Ward has the highest rate of first time entrants to the Youth Justice System.

**Child Protection Plans:**

Normanton (13.1%) followed by Derwent (12.7) Ward have the highest proportion of children with a child protection plan in place in Derby. Allestree (0%) followed by Mickleover and Darley (0.6%) Wards have the lowest proportion. Derwent has the highest rate of 0-14 year olds being admitted to hospital in an emergency for reasons of injury (unintentional and deliberate). In Normanton there are greater than average (for England) levels of unemployment and overcrowding. Both areas have high proportions of teenage pregnancy.

**Children in Care:**

Thirteen percent of children and young people aged 0-18 in care are from Normanton, Derwent and Sinfin areas, followed by 12% in Arboretum. Sinfin is home to the greatest proportion of children living in poverty in Derby, as well as our highest proportion of ‘Priority Families’. Arboretum children show some of the lowest levels of development at age 5, while those in school Year 6 in Normanton are among the most overweight/obese. Of interest is Littleover Ward, one of the city’s least deprived areas but with 5% of children in care. are from this area.
The priorities in this JSNA report are closely aligned with the strategic direction in Derby as set out in the Children and Young People’s Plan 2015 – 2018, our partnership strategy to work together to target services effectively towards vulnerable groups.

The strategy sets the direction for delivering services and programmes that make a difference to the health and wellbeing for children and young people in Derby across the course of their lives. It sets out the priorities we have identified around:

• Early help, prevention and self-help, early learning, school readiness and early year's outcomes.
• Improved health and well-being.

Derby is a complex city which means that partners have very specific priorities that are they are working towards in their individual service areas for children, young people and their families and carers. We work together for:

Our people, our places, our city: Through the Derby Plan 2030
To deliver: A safe, strong and ambitious city to live, for your: start in life, working life, later life

Local Priorities:
For 2015 and beyond members of the Children, Families and Learner's Board (CFLB) will continue to work with the aspiration of the Children and Young Peoples Plan that the Board set in 2013:

Working together to close the gap - Working together to target services effectively towards vulnerable groups including; children in care and children living in poverty to increase their opportunities, reduce inequalities and improve outcomes against the Boards' three priority outcomes:

• Children and young people are safe - Partners of the Board will work together and with the Derby Children's Safeguarding Board to keep children and young people safe through making sure that they have access to good quality services at the earliest opportunity, reducing the likelihood of them being exposed to or participating in 'risky' behaviours. During 2015/16 the focus for the CFLB will be on early help, prevention and self-help.
• Better educational attainment - Working together with all education settings across the city to prepare children and young people for school and providing access to ‘good quality' educational provision to raise attainment at all levels supporting in more young people being work ready. In 2015/16 the focus for the CFLB will be on access to early learning, school readiness and early year's outcomes.
• Improved health and well-being for children and young people - Working together with Derby's Health and Well-Being Board to improve the health and well-being of children and young people through prevention initiatives, clear pathways to care and the delivery of the seven agreed integrated commissioning intentions.

Source: Derby City Council Children and Young People’s Plan 2013 – 2015
### Executive Summary - Key Highlights

Key performance highlights against children and young people plan (2013-2015):

<table>
<thead>
<tr>
<th>Key highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>More children and young people are safe:</strong></td>
</tr>
<tr>
<td>• 5.6% increase in Looked After Children (LAC) during 2014 to 2015</td>
</tr>
<tr>
<td>• Child Protection Plans (CPP) rates have increased and remain above comparator averages</td>
</tr>
<tr>
<td>• The number of early help assessments completed has increased</td>
</tr>
<tr>
<td>• First time entrants to the Youth Justice System have fallen</td>
</tr>
<tr>
<td>• The number of families supported through the Priority Families programme has increased, with our target of 600 families by the end of the first phase in May 2015.</td>
</tr>
<tr>
<td><strong>Better educational attainment:</strong></td>
</tr>
<tr>
<td>• Take up of free childcare has increased with Derby performing very highly across the region in those eligible 2-year olds</td>
</tr>
<tr>
<td>• Early Years Foundation Stage (EYFS) has improved and is now in line with the comparator authority average</td>
</tr>
<tr>
<td>• Young Person who are Not in Education, Employment, or Training (NEET) and unknowns have both improved</td>
</tr>
<tr>
<td>• Quality of education has improved – Early years and maintained schools</td>
</tr>
<tr>
<td>• Phonics and GSCE’s are key areas for improvement alongside closing the gaps with vulnerable groups across all Key Stages</td>
</tr>
<tr>
<td><strong>Improved health and well-being for children and young people:</strong></td>
</tr>
<tr>
<td>• 88.5% of children in care had their annual health assessments. This is the highest performance we’ve seen over the past 5 years.</td>
</tr>
</tbody>
</table>
Our Child’s Journey
An illustration of the scale of social care need in Derby City, the chart below shows a snapshot of the demand for children's social services over the financial year 2014-15, data from March 2015 (2013-14 figures in brackets). The diagram breaks the figures down to a number of ‘staged’ groups but due to the fluid nature of service provision caution should be taken in presuming each stage is a natural flow from the previous one.
Our Child’s Journey

This table illustrates the support pathway for families; it describes the levels of support and the processes by which practitioners can help children and families based on the complexity of needs within the family.

<table>
<thead>
<tr>
<th>Possible Indicators</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal Services:</strong> Children and young people whose needs are being adequately met by family, friends and community and who are accessing universal services e.g. health visiting, GPs, schools, youth settings etc.</td>
<td>• Child or young person generally making good progress in all areas of their life appropriate to their age. Continue meeting child or young persons needs as a universal service, in a safe environment. Safer recruitment. Professional codes of conduct, preventative education e.g. PSHE. All professionals ready to identify and respond to any emerging problem, abuse or neglect should it occur.</td>
</tr>
<tr>
<td><strong>Early Help Services:</strong> Children, young people and their families who would benefit from additional help with moderate difficulties in to make the best of their life choices.</td>
<td>• Health issues which may impact on the child or young persons development and wellbeing • Behaviour inappropriate to age and stage of development • Parenting skills inadequate to meet the child or young persons needs • Family unable to access effective support services to meet specific needs • Child starting to have unauthorisedabsences from school. A practitioner who identifies unmet needs for a child or young person should consider how these needs can best be met, usually by some additional help from within their own agency. Consider using the Common Assessment Framework (CAF) process to help assess and plan to meet needs.</td>
</tr>
<tr>
<td><strong>Child In Need:</strong> Children, young people and their families who have a range of additional needs affecting different areas of life.</td>
<td>• Concerns shared by more than one agency. • Parenting impacting on child and family life causing instability and inconsistency. • Risk taking behaviour impacting on other areas of a child or young persons life. • Mental health and wellbeing and/or behavioural issues • Child or young person no longer in need of a Child in Need or Child Protection Plan, but still has significant needs • Impairment of development without services • Anti-social behaviour • At risk of entering criminal justice system Request support from other agencies such as Family Support, commissioned services, Youth Crime Prevention Team, Education Welfare. Agencies work together to provide a network of support to the child or young person and their family. Hold a multi-agency meeting and use the EHA with child and family to assess their needs, develop and implement with an Action Plan and review progress.</td>
</tr>
<tr>
<td><strong>Child Protection Plan:</strong> Children, young people and their families who need immediate protection or who require support from a statutory service such as CAMHS, Children’s Social Care or Youth Offending Service.</td>
<td>• Risk of abuse, neglect, or exploitation. • Risk-taking behaviour which could lead to significant harm. • Children/young people with severe or complex needs in relation to disability. Children’s Social Care lead multi-agency planning and support through a Child in Need Plan, Child Protection procedures or accommodation by Children’s Social Care. Youth Offending Team lead multi-agency interventions in response to Youth Court Orders to supervise young offenders in the community and in custody.</td>
</tr>
<tr>
<td><strong>Looked After:</strong> Children, young people who have been continuously looked after for at least 12 months</td>
<td>• In local authority accommodation under a voluntary arrangement, where the child’s parents agree to the child being accommodated; or • In local authority accommodation or at home, under compulsory measures decided by the family court Obligation to create a care plan for each child it is looking after. This care plan must so far as is reasonably practicable be agreed with any parent with parental responsibility, or any person the child was living with before they were accommodated and the child himself.</td>
</tr>
</tbody>
</table>
Section 1: Early Help

What is Early Help?

“Those children and young people at risk of harm (but who have not yet reached the “significant harm” threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) identified by local authorities youth offending teams, probation trusts, police, adult social care, schools, primary, mental and acute health services, children’s centres and all Local safeguarding Children Board partners including the voluntary sector where services are provided or commissioned”. Source: Ofsted

There has been a national rise in the number of initial contacts and referrals to children’s services, funding reductions, the impact of the toxic trio, adoption and permanence legislation and guidance, increasing population/changing demographics and inspection frameworks.

Locally, other pressures have included: a changing management structure, difficulty in recruitment and retention of experienced Social Work staff, increases in complex families, especially larger family units and migrant families from Eastern Europe. The Black and Minority Ethnic (BME) population in Derby has increased from 15.7% in 2001 to 24.67% in 2011. Additionally, Derby has 3,300 more children under the age of 4 in 2011 than it did in 2001 and the city has experienced a higher than average population growth over the same period of time. Furthermore, Derby has higher than national averages of children living in the most deprived wards and living in poverty.

Key Issues:

The number of families accessing early help services has risen; with over 800 families in the city having an 'open' early help assessment at the end of March 2015, there was an overall increase in early help case numbers over 2014-15. Further to this Derby City's Priority Families initiative is working to support better outcomes for over 600 families across the city.

The Early Help case load rose by 57 cases over the course of 2014-15 and there were an additional 21 cases worked by early help services over 2014-15 than in 2013-14. The number of cases over the period of the last two years open to early help services seems to confirm an upper limit case load of around 750 - 800 cases.

This data relates to Lead Professional (LP) cases only and does not account for cases where early help staff are involved with a family as part of a Team around the Family approach. This data will be collected through the early help performance framework in 2015-16. Source: Report to the Derby Safeguarding Children’s Board on the Effectiveness of Early Help Arrangements 2014-15

Of the families in the City with an early help assessment, the age cohort with the largest number of early help referrals are those aged 0 – 4 years, which has grown to become the dominant age cohort over the last three years, locally this indicates that we are receiving referrals at an earlier age than we have previously have.
Key Issues:

The large percentage of early help referrals throughout 2014/15 were received from the White British cohort (however, the dominance of this cohort has declined, with new referrals reducing by over 8% between 2012/13 and 2014/15).

Current early help cases represent an above average Black and Minority Ethnic (BME) ratio of the population, with a rise in early help cases across ‘Asian or Asian British’ (3.34% rise), ‘Black or Black British’ (0.85% rise), ‘Dual Heritage’ (3.04% rise) and ‘Other’ (11.99% rise).

The numbers of cases that have escalated to Social Care from early help show a general trend upwards. However, the percentages of cases that have needed to escalate over the past three quarters have reduced quarter on quarter.

The number of Early Help Assessments being completed has increased every quarter over 2014-15, which displays a greater recognition of emerging needs being identified by partner agencies and universal services, allied to a clear referral pathway into locality teams to meet these needs.

The number has increased by over 100 over the course of 2014-15 and displays the successful partnership approach that has been adopted in the city to the use of a single assessment format and process to identify and address the needs of children and families with emerging needs.

What is being done locally to address this:

The Children and Young People’s Department in Derby City is committed to ensuring early help is available to vulnerable young people and their families in order to prevent them from requiring (more costly and socially damaging) higher tariff services in the future.

Derby has a comprehensive range of early help services available across the city, including Multi-Agency Teams (MAT’s), who are co-located with Social Work teams in an integrated locality based model and with whom they have forged close working relationships.

The MAT’s are complemented by Children’s Centre’s as part of the city’s broader early help offer. Children’s Centre’s provide services on both a universal and targeted basis in clusters of locality based centres across the city to families with children under the age of 5. Over the past 18 months, the focus of centres has been on work with more vulnerable families.

Source: Report to the Derby Safeguarding Children’s Board on the Effectiveness of Early Help Arrangements 2014-15
Section 1: Early Help

Summary:

Overall, the picture presents some positive areas and areas for further work in relation to the impact of early help services. However, there are both national and local pressures that impact on services and can militate against the impact that early help services can have.

Additionally, the cases being referred for early help have seen an increase in complexity, as highlighted by the increased number of level 3 and child protection plan cases being managed.

This can divert resources away from early help to more complex needs, thereby potentially diluting some of the impact early help services can have.

