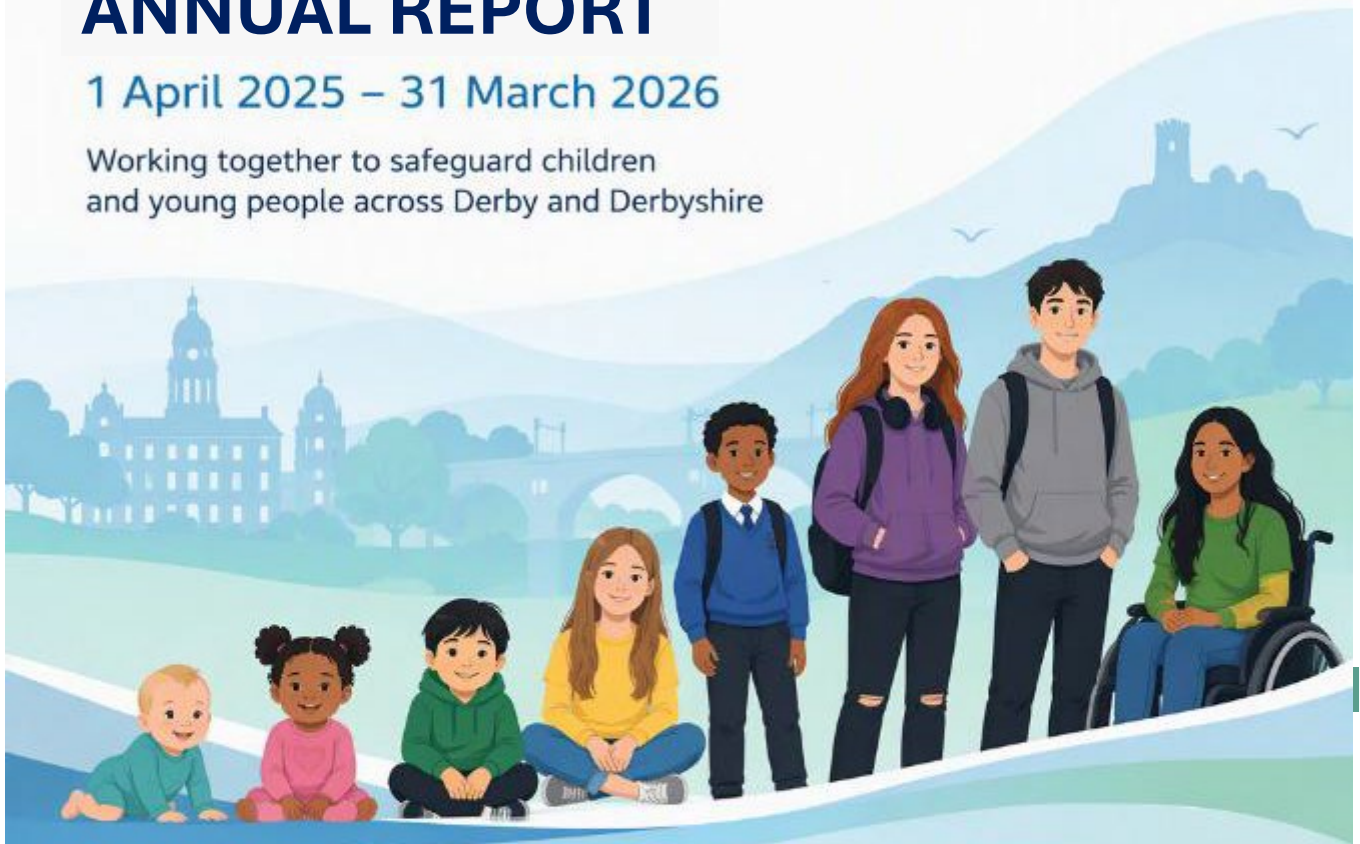


DERBY AND DERBYSHIRE SAFEGUARDING CHILDREN PARTNERSHIP

ANNUAL REPORT

1 April 2025 – 31 March 2026

Working together to safeguard children
and young people across Derby and Derbyshire



Children
at the centre



Stronger
together



Safer
tomorrows

OUR STATUTORY SAFEGUARDING PARTNERS



Derby City Council



A safer, brighter future for every child

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1. Foreword and executive summary

Foreword from the Lead Safeguarding Partners

We are pleased to present the Derby and Derbyshire Safeguarding Children Partnership annual report for 2025/26. It provides a public account of how safeguarding partners and relevant agencies worked together, what we learned, the difference made, and where further improvement is required.