It is also the case that early help interventions can take time for the impact of intervention to be seen with a family and therefore, longer term and ongoing evaluation is required to truly understand the impact of early help services.

What evidence is there that we are making a difference:

- Children in care numbers reduced over 2013-14 but have increased over the past 12 months in line with national trends.
- YOS numbers increased quarter on quarter throughout 2013-14 but have reduced significantly over the last 2 quarters of 2014-15.
- The numbers of cases that have escalated to Social Care from early help show a general trend upwards. However, the percentages of cases that have needed to escalate over the past three quarters have reduced quarter on quarter.
- The number of Early Help Assessments being completed has increased every quarter over 2014-15, which displays a greater recognition of emerging needs being identified by partner agencies and universal services, allied to a clear referral pathway into locality teams to meet these needs.

Recommendations – what are the priorities for improvement:

The two key areas where clients thought improvements could be made by early help staff were in relation to clients not always feeling that they had the opportunity to communicate their views through other means such as written communication, particularly in circumstances where they either did not have either the confidence or skills to verbally communicate in a meeting or other formal environment. The other area for improvement was in the way staff sometimes feedback. It was felt that some feedback can make parents feel blamed for their child’s behaviour/situation.

It has to be added at this point that there was very little in terms of the amount of feedback that related to areas for improvement, which may in itself be an issue in terms of whether the approach being taken to gaining feedback from clients in early help is as robust as it needs to be in order to ensure we can gather intelligence that can help us to continually improve the services we offer.

The number of re-referrals back into a service often gives an indication on whether an intervention has been successful. Early help teams collect data on the number of re-referrals back into the service within three months of case closure. The number of cases where a client was re-referred across 2014-15, was 354 which accounted for 12.4% of the total number of cases that the early help teams worked with across the year.

Source: Report to the Derby Safeguarding Children’s Board on the Effectiveness of Early Help Arrangements 2014-15
Section 2: Priority Families

What is Priority Families?

These families are defined as those where there are a wide range of social, educational, financial and other issues affecting both children and adults, leading to poor outcomes (including, but not restricted to, poor health and wellbeing outcomes) for all members of the families, and intense use of resources across all partners with low chance of improvement.

Priority Families is the terminology now being used by Derby City Council and the wider partnership to refer to the programme of work that is being developed to refer to families presenting with several risks where a number of agencies / partner organisations are involved and are as a consequence, some of our most high cost families. This replaces the term ‘complex families’ which was used in relation to large needs assessment carried out by the City. Priority Families incorporates within it, those families meeting the Coalition’s Troubled Families Unit criteria.

Key Issues:

Having exceeded expectations, the Derby City Priority Families Programme was chosen as an early starter for the expanded programme, turning around 100% of our target of 600 families by the end of the first phase in May 2015.

For the first phase of the programme (74%) of families met 2 out of the 3 criteria and (23%) met all 3 criteria. The highest proportion of families met the unemployment criteria (645 families), education (502), crime (318) and ASB (154).

While retaining its focus on reducing truancy, crime and anti-social behaviour, the expanded programme will apply this approach to a larger group of families with a wider set of problems including domestic violence, debt and children at risk of being taken into care.

The expanded programme aims to Increase emphasis on:

- Earlier Intervention
- Families with multiple problems
- Families that are high cost to the taxpayer
- Significant & Sustained Progress

Eligible families are identified by data sifts and worker nomination. The results of the most recent data sift for the expanded programme (to identify the initial cohort from January 2015) show the spread of these factors across the identified cohort.

Source: CYP/YOS data sift – open cases 01/01/2015
Key Issues:

56% of families worked with between January to June 2015 were White British, 8% White Other. 2% Asian or Asian British, 2% Black or Black British, 2% Mixed – White & Asian, 2% White Irish and the remaining 30% of families ethnicity was not known/provided.

38% of families were being worked at an intensive level and the remaining 62% were receiving a less intensive intervention.

66% of children nominated for the programme in Derby had 15% unauthorised absence from school or more, nationally the average was 52% and regionally 57%.

95% of adults received an out of work benefit in Derby, 83% nationally and 86% regionally.

5% of children were Looked After (LAC) this is in-line with both the national and regional comparator data. 20% of cases were subject to a Child Protection Plan which is above the national average of 11% and regional 6%. 46% of children were identified as Child in Need (CIN), nationally 23% and regionally 18%.

25% of children and young people worked with under the programme were subject to an ASB intervention, above the national average of 20% and 15% of adults were subject to an ASB intervention, 8% nationally and 5% regionally.

28% of adults under the programme with were suffering from mental health problems, this is below the national average of 32% and above the regional average of 24%.

What evidence is there that we are making a difference:

The programme run by councils, is now helping over 110,000 of the most troubled families in England.

Of these nearly 53,000 have had their lives turned around. The first phase of the programme had an impact on the Whole Family:

- Cutting crime and anti-social behaviour
- Parents back in work or more ‘work ready’
- Children back in school
- Big cuts in costs to the state

What is being done locally to address this:

Derby City Council are supporting 2110 families with complex needs over the next five years (2015-20) through the Priority Families Programme, following the launch of the expanded Programme.

Derby is committed to providing a single dedicated worker for every high need troubled family who is responsible for delivering intensive whole-family support. Dedicated workers will come from across our internal teams and key partners. The complexity of the issues that the family face will inform what sort of worker they will be allocated.

Funding for Priority Families initiative in Derby City Council has been spent on two key areas: The first has entailed the direct commissioning of 12 Intensive Family Support Workers (IFSWs); these are split between three different locality bases within Multi Agency Teams and given the ASB/crime criteria, the Youth Offending Service (YOS) also integrated three IFSWs into their service. The intensive level of support and flexibility provided to families through the IFSWs has been fundamental in the success of the programme within Derby.

The rest of the funding for the programme has been allocated to securing input from approved local providers, including those from the 3rd sector, in a range of services including: counselling, mediation, mentoring, drama/art/music therapy and parenting interventions. This support is designed to facilitate the families’ process of change and is accessible through a Integrated Early Help Commissioning Framework (IEHCF).

A broad range of partners and internal teams contribute to the programme including: JobCentre Plus, Police, Fire and Rescue, housing support, Probation, Voluntary and Community Sector, Social Care, Early Intervention teams, Children Centres, Education Learning and Skills, Schools and Youth Offending Service.

Recommendations – what are the priorities for improvement:

- There should be further investigation around resources spent on families – both via IEHCF provision and the Flexible Needs Budget (FNB) to look at correlation between spend and outcome.
- Specific training for workers around common presenting issues such as self-harm and mediation training.
- Data needs to be systematically captured in Derby so evaluation can be carried out to determine the impact of intervention.
- Monitoring of families should continue once cases have been closed to both establish impact of intervention and to act in a preventative capacity with signposting to further early intervention from other agencies if required.
- ‘Champions’ based in localities could be used to promote the Think Family and the Priority Family message, to explain criteria and desired outcomes, including the need for accurate data.
- Use learning from the first phase of the programme to inform the development of a local delivery model for lower level needs.

Source: Derby’s Priority Families: An Independent Evaluation
Section 3: Referrals into Children’s Social Care

What is Children’s Social Care?

Children's Social Care aims to work with parents, carers and young people to offer advice and support before a situation reaches crisis point. Also working in partnership with, and may refer to, other services and community groups, including education, health, housing, benefits agencies and the police. By law, Children's Social Care has to give priority of service to children with specific categories of need:

- Those at risk of serious harm and who may need a protection plan
- Those who are, or may need to be, looked after by Children's Social Care and are unable to remain living at home (birth to 18 years including unaccompanied asylum seeking children and young people)
- Private Fostering - such arrangements have to be notified to the local authority (Children's Social Care)
- Those aged 16 or over who are leaving the care of Children's Social Care or have previously left care and are eligible for Leaving Care services
- Where Children's Social Care involvement is required by the courts

Nationally there has been an increase in the number of referrals to Social Care between 2012-13 and 2013-14 (up 10.8%). The number of referrals seen in our comparator authority average also increased between 2012-13 and 2013-14, up 369 referrals (7.4%).

Key Issues:

Derby had 3201 children in need referrals during 2014-15, which is an increase of 435 referrals from the previous year (up 15.7%). Derby’s rate of referral for 2014-15 is 553.5 per 10,000 population which is slightly below the 2013-14 national rate of 573.0 and the comparator authority average rate of 689.2. This is a slight increase from Derby's rate in 2013-14, when the rate was 479.4. This increase is positive as it indicates that risks to children are being identified and responded to.

80% of the new referrals logged during 2014-15 were for Abuse and Neglect reasons. 6.3% were due to the Child’s Disability and 6.4% was due to Parental Illness or Disability.

9.8% of all new referrals were for expected babies (2.2%) for babies under one year old (7.6%). 29% were for children aged 5 to 9 years old.

57% of new referrals were for children from a White British background, 13% were from an Asian/Asian British background, 10% for a Dual Heritage background and 10% from a White Other ethnicity.

The gender split of new referrals was very close during 2014-15, 48.5% of the new children in need referrals were for females and 49.0% were for males. 2.2% of referrals were for expected babies.
Section 3: Referrals into Children’s Social Care

Key Issues:

Almost 30% of the new children in need referrals created during 2014-15 were from Local Authorities Services, this includes internal referrals (24.6%), referrals from other departments e.g. Youth Offending (2.7%) and referrals from other Local Authorities (3.1%).

21.4% of referrals in 2014-15 were from the police. This is slightly below the national figure seen in 2013-14 (23.9%). 15.9% of referrals were from the Health Service and 15.4% were from schools.

The top five wards in Derby where the 2014-15 new children in need referrals originated from (Please note address is based on where the child was living on 31st March 2015):

- 33.0% of all new referrals were completed for children living in Locality 2 (Sinfin, Boulton, Alvaston and Chellaston)
- 26.0% of all new referrals were completed for children living in Locality 3 (Normanton, Arboretum and Abbey)

What is being done locally to address this:

The continued investment in Early Help and the introduction of the Priority Families programme has been instrumental in the reduction in the number of referrals into Children’s Social Care. There is a range of early help support that is provided for children, young people and their families in Derby to both provide advice and/or intervene where there is evidence of emerging needs with the objective of preventing escalation to higher level services such as child protection. The Priority Families programme also supports the most high cost families within the City provided targeted support.

What evidence is there that we are making a difference:

- Referrals into Children’s social care have increased in recent years, in line with national figures but below comparator authorities. This indicates that risks to children are identified effectively and responded to. It may also be an indicator that MAT team and universal support is proving effective at preventing referrals into social care.
- The proportion of re-referrals is below both the national and comparator figures, suggesting interventions are effective in ensuring not only significant but also sustained improvement, and that families are effectively supported by step down plans.

Recommendations – what are the priorities for improvement:

- Develop better understanding of emerging communities to provide targeted support at the earliest level of intervention.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Sinfin (Locality 2)</td>
<td>434</td>
<td>13.6%</td>
</tr>
<tr>
<td>Arboretum (Locality 3)</td>
<td>347</td>
<td>10.8%</td>
</tr>
<tr>
<td>Normanton (Locality 3)</td>
<td>321</td>
<td>10.0%</td>
</tr>
<tr>
<td>Alvaston (Locality 2)</td>
<td>297</td>
<td>9.3%</td>
</tr>
<tr>
<td>Derwent (Locality 1)</td>
<td>270</td>
<td>8.4%</td>
</tr>
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</table>

Nationally Children’s Social Care Services face continued scrutiny and higher expectations, whilst maintaining the emphasis on keeping children safe and wherever possible helping them to remain in their families. New timescales for specific aspects of support to children, including decisions relating to permanence for children looked after who are unable to return to their immediate family have been introduced.
Section 4: Children’s Social Care Assessments

What are Assessments into Social Care?

The needs and risk of children and young people who are suspected to be at risk of harm are assessed by Children’s Social Care to determine what support the child or young person needs.

Key Issues:

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

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

Of the 2074 Single Assessments completed in Derby during 2014-15, Domestic Violence was identified as an Assessment Factor in almost 55% of all assessments. This could be against the child (343 cases, 16.5%), the parent/carer (672 cases, 32.4%) or another person (124 cases, 6.0%). This compares to a figure of 41% seen nationally in 2013-14.

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

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

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

The top five wards in Derby where the 2014-15 Single Assessments originated from (Please note address is based on where the child was living on 31st March 2015):

- 31.5% of all single assessments were completed for children living in Locality 2 (Sinfin, Boulton, Alvaston and Chellaston)
- 28.8% of all single assessments were completed for children living in Locality 3 (Normanton, Arboretum and Abbey)

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<thead>
<tr>
<th>Ward</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Sinfin (Locality 2)</td>
<td>260</td>
<td>12.5%</td>
</tr>
<tr>
<td>Normanton (Locality 3)</td>
<td>247</td>
<td>11.9%</td>
</tr>
<tr>
<td>Arboretum (Locality 3)</td>
<td>239</td>
<td>11.5%</td>
</tr>
<tr>
<td>Derwent (Locality 1)</td>
<td>179</td>
<td>8.6%</td>
</tr>
<tr>
<td>Boulton (Locality 2)</td>
<td>157</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
What is being done locally to address this:

Locally, an assessment of the child/young person’s need and risk of harm is carried out by qualified children’s social workers. The assessment considers the risk of harm and the support that the child or young person needs.

The assessment will determine what action is appropriate, whether this is a section 47 enquiry, child in need (CIN) plan, coordinated multiagency support through use of the Early Help Assessment (EHA), single agency support or if no further action is needed.

The demand for Children’s Social Care is continually reviewed within Derby and resources are allocated from other locality teams when demand meets the thresholds.

What evidence is there that we are making a difference:

The low levels of re-referral rates to Children’s Social Care within Derby is an indication that assessments are effective and services are providing the correct level of intervention. The low number of children receiving a second or subsequent referral to Social Care is evidential of the difference being made locally.

Locally there have been no serious case reviews since 2012 suggesting that assessments are good and identifying the correct cohort of children to initiate court proceedings.

Recommendations – what are the priorities for improvement:

This shows that the demand for and pressure on services has increased significantly, and the maintenance of good performance figures shows that the service has met this challenge well. However, these trends are likely to continue, meaning this will be an area for continuous improvement to cope with new and increasing challenges.

National Context:

The Single Assessment framework was introduced in response to Working Together to Safeguard Children 2015, adopting the recommendations of Eileen Munro’s review of Child Protection.

The Single Assessment replaces the previous Initial Assessment and Core Assessments within the children and young person’s assessment framework. The Single Assessment will provide an opportunity for social workers to focus on the specific needs and allow appropriate time within the assessment for reflection and direct work with the child/young person to ensure a robust and analytical assessment. It is hoped that the impact of this change will have the following positive consequences:

- Reduced prescription on timescales to allow social workers to specifically respond to that child and family’s specific need;
- Allow greater opportunity for the social work practitioner to engage with children to explore their wishes and feelings, focussing upon the child’s journey and the impact of the concern upon their safety and wellbeing from the child’s perspective;
- Increased opportunity and expectation for the social work practitioner to reflect upon the assessment and the daily lived experiences of the child;
- Greater focus on analysis and less expectation of “filling the boxes”;

Section 4: Children’s Social Care Assessments

National Context:

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The Single Assessment replaces the previous Initial Assessment and Core Assessments within the children and young person’s assessment framework. The Single Assessment will provide an opportunity for social workers to focus on the specific needs and allow appropriate time within the assessment for reflection and direct work with the child/young person to ensure a robust and analytical assessment. It is hoped that the impact of this change will have the following positive consequences:

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- Allow greater opportunity for the social work practitioner to engage with children to explore their wishes and feelings, focussing upon the child’s journey and the impact of the concern upon their safety and wellbeing from the child’s perspective;
- Increased opportunity and expectation for the social work practitioner to reflect upon the assessment and the daily lived experiences of the child;
- Greater focus on analysis and less expectation of “filling the boxes”;

What evidence is there that we are making a difference:

The low levels of re-referral rates to Children’s Social Care within Derby is an indication that assessments are effective and services are providing the correct level of intervention. The low number of children receiving a second or subsequent referral to Social Care is evidential of the difference being made locally.

Locally there have been no serious case reviews since 2012 suggesting that assessments are good and identifying the correct cohort of children to initiate court proceedings.

Recommendations – what are the priorities for improvement:

This shows that the demand for and pressure on services has increased significantly, and the maintenance of good performance figures shows that the service has met this challenge well. However, these trends are likely to continue, meaning this will be an area for continuous improvement to cope with new and increasing challenges.
Section 5: Who are Children in Need

What is Children in Need?

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

Key Issues:

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

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

60% of all open cases were from a White British background. 10% were from an Asian or Asian British ethnic background, 10% were from a Dual Heritage ethnic background and 8.8% were from a White Other background.

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

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

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

26.3% of cases in Derby were open for a duration of less than 3 months as at 31st March 2015. This is slightly higher than the comparator and national averages from 2013-14 (both 24.8%). 41.3% of cases in Derby were open for a duration of 1 year or longer as at 31st March 2015. Last year’s figure was 49.3% which is a reduction of 8%. The 2013-14 comparator figure was (48.4%) and the national figure was (46.8%).

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

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

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
Section 5: Who are Children in Need

Key Issues:

The top five wards in Derby where Children in Need were living at the 31st March 2015 (Please note Children in Care cases (470) and Child Protection cases (314) have been excluded from this ward summary.):

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Sinfin</td>
<td>193</td>
<td>11.5%</td>
</tr>
<tr>
<td>Arboretum</td>
<td>168</td>
<td>10.0%</td>
</tr>
<tr>
<td>Normanton</td>
<td>161</td>
<td>9.6%</td>
</tr>
<tr>
<td>Alvastone</td>
<td>147</td>
<td>8.7%</td>
</tr>
<tr>
<td>Derwent</td>
<td>141</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

What is being done locally to address this:

In these cases assessments by a social worker are carried out under section 17 of the Children Act 1989. The purpose of an assessment is to gather information and evidence about a child’s developmental needs and the parents’ capacity to meet these needs within the context of the wider family and community. This information should be used to inform decisions about the help needed by the child.

A multi-agency training programme is being delivered locally and coordinated by the Safeguarding Board, this includes safeguarding training.

What evidence is there that we are making a difference:

The low levels of re-referral rated to Children’s Social Care within Derby is an indication that assessments are effective and services are providing the correct level of intervention. The low number of children receiving a second or subsequent referral to Social Care is evidential of the difference being made locally.

Recommendations – what are the priorities for improvement:

Today, there is an increased emphasis on family-centered practice. Family-centered practice does not mean only mother-and-child-centered practice. Rather, all family members and individuals who play a role in the family should be engaged, when appropriate, in order to support meaningful outcomes for the entire family. Moving forward in Derby there is increasing priority to engage and recognise the value of fathers to children:

- Appreciate the importance of fathers to the case planning and service provision process;
- Understand the issues unique to working with fathers;
- Effectively involve fathers in all aspects of case management, from assessment through case closure;
- Work successfully with fathers in a wide range of family situations and structures.

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
When a case is referred to children’s social care, it is assessed to determine the level of support required and ascertain if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm (section 47 of the Children Act 1989). If risk of significant harm is suspected then a section 47 enquiry is carried out to determine if steps to safeguard and promote the welfare of the child need to be taken. If concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference will be convened. At the multi-agency child protection conference, the decision will be made as to whether the child needs to become the subject of a child protection plan.

A Child Protection Plan (CPP) is a multi-agency plan formulated by children’s social care to protect a child or young person who is at risk of harm. The plan ensures all agencies work together to support the family to care for the child, and gives clear roles and responsibilities to everyone involved for safeguarding the child or young person and improving their outcomes.

Key Issues:

The number of Section 47 enquiries completed in Derby during 2014-15 has increased again for the fourth year running, rising from 327 in 2011-12 up to 480 in 2014-15. There has been a steady increase seen in the comparator authority average over the past six years. The gap between Derby’s numbers and the comparator authority average is widening. The average number of enquiries completed in our comparator groups was 1089 in 2013-14. The low number in Derby may be due to a system issue. Derby moved from CCM to LCS in April 2015 and it is anticipated that this low number will increase.

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

458 initial child protection conferences were completed in Derby during 2014-15. This is the highest number we’ve seen in Derby over the past eight years. We are in a similar position to our comparator authorities with a rate per 10,000 of 79.2 compared to 67.5 for our comparator average and 56.8 nationally.

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
Key Issues:

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

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

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

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

A higher percentage of new CPP referrals have been consistently received for males rather than females over the period of April 2012 to March 2015. When compared to the total CPP population this demand is consistent as 54% of all current cases relate to males.

The largest percentage of new plans were started for children between the ages of 0 – 4 years, followed by 5 to 9 years and then 10 – 15 years.

The largest percentage of new CPP referrals continue to be received for ‘White British’ children and young people however over the last three years there has been a progressive growth in new referrals for those in the ‘White-Other’ and ‘Other’ category, which may be reflection of the growing new communities within the city (combined growth of 11% for these ethnic groups from April 2012 to March 2015).

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
Key Issues:

The top five wards in Derby where children with Child Protection Plans were living at the 31st March 2015.

- **33.1%** of all child protection plans were open to children living in Locality 3 (Abbey, Normanton, Arboretum)
- **30.3%** of all child protection plans were open to children living in Locality 2 (Alvaston, Boulton, Chellaston, Sinfin)

What is being done locally to address this:

There is a range of early help support that is provided for children, young people and their families in Derby to both provide advice and/or intervene where there is evidence of emerging needs with the objective of preventing escalation to higher level services such as child protection.

Vulnerable Children’s Meetings (VCM) occur across all localities in Derby on a weekly basis; this is a forum in which a group of multi-agency professionals discuss and review cases allocating resources and providing advice back to agencies who are concerned about individual children.

The VCM will discuss the case and (based on all of the available information on that case) make a decision on whether additional resources need to be allocated to that case. This could be either resources internal to the locality team or other broader services available in the community, which the VCM will signpost the referrer to.

What evidence is there that we are making a difference:

The low levels of re-referral rated to Children’s Social Care within Derby is an indication that assessments are effective and services are providing the correct level of intervention. The low number of children receiving a second or subsequent referral to Social Care is evidential of the difference being made locally.

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### Table:

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<thead>
<tr>
<th>Ward</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Normanton</td>
<td>41</td>
<td>13.1%</td>
</tr>
<tr>
<td>Derwent</td>
<td>40</td>
<td>12.7</td>
</tr>
<tr>
<td>Boulton</td>
<td>36</td>
<td>11.5%</td>
</tr>
<tr>
<td>Sinfin</td>
<td>35</td>
<td>11.1%</td>
</tr>
<tr>
<td>Arboretum</td>
<td>34</td>
<td>10.8%</td>
</tr>
</tbody>
</table>
Most children are brought up in their own families, but a small number of children need to live away from their families and grow up in a range of alternative care arrangements which include foster care, residential care and supported independent living. These children are described as being ‘cared for’ and are the responsibility of the local authority which is, in effect, their ‘corporate parent’.

Key Issues:

There were 470 Children in Care as at 31/03/2015. This is an increase from 445 seen at the end of 2014. This is a rise in cases following three years of declining figures. 626 children in were in care at any point during the year. Derby had 174 children ceasing care during 2014-15. This is a slight reduction from 185 that ceased during 2013-14. In Derby we had 55 adoptions and 10 Special Guardianship Orders granted during 2014-15.

We had 191 children starting care during 2014-15. This is an increase from 160 seen during 2013-14. It’s our highest figure of new entrants over the past six years. 68% of Derby’s CIC population enter care as a result of abuse or neglect. 9.38% due to socially unacceptable behaviour, 6.25% due to parents illness or disability and 3.13% due to family dysfunction.

Children in Care - rates per 10,000 was 81.3 as at 31/03/2015. This is an increase from 77 per 10,000 seen in 2014. However the figure of 81.3 is still below the 2013-14 comparator average of 83 per 10,000. 72% of children in care are in foster care, 10% are in children’s homes, hostels and Secure units, 9% are placed for adoption and 3% live with a parent. The largest proportion of children in care in Derby have a legal status of full care orders (48%) this is in line with both our comparators and national figures, with the comparator average being 53% and the national average 46%.

Source: SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
Key Issues:

Derby has a higher percentage of male children in care (61%) on 31/03/2015 and (39%) were female than our comparators (55%) and the national average (55%).

78.9% were White – British, 12.8% were Dual Heritage, 3.4% were Asian or Asian British, 2.8% were Black or Black British and 2.1% from other ethnic backgrounds.

In the different age groups of children in care Derby is in line with comparator and national averages in general, though in the 5 to 9 age group Derby has 24%. This is slightly higher than comparator (23%) and national (20%) figures.