The year was marked by significant national and local change. Alongside maintaining oversight of safeguarding risks, the partnership prepared for Families First reforms, changes affecting health and community safety arrangements, and Local Government Reorganisation. Throughout this period, our shared focus remained on children's safety, lived experiences and outcomes.

We thank children, young people, parents and carers who shared their experiences, and practitioners, managers and partner organisations whose work informed learning and improvement across Derby and Derbyshire.

Derby City Council – Sam Dennis, Chief Executive

ICB DLN Cluster – Rosa Waddingham, Director of Quality (Nursing)

Derbyshire Constabulary – Simon Blatchly, Chief Constable

Derbyshire County Council - Neil Crittenden, Chief Executive

Executive summary

During 2025/26, the partnership strengthened multi-agency safeguarding arrangements and maintained strategic focus on child neglect, domestic abuse and online harms. Learning from reviews, audits, performance information, independent scrutiny and the experiences of children and families informed priorities and improvement activity.

Key progress

- Governance and scrutiny were strengthened through the appointment of an Independent Scrutineer, a formal scrutiny workplan and revision of the scrutiny strategy.
- The Quality Assurance Strategy and performance framework were reviewed to improve the use of evidence, outcomes and assurance.
- The partnership performance framework and dashboard were updated to strengthen the consistency, visibility and use of safeguarding intelligence for oversight and assurance.
- The Child Neglect Strategy, delivery plan and supporting practice resources were developed, including work to revise the Graded Care Profile.
- The Domestic Abuse Handbook was completed and promoted, and Operation Encompass arrangements were strengthened to improve information shared with education settings.
- The Schools and GP Communication initiative strengthened information sharing between education and primary care to support better-informed safeguarding responses.

- Online harms procedures and resources were updated in response to emerging risks and feedback from education partners.
- Learning from reviews was translated into briefings, best practice guides, procedures, training and action plans.
- Partnership communication and engagement were strengthened through the stakeholder webinar and wider sharing of governance updates, review learning, priority progress and safeguarding resources.
- The partnership supported Families First development across Derby and Derbyshire and reviewed its business unit and subgroup structure to reduce duplication and protect core statutory functions.

Strongest evidence of difference

Learning and assurance activity led to clear changes in local arrangements, guidance, tools, training and multi-agency processes. Examples include improved timeliness and content of Operation Encompass notifications, new practice resources, stronger police and children's services decision-making about Police Protection powers, and the use of parent feedback to develop Keeping Babies Safe work.

Further evaluation is needed to demonstrate how these changes are improving outcomes for children and families. During 2026/27, stronger evaluation, re-audit, child and family feedback and outcome measures will be used to test whether improvements are embedded and sustained.

Main challenges

- Demonstrating consistently what has changed for children and families, not only what activity has been completed.
- Maintaining effective safeguarding leadership, accountability and capacity during significant organisational reform.
- Improving consistency in thresholds, assessment, information sharing, planning and use of safeguarding tools.
- Use the lived experiences of children and families, alongside performance data and thematic analysis, to identify partnership-wide strengths, risks, trends and inequalities.
- Keeping online harms visible across workstreams following changes to governance.
- Matching the partnership's ambition and statutory responsibilities to sustainable resources.

2. DDSCP at a glance



From evidence to improvement

1. Review and listen: reviews, audits, data, scrutiny and lived experiences.
2. Identify learning: strengths, risk, variation and gaps.
3. Take action: strategies, procedures, tools, training and multi-agency change.
4. Test practice: audit, performance measures, feedback and scrutiny.
5. Provide assurance: report what changed, what remains uncertain and what happens next.