The percentage of new referrals relating to males is consistently higher than females for new LAC cases with 57% of all LAC referrals relating to males between April 2012 and March 2015. However it should be noted that when the total LAC dropped in 2013/14 the gap between males and females dropped from over 19% to 5% before rising again to 19% in 2014/15 when LAC numbers increased again indicating that it is males driving the increase in demand.

The largest percentage of new LAC cases relate to those aged 0 – 4 years, which is consistent with all levels of support/ intervention. This is supported by an increase in this age group in 2014/15 where there has also been an overall increase in LAC numbers.

88.5% of children in care had their annual health assessments, this is the highest performance we’ve seen over the past 5 years. 92.5% had their teeth checked which is an increase on the previous year (85.3%). 77.4% had the health development checks. 97.8% had up to date immunisations.

A Strengths and Difficulties Questionnaire (SDQ) should be completed for every child aged between 5 to 16 who has been looked after for at least 12 months. SDQ’s we’re showing a 67.6% completion rate and an average score of 16.1 for 2014-15. This is the highest completion rate seen over the past four years. It’s a slight improvement on last year’s final figure of 66.0%.

The average score for SDQ’s in 2014-15 was 16.1 which is our lowest average score for the past four years. Its dropped from 16.9 in 2012, 16.8 in 2013 and then 16.3 in 2014. Derby has the highest average SDQ score of our comparator authorities and exceeds the national and comparator authority averages. When all local authority average scores are ranked from high to low, Derby features in the top ten for higher scores.

The top five wards in Derby where Children in Care on the 31st March 2015 originated from:

• 33.6% of all Children in Care had an originating address in Locality 3 (Abbey, Normanton, Arboretum)
• 31.7% of all Children in Care had an originating address in Locality 2 (Alvaston, Boulton, Chellaston, Sinfin)

Source: DfE children in care article
What is being done locally to address this:

In common with all local authorities in England, Derby provides information on the emotional and behavioural difficulties of children and young people in their care. A Strengths and Difficulties questionnaire is completed for each looked after child as part of an annual health review. This is a screening tool for mental health problems which may have been previously unidentified, and which can be used to support a referral to a local targeted and specialist mental health service.

A new family support scheme is due to be introduced in locality 3 during August 2015 to address high levels of Child Protection and Children In Care from this locality.

What evidence is there that we are making a difference:

Strengths and Difficulties Questionnaire (SDQ) should be completed for every child aged between 5 to 16 are at the highest completion rate for the past Four years.

Increasing numbers of children leaving ceasing care is through adoption (30%), which is above the national average of 17%.

Recommendations – what are the priorities for improvement:

• A key priority in Derby is to address the emotional health and well-being of Looked after Children by creating a merged service as part of the transformation plan for Future In Minds.
• Moving forward in Derby there is increasing priority to engage and recognise the value of fathers to children
• Safely reduce the numbers of looked after children.
• Improve outcomes for looked after children as compared with that of the general population.
• Provide access to high quality universal and targeted health and educational services.
• Provide support and positive opportunities to progress into further education, training and employment.
• Ensure looked after children have optimal placement choice and stability.
• Provide clear arrangements and enable participation by children and young people in decisions and matters that affect their lives.
• Improve and sustain health and emotional wellbeing.
• There is a local and national emphasis on increasing the numbers of foster carers and speeding up the permanency process for prospective foster carers and adopters in relation to LAC requiring timely health assessments.
Our Children’s Needs

Derby City Council
Section 8: Health and Well-being – Avoidable Injuries

What are avoidable injuries?

The term avoidable injury includes both unintentional and intentional injuries. Avoidable injuries are a leading cause of death and hospital admission for 1-15 year olds in the UK.

The primary cause of avoidable injuries varies by age of a child. Poisoning, burns and scalds are the main cause of injuries for the under 5s and Falls are a common cause for all age groups. Self-harm is an important cause of avoidable injuries in older children, this is considered elsewhere in this document.

Injuries can cause considerable long-term physical issues including disability, scarring or disfigurement and the need for on-going medical care including surgery. Injuries also have emotional and psychological impacts of both sustaining and living with the outcomes of an injury; these can affect both the child and wider family.

Key Issues:

Local indicator data demonstrates that the rate of A&E attendances for 0-4 year olds and deaths or serious injuries of children in road traffic accidents are comparable with the national average.

Conversely, the rate of admissions for 0-14 year olds is lower than the national average, whilst admissions in older children and young people (15-24 year olds) are higher than national rates.

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<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendances (0-4)</td>
<td>10,371</td>
<td>574.5</td>
<td>525.6</td>
<td>1,684.5</td>
<td>252.7</td>
</tr>
<tr>
<td>Hospital admissions caused by injuries in children (0-14)</td>
<td>421</td>
<td>86.4</td>
<td>112.2</td>
<td>214.1</td>
<td>64.4</td>
</tr>
<tr>
<td>Hospital admissions caused by injuries in young people (15-24)</td>
<td>546</td>
<td>150.4</td>
<td>136.7</td>
<td>291.8</td>
<td>69.6</td>
</tr>
<tr>
<td>Children killed or seriously injured in road traffic accidents</td>
<td>11</td>
<td>22.1</td>
<td>19.1</td>
<td>48.3</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Definition:
Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2013/14.
Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2013/14.
Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2013/14.
Crude rate of children (aged 0-15 years) who were killed or seriously injured in road traffic accidents per 100,000 population, 2011-2013.
Section 8: Health and Well-being – Avoidable Injuries

National Context:

The impact and consequences of avoidable injuries are major contributors to health inequalities with children from the most disadvantaged backgrounds at significantly increased risk.

Rates of injuries in children follow a strong socio-economic gradient with those in the most deprived groups experiencing the greatest risk.

Children with a disability (physical or learning) and those from minority ethnic groups experience a higher rate of injuries than other children.

The accommodation in which a child lives can expose them to a greater injury risk which in part explains the strong socio-economic gradient seen. Living in multiple occupied housing; social and privately rented housing; temporary accommodation and high rise are all associated with greater risk of injury.

Key Issues:

A conservative estimate is that there are 24,000 cases of attempted suicide by adolescents (of 10-19 years) each year in England and Wales, which is one attempt every 20 minutes. Self-harming in young people is not uncommon (a separate study suggests that 10–13% of 15–16-year-olds have self-harmed). A Samaritans study found that four times more adolescent females self-harmed than adolescent males.

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. Incidents can be avoided through improved education, awareness, road infrastructure and vehicle safety. There were 40.5 per 100,000 population reported road deaths and serious injuries in Derby.

Source:

• Samaritans, (2003), “Youth and self harm: Perspectives – A report”
Section 9: Health and Well-being – Mental health and emotional wellbeing

What is mental health?

“A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Emotional wellbeing is defined as: “A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. A mental illness ‘is a clinically recognisable set of symptoms or behaviour associated in most cases with considerable stress and substantial interference with personal functions.’ (ICD-10 definition).

Key Issues:

It is estimated population within the area, gives a figure of 2,830 children aged 2 to 5 years inclusive living in Derby who have a mental health disorder.

Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems.

Estimated number of children with mental health disorders by age group and sex (2014):

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of children aged 5-10</th>
<th>Estimated number of children aged 11-16</th>
<th>Estimated number of boys aged 5-10</th>
<th>Estimated number of boys aged 11-16</th>
<th>Estimated number of girls aged 5-10</th>
<th>Estimated number of girls aged 11-16</th>
<th>Estimated number of girls aged 5-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derby</td>
<td>1,590</td>
<td>2,085</td>
<td>3,675</td>
<td>1,075</td>
<td>2,270</td>
<td>520</td>
<td>890</td>
</tr>
</tbody>
</table>

Estimated number of children with conduct disorders by age group and sex:

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of children aged 5-10</th>
<th>Estimated number of children aged 11-16</th>
<th>Estimated number of boys aged 5-10</th>
<th>Estimated number of boys aged 11-16</th>
<th>Estimated number of girls aged 5-10</th>
<th>Estimated number of girls aged 11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derby</td>
<td>1,030</td>
<td>1,235</td>
<td>740</td>
<td>780</td>
<td>290</td>
<td>455</td>
</tr>
</tbody>
</table>

Section 9: Health and Well-being – Mental health and emotional wellbeing

National Context:

Nationally, one in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.

Estimated number of children with emotional disorders by age group and sex:

<table>
<thead>
<tr>
<th></th>
<th>Estimated number of children aged 5-10</th>
<th>Estimated number of children aged 11-16</th>
<th>Estimated number of boys aged 5-10</th>
<th>Estimated number of boys aged 11-16</th>
<th>Estimated number of girls aged 5-10</th>
<th>Estimated number of girls aged 11-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derby</td>
<td>485</td>
<td>930</td>
<td>230</td>
<td>405</td>
<td>260</td>
<td>530</td>
</tr>
</tbody>
</table>

What is being done locally to address this:

There are a range of services, delivered by partners across the statutory and voluntary sectors, to support the emotional and mental health of children and young people in Derby. This forms a comprehensive spectrum of support from universal through to highly specialist and rehabilitative services.

The child and adolescent mental health service is committed to providing comprehensive and targeted treatments, delivered in the heart of our communities, which positively impact upon the emotional and psychological wellbeing of children and young people.

Our specialist CAMHS teams provide services for Derby City and South Derbyshire residents and employ a range of highly qualified and specialist clinicians and therapists. We maintain close links with adult mental health services and our colleagues in the early interventions service, as well as youth offending teams and Breakout, Derby City’s young people’s substance misuse service. Our assessments and subsequent care delivery are geared towards ensuring speedy access to the right level of service for the individual and family needs. We also provide a flexible out-of-hours service, including after school and evening services.

What evidence is there that we are making a difference:

A range of services across Derby fulfil best practice guidance in terms of both the types of service and the nature of interventions and support delivered.

Recommendations – what are the priorities for improvement:

To demonstrate the effectiveness of investment in this area would require more robust measures of uptake, outcomes and progress across the full range of services. Source: Derbyshire Healthcare NHS Foundation Trust
Section 10: SEND

What is SEND?

For children and young people of compulsory school age, they have a special educational need/learning difficulty or disability if they:

- have a significantly greater difficulty in learning than the majority of others of the same age; or
- have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

A child under compulsory school age has special educational needs if they fall within the definitions above or would do if special educational provision was not made for them.

Children and young people with special educational needs or disabilities may need extra help or support, or special provision made for them to allow them to have the same opportunities as others of the same age. If a child or young person has special educational needs or disabilities their needs will fall into one or more of the following four areas: communication and interaction, cognition and learning, physical and sensory, emotional, social and mental health.

Key Issues:

It is hard to obtain accurate information regarding the exact numbers of children with disabilities living in Derby City. There are 3261 children recorded with Special Educational Needs & Disability (SEND).

The number of children living with disabilities is rising and will continue to rise over the next 10 years, partially due to better survival rates at birth and partially due to a rise in the size of the population and young families living in Derby City. There are 3261 children recorded with Special Educational Needs & Disability (SEND). Estimates predict that by 2021 there are likely to be 295 more children and young people living with varying levels of disability.

It is estimated that there are between 1910-3046 children under 18 with disabilities in Derby and 3261 children recorded with Special Educational Needs & Disability (SEND). Boys are much more likely to have SEND than girls.

Numbers are likely to rise, with medical advances and more awareness of conditions such as ASD. A rise of 295 children by 2021 is projected, with the largest increase in the 10-14 age group.

There is a projected increase in 10-14 year olds, a smaller increase in 5-9 age groups, a slight increase in the under 5s and a small drop in the 15-19 age group. There is an increase of 9% between 2013 and 2021.

Source: Public Health Directorate report – A needs assessment for disabled children in Derby City
Key Issues:

It is also possible that the numbers of children with a diagnosis of learning/behaviour disabilities and ASD will increase. Over the period 2008-2012 Derby experienced an increase in the number of “children on the autistic spectrum known to schools” of 134% (an increase in numbers from 141 to 331). The rate of ASD per 1000 child population is now 8.11, which is similar to the English average. Local health professionals consider this to be an accurate reflection of the trend in increasing need for services they have experienced and consider this trend is likely to continue.

There are 1309* children with statements, in Derby, the most common age for a child to be issued with a statement is either 10, 11 or 4 years old.

The top 3 primary needs for all statemented children are (ASD, MLD and BESD) account for 58% of the total statemented population, with ASD accounting for 28% alone. This highlights that ASD is the most important and prevalent need both in Derby and OOA placements.

Out of the total population of children with statements, there are 934 males and 377 females with statements, the number of pupils in special/ ERF in Derby is higher than the national average, the majority (37%) of ERF places are taken by pupils with ASD, the key age to influence children going OOA are years 5 and 6 (transition points).

What is being done locally to address this:

In schools (or pre-school) there is a SEN Co-ordinator (SENCO), who is responsible for co-ordinating help for children with special educational needs. You will be able to talk over your concerns with the teacher and/or SENCO and find out what the school thinks.

Working together with your child’s teachers will often help to sort out worries and problems. Schools can offer strategies and support, set extra targets and when needed involve additional professionals to help, such as educational psychologists.

Source: Impower – Derby SEN&D case for change report
What is being done locally to address this:

Derby’s Local SEND Offer available online which brings together a wide range of relevant information for children and young people with SEND and their families.

Recommendations – what are the priorities for improvement:

- Establish a new dialogue with mainstream. Develop a narrative to understand how to work together and empower them to help themselves.
- Establish a specific heads focus / reference / task group to lead on solutions alongside LA (getting schools to own the issue as well)
- Use the early warning signs we established as a result of the case review, to identify and prevent possible future OOA placements
- Develop and establish a SEN&D model/ threshold with the key priority to increase placements in mainstream schools (this should include focus on remodelling criteria, framework, thresholds and expectations).
- As part of framework, establish a Heads lead management group similar to secondary exclusions i.e. the managed moves model, whereby all schools take proportion of challenging pupils.
- Framework to clarify which school’s roll the child remains on even though they receive their education in another school. E.g. ERS. Avoiding the issue around ERS school’s standards being an issue as a result of SEN&D and challenging pupils. Schools should take more responsibility of pupils on roll.
- Establish link with partner LA who operates a similar model, and have experienced this journey. Or leverage support networks around schools to address issues holistically.
- Following the establishment of above framework, develop capital strategy in terms of school accommodation / places need with a full appraisal.
- Establish a flexible framework to support schools, depending on the types of need that they are supporting e.g. – what do they get if they have a child with x needs at y level of complexity. There should be a clear threshold setting as part of this and a clear policy of what additional resources schools would receive (to manage expectations that does not mean new capital facilities).
- Consider a stronger role and support model from early intervention and/or locality services.
- Establish a multi agency response, similar to the locality model in social care, to tackle the issues around BESD. The action is wider than just SEN&D&D and needs to be considered strategically e.g. with parenting, priority families, CAMHS etc.
Section 11: Neglect

What is neglect?

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Key Issues:

Local Authorities have a duty to protect and promote the welfare of children in need in the area. Abuse or neglect continue to be the most common primary needs for children in Derby, followed by family dysfunction. Child disability or illnesses ranks highly as a primary need code. 2,350 children living in Derby are classed as being "in need".

**Derby City** is ranked as the 88th most deprived local authority, with some of our wards being the most deprived in the country. The percentage of children living in poverty within the city is above the national average at over 23% compared to 19% across the country. Further to this, **32% of Derby’s under 18’s live in the most deprived wards** compared to a ‘usual resident’ population of 26%.

Neglect was a feature in at least **2/3 of the serious case reviews for Derby City during between 2008 - 2012**. Past neglect was a factor in eleven out of fourteen reviews relating to the suicide of a young person.

There remain some **significant gaps between the health and well-being of residents across the different wards of the city, with Derby being 'poorer' than national averages in a number of areas**; a position significantly influenced by some of our most deprived wards. During the year it became apparent that there were **increasing incidences of neglect noted amongst Roma families** and a disproportionately **high number of cases in care proceedings** compared with the demographic population in Derby.

**Derby has a significantly higher proportion of children living in poverty.** This gives a significantly **higher proportion of children eligible for and claiming free school meals**; significantly higher rate of under 18 teenage conceptions; significantly higher rate of children’s (at age 12) tooth decay; significantly higher rate of children and young people smoking; significantly higher rate of acute sexually transmitted infections. Childhood obesity is also a significant problem for many children.

The percentage of CP cases involving neglect is slightly lower in Derby than comparators. However, the number of cases has increased. Again this is reflective of the general increase in demand for services, but also better identification of neglect.

**Derby has a slightly lower average** There is a higher than average proportion of children living in poverty in Derby, with a larger proportion of the more deprived wards being under the age of 18. Disproportionate number of incidences of neglect in the Roma community.

Source: DfE SFR43-2014 Children in Need Statistical Release 2013-14
Section 11: Neglect

National Context:

There are currently over 50,000 children identified as needing protection from abuse in the UK.

It is estimated that for every child identified as needing protection from abuse, another 8 are suffering abuse.

Over 24,300 children were identified as needing protection from neglect last year, with 1 in 10 children having experienced neglect.

Neglect is a factor in 60% of serious case reviews.

What is being done locally to address this:

There is a range of early help support that is provided for children, young people and their families in Derby to both provide advice and/or intervene where there is evidence of emerging needs with the objective of preventing escalation to higher level services such as child protection.

Derby offers a wide range of parenting programmes and open access groups through Children’s Centres, and commissions a number of parenting support services, such as one to one support in the home establishing a routine for caring and interacting with children and parenting courses as part of our early help offer.

Commissioned services are targeted to the areas of the greatest need and should result in a reduction in demand to children’s social care.

A training programme for workers is being delivered locally and coordinated by the Safeguarding Board, this includes training to ensure a consistent approach in working with cases where neglect is an issue.

The Graded Care Profile (GCP or the Profile) has been developed to identify strengths and weaknesses in the quality of parental care and has an objective measuring scale to determine levels of care that have implications for a child's physical and emotional well-being and development.

In cases of neglect, it will supplement information contributing to the assessment of the child and not replace it. Therefore the Early Help Assessment (EHA) will remain Derby’s early help assessment and social work staff will continue to use the single assessment. The Profile can indicate precisely where a deficit of actual care is located1. This information can then be used to target interventions more effectively and to then monitor progress being made.

What evidence is there that we are making a difference:

A new family support scheme is due to be introduced in locality 3 during August 2015 to address high levels of Child Protection and Children In Care from this locality.

There is a range of early help support that is provided for children, young people and their families in Derby to both provide advice and/or intervene where there is evidence of emerging needs with the objective of preventing escalation to higher level services such as child protection. The Priority Families programme also supports the most high cost families within the City provided targeted support.
Key Issues:

The Derby Child Sexual Exploitation (CSE) strategy is implemented and maintained by multi-agency partners within an operational sub group of the Derby Safeguarding Children Board (DSCB). We have a well-developed strategy to tackle CSE that has made significant progress over the last 4 years. This has resulted in the DSCB and partners achieving national recognition for proactive and forward thinking approaches to tackling CSE and related issues.

The CSE strategy is delivered through the ‘3 P’s’ approach outlined in the Department of Children, Schools and Families guidance: Safeguarding Children and Young People from Sexual Exploitation (2009);

- Prevention through heightened awareness amongst children, professionals, families and communities,
- Protection of children and young people through direct and indirect work with children and families and equal focus on
- Prosecution or disruption of offenders.

Our work is also guided by a multi-agency problem profile and Derby CSE Action Plan, the national CSE action plan and good practice guides from OFSTED, CEOP, UKHTC, National Working Group and the ACPO Action Plan.

Derby remains very alert to the risks of CSE for children in the City, working hard to protect children but open to challenge where more can be done.

Central to the success of the DSCB strategy is close collaboration between key multi-agency partners. The work of those partners has ensured that many children and young people in Derby have been protected from CSE and received intensive support through a coordinated multi-agency child protection plan where there was an identified risk of CSE. Partners are committed to developing and continuing this important work.

Section 12: Child Sexual Exploitation

What is Child Sexual Exploitation?

“Sexual exploitation is child abuse and children and young people who become involved face huge risks to their physical, emotional and psychological health and well-being.”

“Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, sexual acts or activities. Child sexual exploitation grooming can occur through the use of technology without the child’s immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person’s limited availability of choice resulting from their social/economic and/or emotional vulnerability” (The Department of Children, Schools and Families and the Home Office, July 2009).
Section 12: Child Sexual Exploitation

Key Issues:

The CSE strategy has recently been updated jointly with Derbyshire Safeguarding Board to reflect on-going learning, national guidance and research. Associated with this is a robust action plan which is implemented by the CSE operational Sub Group and monitored for effectiveness through the Vulnerable Young People’s sub-group of the Board.

The Police have a separate CSE unit which is well resourced and pro-active. CSE is high profile and receives significant senior officer attention. The Police are actively engaged in multi-agency work and preventative projects. The Police were applauded nationally for their work in Operation Retriever. The Council has examined findings from the Jay report (corporate governance) and taken steps to be compliant.

Source: Children, Families and Learners Board Child Sexual Exploitation presentation - July 2015

71 Young people were subject of CSE strategy meetings during this year, a slight reduction over the previous three years of between 80 and 90

There were 52 new requests for CSE meetings in 14/15 compared with 64 in 13/14 and 127 in 12/13. Early on in 2014, an audit was undertaken to ensure referral thresholds were being correctly applied. This indicated the decrease can be attributed to professionals better understanding thresholds and identifying and managing low level risk appropriately.

At the first meeting, 28% were identified as low risk, 28% medium risk and 44% high risk, using the standard risk assessment.

45 young people ceased to be subject to CSE meetings this year; of those 49% had the risk reduced after intensive support. This compares very favourably with 40% of cases in 2013/14, and only 28% in 2012/13.

9% of closures were due to the young person being escalated to a child protection threshold, comparable to 7% in 2013/14 and a sustained improvement on the 36% in 2012/13.

Cases are thoroughly reviewed under the multi-agency strategy and are only closed where there is a sustainable reduction in risk to the child or an alternative plan put in place.

Of the new referrals, 27% (14) are children in care, 3 of those are looked after children from other local authorities, placed in Derby. This is a relatively high proportion, with most of those young people coming into care because of CSE and other associated risks and difficulties.

Of new requests for CSE meetings, 86% were female and 14% male. This means the number of referrals for males has increased again this year, but is still relatively low.

The ethnicity of children and young people newly referred is: White British 32 (62%), BME Communities 20 (38%) of which 12 were non-British White (23%). This is still suggestive of under-reporting from within black and Asian communities.

There have been 39 professionals meetings, 23 Initial CSE meetings, 19 first reviews and 20 further reviews. The average for young people attending their meetings over the year is 63%, this is a significant improvement on last year’s 42%, but still requires work. Evidence from CSE meetings show that where a young person is engaged on the strategy, there is a greater success rate. The number of parents attending has increased significantly, with a 73% average this year, compared to 48% last year. See appendix C & D for the impact of this.

What is being done locally to address this:

- **CSE Strategy Updates** - The CSE Procedures and Risk Assessment Toolkit were updated in January 15. The toolkit was updated through collaboration with Derbyshire Safeguarding Children Board and is now in use across the whole of Derbyshire. This will ensure consistent risk assessment of all cases and has already made a considerable difference to the number of referrals to the Derbyshire strategy.

- **Problem Profile** - The Child Sexual Exploitation Problem Profile has been produced as an annual review of multi-agency cases of CSE. It produces an analysis of current cases, risk factors and persons or areas of concern. The aim is to assist a multi-agency understanding of Child Exploitation issues across Derbyshire and is viewed in the context of the national picture. The current problem profile was updated in February 2015. This brings up to date the single agency Police problem profile on CSE from 2014.

- **CSE Champions** - We now have 54 CSE champions, including designated leads in secondary and primary schools. All partner agencies are required to provide a CSE champion within their agency and a manager to monitor CSE work.

- **Licensed premises** - The Say Something if You See Something Campaign (SSSS) has been running in Derby city for approximately 18 months. In the last year every taxi company and takeaway in Derby has been visited. Over the Christmas period the CSE champions and Licensing teams targeted public houses and clubs.

- **Licensing and Environment Services** - All teams within the Environment and Regulatory Services work with internal and external partners to ensure that safeguarding is embedded into the operation of businesses within the City.

- **Chelsea’s Choice** - is an applied theatre production, based on real stories of CSE. The play was delivered in 18 City schools; on 2 of those deliveries the audience were drawn from mainstream schools, pupil referral units and special needs schools. The play was also interpreted for deaf and hearing impaired children. The number of young people who attended the play in Derby is 5,090 and approximately 130 professionals.

- **Work in schools** - Schools have been supported and encouraged to incorporate CSE awareness into the curriculum at primary and secondary level.

- **Community Awareness Campaigns** - Partners including the Police, Safe and Sound and CSE Champions have delivered community awareness sessions.

- **Training Delivered** - The DSCB runs a 1 day course titled, Child Sexual Exploitation Awareness Course. Over the last year we have run the course 4 times. 89 professionals from various agencies attended those courses and feedback has been extremely positive.