3. Local context and safeguarding arrangements

The Derby and Derbyshire Safeguarding Children Partnership (DDSCP) operates across the geographical areas of Derby City and Derbyshire County, supporting partners to safeguard and promote the welfare of children and young people living within diverse urban, rural and semi-rural communities. Evidence from local population and needs data demonstrates continuing demand for safeguarding support, increasing levels of deprivation and growing complexity of need.

Children living in Derby

In Derby, there were 59,411 children aged 0-17 years¹. 27.9%² are living in low-income households, an increase from the previous year. The table below provides an overview of the profile of statutory and early help intervention across Derby City as at 31st March 2026.

At the end of March 2026, for every 10,000 children living in Derby there were:

Derby City	This year	Last year	Statistical neighbours	National
Children supported through targeted Early Help	62.9	62.8		
Children supported under a Child in Need plan	70.2	84.9	91.4	86.2
Children on a Child Protection Plan	38.0	42.1	56.6	41.6
Children in the care of the local authority	82.4	90.7	97.6	67.1

Compared with the previous year, rates of statutory intervention decreased, while targeted Early Help remained stable. Rates of children in need and children subject to Child Protection Plans were below both statistical neighbour and national averages. The rate of children in care was below the statistical neighbours but above the national average. Abuse and neglect continued to be the primary presenting need, representing 68.3% of Children in Need plans and 72.2% of Looked After Children cases. Neglect, at 53.4% and emotional abuse, at 32.2%, were the most prevalent categories within Child Protection Plans.

Separate education data recorded 7,143 children receiving Special Education Needs and Disabilities (SEND) Support in Derby schools, compared with 6,792 in 2025 and 6,375 in 2024).

Children living in Derbyshire

Across Derbyshire, approximately 153,116 children¹ and young people aged 0-17 live in the county, with 21.8%² living in low-income households, also rising from the previous year. The table below provides an overview of the profile of statutory and early help intervention across Derbyshire as at 31st March 2026.

¹ 1ONS Mid-Year Population Estimates:

² DfE Local Authority Interactive Tool (LAIT)

At the end of March 2026, for every 10,000 children living in Derbyshire there were:

Derbyshire	This year	Last year	Statistical neighbours	National
Children supported through targeted Intervention	130	77		
Children supported under a Child in Need plan	90	95	80	86.2
Children on a Child Protection Plan	45	47	35	41.6
Children in the care of the local authority	64	66	71	67.1

Overall, Derbyshire has seen a substantial increase in children receiving targeted interventions, alongside small reductions in Children in Need, Child Protection and Children in Care rates, although statutory intervention rates remain above both statistical neighbour and national averages for Children in Need and Child Protection Plans. Abuse and neglect continue to be the primary presenting need, representing 44% of Children in Need plans and 62% of Looked After Children cases, with neglect (75%) the most prevalent category within Child Protection Plans.

Separate education data recorded 17,305 children receiving Special Education Needs and Disabilities (SEND) Support in Derbyshire, and 9,451 children with an Education, Health and Care Plan.

Assurance arising from inspections

Derby City Council

Derby City Council Children's Services experienced an [Inspection of Local Authority Children's Services](#) (ILACS) during May 2025. There were graded as Outstanding in all five judgement areas. Children in Derby benefit from:

- High-quality social work practice.
- A stable and skilled workforce and effective multi-agency support.
- Investment in early help and family networks helping children to remain safe and thrive.
- Children in care benefit from consistent relationships, secure and permanent homes and effective life story work.
- Care leavers receive committed support and access to a range of suitable accommodation.
- Strong leadership and a focus on ensuring services respond effectively to vulnerability, deprivation and demographic change.

Derby City Council Youth Justice Service experienced an [inspection of youth justice work with children and victims](#) in September 2025. The service was graded as Outstanding. The inspection found:

- Work with children across assessing, planning, and delivery was impressive and consistently strong.