- **Disruption** - Last year 12 abduction orders were served to disrupt contact between children and adults.

- **Police Operations** - There have been 6 Police operations in the last year in context to CSE.

What evidence is there that we are making a difference:

75% (15/20) of the young people were seen as safer and/or receiving on-going support as a result of interventions around them being missing - 3 were given advice only as of their return interview before the case was closed, 1 was monitored and subsequently referred for support, and 1 was not seen at all since was found to be living with relatives in another city.

Recommendations – what are the priorities for improvement

- Efforts to be made to engage with minority groups; to be developed within the community engagement strategy to ensure this addresses any under-reporting.
- When focusing on raising awareness and education with potential victims the 10-16 year old age group should be prioritised.
- To design an information collection template for the duration of a CSE investigation, to include more on disclosures, offence periods/timings, offender methodology.
- To consider information gathering from offenders, post-conviction to build up an offender profile. This could be included within the intelligence collection plan.
- A clear focus needs to be on raising awareness of online CSE to parents, encourage reporting and ensuring appropriate support mechanisms are in place for parents/carers as well as victims.
- Professionals should ensure they are familiar with recognising these forums when interacting with young people, to ensure opportunities are not missed. Additionally, the process of utilising secondary platforms should be highlighted in any training and awareness campaign as a risk indicator.
- The link between missing and CSE needs to be fully embedded with front line practitioners to ensure the correct robust response.
- Local safer neighbourhood officers should be focused upon raising awareness of CSE risk indicators, the recording process and the CSE toolkit.
- Consideration to be given to potential civil order to curtail offenders use on certain social media platforms. Additionally, positive use of conditional bail, ensuring this is policed, will provide further enforcement opportunities and support any civil opportunities.
- Ensure the policing policy is incorporated into the partnership communication strategy to ensure a consistent message across agencies.
- 14 and 15 year olds could be focused upon in respect of education, awareness raising and intervention.
- Ensure the warning signals around victims of CSE residing in care home, missing incidents, previous CSE links, ASB and drug use are incorporated into any training delivered to frontline practitioners.
- To provide a uniform approach to identifying key flags and indicators of CSE and be able to provide statistical information on this.

Section 13: Domestic Abuse and Sexual Violence

What is Domestic Abuse and Sexual Violence?

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, emotional and financial (Home Office, March 2013). Domestic abuse and sexual violence seriously impacts the safety, health and wellbeing of adults, children, families and communities across Derby.

Key Issues:

Our ambition for Derby is that everyone can live safe lives, without the threat or experience of domestic violence and abuse or sexual violence, because it is not tolerated by our residents or our organisations

Whilst recognising that men experience these forms of abuse (approx. 38%) the prevalence of intimate partner violence remains highest with women, with the severity of the violence and control is also higher and with more serious psychological consequences. Research suggests that male victims are nearly twice as likely to not tell anyone about partner abuse.

Prevalence is higher for younger groups (16 to 24 year olds for domestic abuse and 16-19 year olds for sexual violence.

Evidence suggests there is little variation in reported domestic violence and abuse and sexual violence however in some BME populations there may be cultural and social factors that increase the risks such as honour based violence and forced marriage as well as reluctance to report.

Data indicates that someone with a long term illness or a disabled person are more likely to be a victim. Risks increase where drug and alcohol feature in the relationship including use of prescription drugs.

Poverty and not social class is linked to higher risk. Local data suggests incidents are greater in areas of highest deprivation.

Evidence is increasing that partner abuse is as prevalent among same sex couples. Fear of discrimination may mean Lesbian, Gay, Bisexual and Transgender (LGBT) groups are less willing do not disclose.

Lifelong detrimental outcomes are often seen in those who witness and experience abuse and violence. Safe, stable and nurturing relationships with parents/carers are lacking and support to develop life skills to have ways to cope that are positive.

Source: Derby and Derbyshire Domestic Violence and Abuse and Sexual Violence Strategy 2015-2018
What is being done locally to address this:

Regular Multi-Agency Risk Assessment Conferencing (MARAC) – multi-agency victim-focussed meetings take place to share information on the highest risk cases of domestic violence and abuse between statutory and voluntary sector agencies.

Front line practitioners also carry out a CAADA assessment to identify high risk cases of domestic abuse, stalking and ‘honour’-based violence for referral to MARAC.

The Freedom Programme is delivered locally in Derby for women who have been affected by domestic violence. It aims to help women to gain a better understanding of the beliefs held by abusive men, illustrate the effects of domestic violence on children, improve the confidence and self-esteem of women who have been affected by domestic violence, and provide a supportive environment.

Domestic Abuse training is delivered through the local safeguarding board to enable staff to effectively work together with others to safeguard and promote the welfare of children who are living in a household with domestic violence.

Recommendations – what are the priorities for improvement:

Our primary focus is about managing those at highest risk of serious harm and/or homicide and delivering services to meet local need. Consultation with partner agencies and service providers has indicated that the top priorities for future commissioning include:

- ensuring a robust Multi-Agency Risk Assessment Conference (MARAC) and Independent Domestic Violence Advisors (IDVA) model
- Emergency Accommodation (refuge) and housing related support
- Medium risk outreach support services including Freedom Programme, helpline and drop in provision
- Specialist children’s domestic violence and abuse support
- Voluntary Perpetrator Programme
Section 14: Emergency Admissions to Hospital

What is Emergency Admissions to Hospital?

“Many emergency admissions to hospital are avoidable and many patients stay in hospital longer than is necessary. This places additional financial pressure on the NHS as the costs of hospitalization are high. Growth in emergency admissions is a sign that the rest of the health system may not be working properly. Making sure patients are treated in the most appropriate setting and in a timely manner is essential to taking the pressure off emergency hospital admissions.”

Source: Amyas Morse, head of the National Audit Office, 31 October 2013

Key Issues:

In 2013/14, there were 10,371 A&E attendances by children aged four years and under. This gives a rate which is higher than the England average. The hospital admission rate for injury in children is lower than the England average, and the admission rate for injury in young people is higher than the England average.

Admissions for 38 children aged under one cost £0.9 million a year.

Young people and alcohol
In comparison with the 2006/07-2008/09 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is similar to the England average. Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

In comparison with the 2008/09-2010/11 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men. Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

Source: CHIMAT
Southern Derbyshire Child Health Profile:

• The rate of **A&E Attendances in children under 5 years** is significantly **higher than for the Cluster**, ranging by practice from **362 to 806 per 1,000**.

• The rate of **A&E Attendances in children aged 5-18 years** is significantly **lower than for the Cluster**, ranging by practice from **218 to 973 per 1,000**.

• The rate of **hospital admission for asthma in under 5 year olds** is similar to that for the Cluster, ranging by practice from **0 to 691 per 100,000**.

• The rate of **hospital admission for asthma in 5-18 year olds** is similar to that for the Cluster, ranging by practice from **0 to 734 per 100,000**.

• The rate of **unplanned hospital admission for asthma, diabetes and epilepsy in under 19 year olds** is similar to that for the Cluster, ranging by practice from **0 to 753 per 10,000**.

• The rate of **hospital admission for lower respiratory infections in under 19 year olds** is significantly **lower than for the Cluster**, ranging by practice from **0 to 741 per 100,000**.

• The rate of **hospital admissions for gastroenteritis in under 1 year olds** is significantly **lower than for the Cluster**, ranging by practice from **48 to 761 per 10,000**.

• The rate of **hospital admission for alcohol specific conditions in under 18 year olds** is similar to that for the Cluster, ranging by practice from **0 to 179 per 10,000**.

• The rate of **emergency hospital admission following unintentional or deliberate injury in under 15 year olds** is similar to that for the Cluster, ranging by practice from **18 to 186 per 100,000**.

• The rate of **emergency hospital admission following unintentional or deliberate injury in 15-24 year olds** is similar to that for the Cluster, ranging by practice from **0 to 234 per 100,000**.

• The rate of **emergency hospital admission following accidents in under 18 year olds** is similar to that for the Cluster, ranging by practice from **0 to 85 per 100,000**.

• The rate of **emergency hospital admission following assault in under 18 year olds** is significantly **higher than for the Cluster**, ranging by practice from **0 to 118 per 100,000**.

• The rate of **emergency hospital admission following self-harm in under 18 year olds** is significantly **higher than for the Cluster**, ranging by practice from **0 to 520 per 100,000**.

*See appendix 8 for cluster information*
Section 14: Emergency Admissions to Hospital

Key Issues and Gaps:

The chart below shows how children’s health and wellbeing in Derby compares with the rest of England:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local no.</th>
<th>Local value</th>
<th>Eng ave.</th>
<th>Eng worst</th>
<th>Eng best</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E attendances (0-4 years)</td>
<td>10,371</td>
<td>574.5</td>
<td>525.6</td>
<td>1,684.5</td>
<td>252.7</td>
</tr>
<tr>
<td>Hospital admissions caused by injuries in children (0-14 years)</td>
<td>421</td>
<td>86.4</td>
<td>112.2</td>
<td>214.1</td>
<td>64.4</td>
</tr>
<tr>
<td>Hospital admissions caused by injuries in young people (15-24 years)</td>
<td>546</td>
<td>150.4</td>
<td>136.7</td>
<td>291.8</td>
<td>69.6</td>
</tr>
<tr>
<td>Hospital admissions for asthma (under 19 years)</td>
<td>83</td>
<td>136.1</td>
<td>197.1</td>
<td>509.1</td>
<td>54.6</td>
</tr>
<tr>
<td>Hospital admissions for mental health conditions</td>
<td>35</td>
<td>60.5</td>
<td>87.2</td>
<td>391.6</td>
<td>25.6</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm (10-24 years)</td>
<td>312</td>
<td>605.1</td>
<td>412.1</td>
<td>1,246.6</td>
<td>119.1</td>
</tr>
</tbody>
</table>

What is being done locally to address this:

Children’s Centres and health visitors are key sources of support and education for parents, providing them with the confidence to manage minor illnesses in their child.
Between 1st January 2013 and 31st March 2015, there were 149 child deaths – 115 of which were completed cases and evaluated by the Child Death Overview Panel in August 2015.

Modifiability
Within 26 of the 115 completed cases (23%), modifiable factors were identified. The CDOP identified that the most common factors across modifiable cases were acute/sudden onset illness and other chronic illness – both of which are intrinsic to the child. This was followed by factors relating to service provision – access to health care and prior medical intervention. The most common factors in the family and environment were smoking by a parent/carer in the household (9; 35%) and smoking during pregnancy (8; 31%). During this time period, there was also a death related to nappy sacks.

In-depth analyses revealed clear differences in the characteristics of children within the modifiable and non-modifiable cases. These stemmed from: 1) deprivation 2) location of death and 3) safeguarding issues.

Deprivation
65% of modifiable cases (n=17) originated from the more deprived local quintiles of 1 and 2. On the other hand, non-modifiable cases appeared to show a more even spread across the deprivation quintiles. (Local deprivation quintiles were calculated by first extracting the child’s IMD score from their lower super output area (LSOA) of residence. The LSOAs were then sorted from the most to the least deprived, before being divided into quintiles.)

Location of death
83% of incidents with no modifiable factors arose in an acute hospital, whilst the home was the most common location within modifiable cases (50%).

Safeguarding issues
The table below reveals that a markedly higher proportion of children within modifiable cases had associated safeguarding issues than those within non-modifiable cases.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>No modifiable factors identified</th>
<th>Modifiable factors identified</th>
<th>No modifiable factors identified (as a proportion of cases with no modifiable factors identified)</th>
<th>Modifiable factors identified (as a proportion of cases with modifiable factors identified)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child or family known to social care</td>
<td>15</td>
<td>10</td>
<td>16.9%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Child or family known to police</td>
<td>13</td>
<td>7</td>
<td>14.6%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Child or family known to both social care and police</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Total</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Secondary suppression was implemented in order to protect the confidentiality of cells that pose an unacceptable risk of disclosure.
• 41% of cases within the latest CDOP report arose within Derby city.

• In addition to this, the crude rate of deaths per 1,000 amongst 0-17 year-olds within the city was significantly higher than that of the county (0.41 compared with 0.20). This is particularly notable when considering that Derby city has a child population that is almost three times smaller than that of the county.

The table below demonstrates that both the City and County had the highest proportion of deaths in children under 1. However, this issue is magnified within the City, with over half of the child deaths arising in babies aged 0-27 days.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Derby City</th>
<th>Derbyshire County</th>
<th>Derby City %</th>
<th>Derbyshire County %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-27 days</td>
<td>25</td>
<td>25</td>
<td>53.2%</td>
<td>39.7%</td>
</tr>
<tr>
<td>28 days-1 year</td>
<td>9</td>
<td>11</td>
<td>19.1%</td>
<td>17.5%</td>
</tr>
<tr>
<td>1-4 years</td>
<td>10</td>
<td>9</td>
<td>21.3%</td>
<td>14.3%</td>
</tr>
<tr>
<td>5-9 years</td>
<td>&lt;5</td>
<td>6</td>
<td>*</td>
<td>9.5%</td>
</tr>
<tr>
<td>10-14 years</td>
<td>&lt;5</td>
<td>6</td>
<td>*</td>
<td>9.5%</td>
</tr>
<tr>
<td>15+</td>
<td>&lt;5</td>
<td>6</td>
<td>*</td>
<td>9.5%</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>63</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Neonatal deaths were the most common event within Derby city, which were followed by sudden unexpected, unexplained deaths.

<table>
<thead>
<tr>
<th>Event</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal death</td>
<td>25</td>
<td>53%</td>
</tr>
<tr>
<td>Sudden unexpected, unexplained death</td>
<td>9</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>Known life limiting condition</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Drowning</td>
<td>&lt;5</td>
<td>*</td>
</tr>
<tr>
<td>Other non-intentional injury/accident/trauma</td>
<td>&lt;5</td>
<td>*</td>
</tr>
<tr>
<td>No data</td>
<td>&lt;5</td>
<td>*</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100%</td>
</tr>
</tbody>
</table>
Quality enhancement:

The following actions have been implemented as a result of the recent CDOP review:

1. *Implementation of carbon monoxide monitoring for all pregnant women at the Royal Derby Hospital.* This will help to identify those who do smoke, and subsequently ensure that they have timely access to smoking cessation services.

2. *The development and utilisation of an action log that will be shared in the near future.*

3. *Identification of data quality issues that will assist in the development of a more robust database.*

4. *Contribution to national consultation for a CDOP database.*

5. *Investigation into previous consanguinity trends.* This will stimulate a more proactive approach towards the prevention of child deaths related to consanguinity.

6. *Discussions surrounding the integration of stillbirth reporting within CDOP.* This will provide a broader perspective on the preventative measures required to address child deaths.

7. *Partnership working with the Royal Society for the Prevention of Accidents (ROSPA).* This has initiated upstream work, such as increasing the awareness of the nappy sac campaign.

8. *Promotion of key messages about keeping babies safe.* A “keeping your baby safe leaflet” is currently being developed and piloted by parents.
Our Priorities
Demand Management

Children in need

- Over the last three years...
- New referrals for those aged 4 years and under have increased
- Referrals from BME groups have increased
- There has been 8% more males subject to an early help referral than females

Early help services

- Over the last three years...
- There has been limited variance in males and females subject to a CIN referral
- There has been growth in demand from the 5 - 9 year old cohort
- Although there has been a growth in BME groups, this is to a lesser extent than for other levels of support / intervention

Child protection plans

- Over the last three years...
- New referrals for those aged 0 - 4 years have grown
- New plans for BME groups in particular those relating to new communities have increased
- Plans are lasting longer
- There was a rise in large sibling groups in 2013/14
- There are more plans for families in locality 3/4

Looked after children

- Over the last three years...
- Increasing LAC numbers appear to correlate to an overall increase in demand from males and children within the 10 - 15 age group
- Representation of BME groups in new referrals have grown considerably with increases in 'Asian Asian British', 'White Other' and 'Other'
Further developing the JSNA

Historically, the JSNA in Derby, as in many places was developed to be a ‘hard copy’ version produced every few years. This was labour intensive to produce and became almost immediately out-of-date.

To improve the timeliness of the JSNA and increase its accessibility, we have been working towards a JSNA which is web-based and interactive.

The first stage of this process has been to move away from the ‘hard copy’ version with the development of a web-based version.

Whilst the web-based JSNA is not fully interactive, it provides an ‘information portal’ with access to summary and context information, locally produced reports and needs assessments alongside links to nationally produced information profiles and tools.

The next step in the development of our local JSNA is an online interactive and dynamic version.

This version will allow access to up-to-date information that can be interrogated and viewed in a range of different ways including geographical data and maps.

This work is still in development with a ‘live’ version planned to be launched in summer 2015.
Supporting Material

Derby City Council
The health of women prior to, during and after their pregnancy is closely associated with the outcomes of both the mother and child. Antenatal health care has a unique and vital contribution to make to improving maternal and infant health outcomes and reducing health inequalities, ensuring that every child has the best start in life and is ready to succeed. During the postnatal period there is significant potential to improve the health and well-being of both mother and baby, particularly around future pregnancy, stopping smoking, sexual health, emotional health, healthy diet, physical activity, weight management.

Rates of infant mortality are higher in Derby than the national average although this difference is not statistically significant. There are a greater proportion of children in Derby than the national average who have a low birth-weight. Low birth-weight is closely associated with infant mortality and ill-health in infants and children. It is influenced by a range of factors including maternal nutrition, smoking, alcohol intake and age and gestational age. Over 15% of women in Derby smoke at the time of delivery, higher than the national average.

Breastfeeding protects the health of baby and mother, and reduces the risk of illness. Infants who are not breastfed are more likely to have infections in the short-term; such as gastroenteritis, respiratory and ear infections. In the longer term they will be at higher risk of developing Type 2 Diabetes as well as high levels of blood pressure and cholesterol.

The rate of breastfeeding initiation (72%) is lower in Derby than nationally.

Poor maternal health disproportionally affects those of a lower socio-economic status and teenage mothers. Consequently the children of these women are more likely to experience poor health outcomes related to maternal health before, during and after pregnancy.
Appendix 1: Health and Well-being – Maternal Health

What is maternal health?

The health of women prior to, during and after their pregnancy is closely associated with the outcomes of both the mother and child. Antenatal health care has a unique and vital contribution to make to improving maternal and infant health outcomes and reducing health inequalities, ensuring that every child has the best start in life and is ready to succeed. During the postnatal period there is significant potential to improve the health and well-being of both mother and baby, particularly around future pregnancy, stopping smoking, sexual health, emotional health, healthy diet, physical activity, weight management.

Key Issues and Gaps:

Rates of infant mortality are higher in Derby than the national average although this difference is not statistically significant. There are a greater proportion of children in Derby than the national average who have a low birth-weight. Low birth-weight is closely associated with infant mortality and ill-health in infants and children. It is influenced by a range of factors including maternal nutrition, smoking, alcohol intake and age and gestational age. Over 15% of women in Derby smoke at the time of delivery, higher than the national average.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local no.</th>
<th>Local value</th>
<th>Eng. Ave</th>
<th>Eng. Worst</th>
<th>Eng. Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>17</td>
<td>4.7</td>
<td>4.1</td>
<td>7.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Low birthweight of all babies</td>
<td>320</td>
<td>9.5</td>
<td>7.4</td>
<td>10.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Smoking status at time of delivery</td>
<td>479</td>
<td>15.1</td>
<td>12.0</td>
<td>27.5</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Definitions:
Infant mortality - Mortality rate per 1,000 live births (age under 1 year, 2011-13)
Low birth weight - Percentage of live and stillbirths weighing less than 2,500 grams, 2013
Smoking at time of delivery - % of mother smoking at time of delivery, 2013/14

Breastfeeding protects the health of baby and mother, and reduces the risk of illness. Infants who are not breastfed are more likely to have infections in the short-term; such as gastroenteritis, respiratory and ear infections. In the longer term they will be at higher risk of developing Type 2 Diabetes as well as high levels of blood pressure and cholesterol. The rate of breastfeeding initiation (72%) is lower in Derby than nationally.

Poor maternal health disproportionally affects those of a lower socio-economic status and teenage mothers. Consequently the children of these women are more likely to experience poor health outcomes related to maternal health before, during and after pregnancy.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local no.</th>
<th>Local value</th>
<th>Eng. Ave</th>
<th>Eng. worst</th>
<th>Eng. Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding initiation</td>
<td>2526</td>
<td>71.6</td>
<td>73.9</td>
<td>36.6</td>
<td>93.0</td>
</tr>
</tbody>
</table>

Definition: Percentage of mothers initiating breastfeeding, 2013/14
Obesity

Being overweight or obese can lead to both chronic and severe medical conditions, and the cost to society and the economy of these conditions is high and increasing.

The proportion of obese children at year 6 in Derby in 2013-14 was higher at 20.8% than the national average. In Derby 8.5% of reception aged children in 2013-14 were obese which is slightly lower than the national population this age.

In general, children classed as White British have lower obesity prevalence than most other ethnic groups, with highest rates tending to occur in Black and Bangladeshi groups. Obesity disproportionally affects those in lower socio-economic groups.

Smoking

National estimates of smoking prevalence in people aged under 18 years indicate that 4% of 11 – 15 year olds are regular smokers (reported smoking at least once a week). Regular smokers smoked on average about 36 cigarettes per week. Smoking increases with age in both boys and girls, but girls have a higher prevalence in ages 13-14 years compared to boys. In older teenagers (aged 16 – 19 years) the prevalence of smoking is 18% in men and 19% in women aged 16-19 years.

Immunisation and Vaccination

Vaccination is regarded as being one of the most important and successful public health measures in terms of preventing illness and mortality. Children and young people at highest risk of not being immunised include looked after children, those not registered with a GP (children of parents who are homeless, asylum seekers and drug users for example), minority ethnic groups (especially those whose first language is not English), children with physical/mental learning difficulties, children of teenage/single parents etc.

Overall immunisation rates for children in Derby are very good with performance around the 95% target and generally higher than the national average and similar to the family group average. The only area of concern is around uptake of the second dose of the MMR vaccine, whilst better than the national and family group average, remains significantly below the 95% target.
Sexual health

Access to good sexual health services is essential for young people. Young people are disproportionately affected by sexual ill health; they are more likely to engage in risky behaviours and are less likely to use contraception; therefore they are at increased risk of both pregnancy and sexually transmitted infections (STIs).

Although just one in eight of the population are within this age range, this group accounts for around half of the newly diagnosed STIs in the UK—65% of all chlamydia, 56% of all genital warts and 57% of all gonorrhoea infections (15–24 year old heterosexuals). However, this does not include diagnoses made in other settings and those that remain undiagnosed, therefore the figures underestimate the true level of infection in young people. Young gay and bisexual men have a higher risk of acquiring STIs: 34% of genital warts, 24% of gonorrhoea, 22% of genital herpes and chlamydia and 13% of syphilis cases diagnosed in 2011 were in those aged 15–24.

The higher prevalence of chlamydia in the 15–24 age group has resulted in the establishment of a National Chlamydia Screening Programme (NCSP) aiming to test all sexually active under-25s annually, or with each change of partner, as a routine part of primary care and sexual health consultations.

The rate of acute STI in 15 – 24 year olds in Derby is higher than the national average 38.3 per 1,000 population and the rate of chlamydia diagnosis in this age group above the national target (25.3 in 2011 against a target of 24). However, the number of young people tested for STIs outside genitourinary medicine (GUM) clinics is lower than the national average. This implies that an important proportion of young people with STIs are not being diagnosed and treated.

Teenage pregnancy

There is growing recognition that teenage pregnancy and early parenthood can lead to poor educational achievement, poor physical and mental health, poverty, and social isolation.

Most teenage pregnancies are unplanned and around half end in an abortion.

While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby’s health, the mother’s emotional and mental health and well-being.

In line with the national picture, rates of under 18 conceptions and the percentage of new mothers who are teenagers in Derby City have declined since 1998. However, both these rates remain significantly greater than the national average with a rate of 41.4 pregnancies per 1,000 15-17 year olds in 2013.

Teenage pregnancy is associated with poverty, low aspirations and not being in education, employment or training. Socioeconomic disadvantage can be both a cause and an effect of young parenthood.

Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems. There is evidence of an association between alcohol use and teenage conception, regretted sex or forced sex.
Appendix 4: Health and Well-being – Risky behaviours and substance misuse

The data below reflects the number of young people in specialist substance misuse services in Derby during 2011-12, 2012-13 and 2013-14; the number of young adults in young people only specialist services; and the number of young people who have received specialist treatment within a secure setting.

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of young people (aged under 18) in specialist services in the community</td>
<td>61</td>
<td>19126</td>
<td></td>
</tr>
<tr>
<td>Number of young people (aged 18-24) in young people only specialist services in the community</td>
<td>15</td>
<td>3106</td>
<td></td>
</tr>
<tr>
<td>Number of young people (aged under 18) in specialist services within the secure estate</td>
<td>23</td>
<td>1702</td>
<td></td>
</tr>
</tbody>
</table>

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. They are more likely to be not in education, employment or training (NEET), have contracted a sexually transmitted infection (STI), experiencing domestic violence, experiencing sexual exploitation, be in contact with the youth justice system, be receiving benefits by the time they are 18, and half as likely to be in full-time employment.

Universal and targeted services have a role to play in providing substance misuse advice and support at the earliest opportunity. Specialist services should be provided to those whose use has escalated and is causing them harm. There should be effective pathways between specialist services and children’s social care for those young people who are vulnerable and age-appropriate care should be available for all young people in specialist services.

Source: National Drug Treatment Monitoring System 2013-14
This section considers substance misuse in the context of risky behaviours. Sexual health, teenage pregnancy, and self-harm are considered elsewhere in this document.

Drug misuse can have a major impact on young people’s health, education, families and their long-term chances in life.

In Derby, the estimated prevalence rate of opiate and/or crack cocaine users aged 15-24 in 2011/12 was 8.6 per 1,000. This was significantly higher than its nearest neighbour (5.3), regional average (5.1) and national average (4.7). The modelled prevalence of regular smokers in Derby aged 11-17 years is not significantly different from the national average.

This figure reflects under-18 hospital admission trends. The rate of under-18 hospital admissions has declined in Derby over recent years.

Although Derby is lower than its nearest neighbour, it remains above the regional and national averages. However, the relatively wide confidence intervals for this period indicate that this difference is not statistically significant.

Since 2007/08, Derby has shown a substantial drop in the rate of under-18s admitted to hospital with alcohol specific conditions.

This chart provides a breakdown of hospital admissions due to substance misuse in 15-24 year-olds. Locally, the rate of hospital admissions for substance misuse in young people continues to increase.

In addition, Derby now exceeds its nearest neighbour as well as the regional and national averages. However, the difference between Derby and its comparators is not statistically significant.

Sources: National Treatment Agency 2011-12; Local Authority Child Health Profiles 2015; Derby Community Safety Partnership Young person’s Specialist Substance Misuse Needs Assessment 2010; Local Health Profiles 2009-2012
There have been recent changes to Derby’s population including an increase in GRT pupils that impacts on outcomes particularly in the earlier phases (Ofsted thematic in 2013). The percentage of children living in poverty within the city is above the national average at 23.4% compared to 20.1%.

The number of families accessing early help services has risen; with over 500 families in the city having an 'open' early help assessment at the end of March 2015. Further to this Derby City’s priority families initiative (nationally known as 'troubled families') is working to support better outcomes for over 600 families across the city.

Although still below national averages the quality of early year's providers in the city has improved by over 10% in the last 12 months, meaning children are getting more access to 'good' quality early year's education. The percentage of eligible 2 year olds accessing free nursery places has also risen to over 1,200 children, which is above the national average take-up of 55%. It should also be noted that there is a higher than average demand for special educational support with recent rises in autism.

There is therefore a higher than average percentage of pupils in the city which are eligible for FSM (primary and special schools), have EAL, are of GRT heritage etc. which adds to the complexities that schools at all levels need to manage to support pupils to achieve good outcomes.

• 19% gap between those eligible and claiming for FSMs, which has increased by 2% from 2013.
• 41% gap between those with a special educational need compared to those pupils without any special educational needs, a gap that has widened by 7% from 2013 to 2014.
• 21% gap between those pupils with English as an additional language compared to those pupils that have no EAL, a gap that has increased by 7% between 2013 and 2014.

Appendix 5: Early Years

Early years interventions encompass the specific programmes and services which help to give young children the best start in life and support them to reach their full potential. There are universal services for all children, for example the advice and support given by health visitors, Sure Start Children’s Centres and the free entitlement to early learning for three and four-year olds and more targeted programmes for vulnerable young children such as funded early learning places for two-year olds from low income families.

By investing in early years interventions we can help support the healthy development of children both socially and emotionally and early interventions can help reduce and prevent the likelihood of development issues meaning that children will have better health, education, social and employment outcomes as adults.

Derby’s Children and Young People Plan states that Derby will: ‘Work together and with the Derby Children's Safeguarding Board to keep children and young people safe through making sure that they have access to good quality services at the earliest opportunity, reducing the likelihood of them being exposed to or participating in 'risky' behaviours.’
Early Years Foundation Stage (EYFS) outcomes have improved significantly since 2013 and the rate of improvement is faster than national (10% in Derby compared to 8% nationally). However, the percentage of pupils achieving ‘a good level of development’ remains very low at 51%. The percentage of children scoring at or above expected levels has increased for 16 of the 17 early learning goals. Over 75% children achieved expected or above expected levels in listening and attention, physical development, personal, social and emotional development, understanding of the world and expressive arts and design.

Derby’s performance is lower than that of similar Local Authorities and is significantly lower than national. An increasing number of Gypsy/Roma pupils enter Derby schools with little or no pre-school experience and this factor needs to be taken into account when analysing end of Foundation Stage outcomes.

Standardised progress measures are not produced for EYFS, however schools’ internal data suggests that these outcomes represent good progress from children’s starting points, reflecting the good or better teaching in this key stage. Ofsted reports confirm that teaching is judged good or better in 80% schools with Nursery and Reception pupils.

The team working with Early Years settings and child-minders will continue to focus on improving the quality of provision using outstanding practitioners from schools to support less effective settings. Training for Early Years teachers in schools will be provided by the Nursery Schools’ Training Hub (NEEDU) and schools will be signposted to good practice within and beyond the LA.

Derby’s average for Personal, social and emotional development (PSE) is lower than both our comparator authorities’ and national averages (particularly in emotional development - Derby 76%, comparator authorities 81% and national 85%). Nationally, compared to 2011, the percentage of children working securely represents a rise of 1 or 2%. Derby has improved by 1% in 'disposition and attitudes' and 'emotional development' and by 2% in 'social development'.

Summary:
- Improvement in percentage achieving ‘good level of development’ (GLD) and percentage of children at or above expected levels in each early learning goal.
- Faster than national rate of improvement.
- Teaching good or better in 80% schools with Nursery and /or Reception children.

Areas for Development:
- Low GLD compared to national (51% / 60%)
- Gap between all pupils and ‘vulnerable groups’
- Derby ranking dropped from 140th to 144th
- Attainment gap between lowest 20% and median wider than national (34% /41%)
In Derby the average number of days between a child entering care and moving in with their adoption family is 721, this is an increase of 6 days since the previous reporting period.

Although the average number of days over three years has increased, it is worth noting that for the one year trend Derby has shown improvement again this year, for the second year running.

**Derby is over the expected threshold by 174 days.** This is a considerable deterioration compared to last year as Derby was 107 days over the threshold. The threshold for 2011-2014 reduced to 547 days from the threshold of 608 days in 2010-2013. Three of our comparator authorities have met the appropriate threshold for this measure.

Derby has the highest number of days out of our comparator group in terms of average days taken between a court order being granted and a matching to a suitable adoptive family. Derby is 217 days over the national threshold of 152 days (a reduction from the threshold of 182 days for 2010-2013). The one year trend for Derby has also not improved from 2013.

The average time in Derby during the years 2011-2014 is longer than it was in 2010-2013, increasing from 333 days up to 369 days. Only one of our comparator authorities met the appropriate threshold for this measure.

Derby has seen a drop in performance for the Percentage of children who wait less than 18 months between entering care and moving in with their adoptive family with 41% of children waiting less than 18 months between entering care and moving in with their adoptive families. 2010-2013 saw 50% for this measure, but the timescale has been reduced from 20 months to 18 months. Derby stand below the national (51.0%) and comparator (52.3%) averages for this measure.
Derby has a high percentage of children ceasing care through adoption, with a combined percentage of 30%. The national average is 17% and our comparators average is 22%. Derby also has a higher percentage of children who transferred to adult residential social care (14%). This is double the national average (2%) and higher than our comparators at 5%.

Derby has had 130 children adopted over a three year period which equates to a performance of 24%. This is considerably higher than the national average (14%), and also higher than the comparator authority average (18.8%).

20% of adoptions are children from ethnic minority backgrounds. This is significantly higher than the national average of 8%, and the comparator average of 13.3%. 13% of adoptions are children aged five or over. This is significantly higher than the national average of 5% and the comparator authority average of 6.1%.

The national average target of care proceedings is 26 weeks, as of September 2015 the average length in Derby was 19.1 weeks, which is within the top 25% nationally.

During the three year period 1st April 2011 to 31st March 2014, 30 children in Derby had their plan changed away from adoption. This equates to a figure of 12% which is in line with the national average of 12% and the comparator authority average of 12.5%. It is a decrease of 4% from the last three year cycle.

On average since March 2011 there have been 45 / 46 children entering and exiting care every 3-months / per Quarter, which has meant our figures have stabilised. In 2013/14 there were a total of 162 entrants into care and 174 exits.

Derby had 58% of its care leavers in education, employment or training on their 19th, 20th or 21st birthday. This was above the national average of 45% and the comparator authority average of 39%. The measures now look at children aged 19, 20 or 21 who were looked after for at least 13 weeks after their 14th birthday, including some time after their 16th birthday.

Derby had 89% of their care leavers in suitable accommodation on their 19th, 20th or 21st birthday. This compares to 73% seen in our comparator average and 78% seen nationally.
## Appendix 7: Derby City Wards and Localities

<table>
<thead>
<tr>
<th>Locality</th>
<th>Ward</th>
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<tbody>
<tr>
<td>Locality 1:</td>
<td>Oakwood</td>
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<tr>
<td></td>
<td>Derwent</td>
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<tr>
<td></td>
<td>Chaddesden</td>
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<td></td>
<td>Spondon</td>
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<td>Locality 2:</td>
<td>Alvaston</td>
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<td>Sinfin</td>
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<td>Boulton</td>
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<td>Chellaston</td>
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<td>Locality 3:</td>
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<td>Arboretum</td>
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<td></td>
<td>Normanton</td>
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<td>Locality 4:</td>
<td>Mickleover</td>
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<td></td>
<td>Littleover</td>
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<td></td>
<td>Blagreaves</td>
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<td>Locality 5:</td>
<td>Allestree</td>
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<td>Mackworth</td>
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<td></td>
<td>Darley</td>
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</tbody>
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Appendix 8: CCG Clusters

CCG Cluster groups are based on the NHS England groupings of CCGs, that are used for the likes of the national Commissioning for Value and Right Care packs.

The list is below:

- NHS Bedfordshire CCG
- NHS Nene CCG
- NHS East and North Hertfordshire CCG
- NHS Gloucestershire CCG
- NHS Wiltshire CCG
- NHS West Leicestershire CCG
- NHS Mid Essex CCG
- NHS Somerset CCG
- NHS Wakefield CCG
- NHS Ipswich and East Suffolk CCG
Sources:

- Derby and Derbyshire Pharmaceutical Need Assessment 2015
- Office for National Statistics
- Derby City Council Children and Young People’s Plan 2013 – 2015
- Report to the Derby Safeguarding Children’s Board on the effectiveness of Early Help Arrangements 2014-15
- CYP/YOS data sift – open cases 01/01/2015
- Derby’s Priority Families: An Independent Evaluation
- SFR36-2014 Statistical First Release 2013-14 - 10/12/2014
- Derbyshire Healthcare NHS Foundation Trust
- DfE SFR43-2014 Children in Need Statistical Release 2013-14
- Children, Families and Learners Board Child Sexual Exploitation presentation - July 2015
- Sharp, N., 2011; Cockbain, E. and Brayley, H., 2012; Child Exploitation and Online Protection Centre (CEOP), 2011.
- Derby Safeguarding Children Board Review of Serious Case Reviews and Learning Reviews 2008 – 2014
- Derby and Derbyshire Domestic Violence and Abuse and Sexual Violence Strategy 2015-2018
- Amyas Morse, head of the National Audit Office, 31 October 2013
- CHIMAT
- Derby City & Derbyshire County Child Death Overview Panel Annual Reports 2013 & 2015
- Public Health Directorate report – A needs assessment for disabled children in Derby City
- Impower – Derby SEN&D case for change report
- National Drug Treatment Monitoring System 2013-14
- National Treatment Agency 2011-12; Local Authority Child Health Profiles 2015; Derby Community Safety Partnership Young person’s Specialist Substance Misuse Needs Assessment 2010; Local Health Profiles 2009-2012