- Work with victims was high-quality, individualised, and responsive, and it was driving positive outcomes and safety for victims.
- Staff utilised their professional skills to help children lead their best lives and to provide effective support to victims.
- Staff were humble in their approach, caring, and thoughtful. They cheered children on to achieve great things and supported them to make positive changes to their lives.
- Engagement with victims was personalised and driven by their needs and wishes.
- Victims were consistently supported to make informed choices and were provided with high-quality information about what to expect about the service and support that was on offer.
- YJS had access to a wide variety of services and interventions where co-location of providers was working well.

Derbyshire County Council

Derbyshire County Council Children's Services experienced a [focused visit](#) in May 2025 as part of the ILACS framework. The inspection looked at the local authority's arrangements for children subject to a child-in-need or child protection plan. Main findings included:

- Children subject to child-in-need or child protection plans receive a timely and responsive service, supported by thorough assessments, regular visits and reviews, and committed social workers.
- Children generally benefit from continuity of their allocated worker, helping plans to begin promptly and supporting consistent relationships with children and families.
- Multi-agency strategy discussions and information sharing were found to support timely assessment of risk and prompt action where there were concerns about significant harm.
- Social workers use a range of direct-work approaches to understand children's experiences and ensure their views are taken seriously, with particularly detailed observation of care for babies and younger children.
- Family networks are routinely involved in work with children, with their contribution to child-in-need meetings and core groups valued and promoted.
- Disabled children benefit from social workers who understand their needs, advocate for them and maintain high aspirations, with well-planned transitions to adulthood.

The local authority will build on management oversight of key decisions and strengthening recording, interim safety plans and escalation where partner responses are delayed; ensuring children's plans clearly demonstrate the impact of support on their progress, needs and risks; working with partners to support timely access to specialist domestic abuse, mental health and substance misuse services following referral; and making pre-proceedings letters and meeting records clear and accessible for parents.

Safeguarding arrangements

The four statutory safeguarding partners are:

Derby City
Council

Derbyshire
County Council

NHS Derby and Derbyshire
Integrated Care Board

Derbyshire
Constabulary

They work with relevant agencies through the Chief Officer Group, Executive Board and multi-agency groups covering quality assurance, child safeguarding practice reviews, education, learning and organisational development, policy and procedures, district safeguarding and thematic priorities. The annual report should be read alongside the DDSCP's published safeguarding arrangements and governance documents available on the [DDSCP website](#).

During the reporting period, the partnership implemented the requirements of Working Together to Safeguard Children 2026 and reviewed its governance arrangements to ensure they remained effective and compliant. This included strengthening the involvement of education as a strategic partner in governance, assurance and priority activity. The partnership also reviewed subgroup effectiveness and strengthened quality assurance arrangements to better evidence the impact of safeguarding activity on children and families.

The DDSCP is accountable through its own statutory safeguarding arrangements and is committed to strong strategic alignment with other partnership boards across Derby and Derbyshire, ensuring that shared priorities, intelligence and assurance support effective, coordinated partnership arrangements. Its priority groups report progress, risks, learning and assurance through the Executive Board and Chief Officer Group.

Where DDSCP priorities overlap with community safety, its priority thematic groups share intelligence, risks and assurance through joint workplans, shared membership and thematic boards. The Domestic Abuse and Sexual Violence (DASV) Board provides strategic oversight of the local multi-agency response to domestic abuse and sexual violence, aligning priorities for adults and children and monitoring delivery, performance and outcomes. SOCEX coordinates the multi-agency response to exploitation and serious organised crime across Derby and Derbyshire. Both boards report assurance to the Responsible Authorities Chief Officer Group (RACOG), which oversees delivery and escalates matters requiring wider action. Safeguarding matters are reported back via thematic priority groups through to the DDSCP Executive Board and Chief Officer Group, providing a clear two-way route for accountability, coordination and escalation.

The [Child Death Overview Panel](#) (CDOP) provides an annual report to ensure that learning and emerging themes are taken forward across our partnership. Reviews undertaken during this period continued to identify the impact of wider safeguarding, health and socioeconomic factors on outcomes for children. Key themes included:

- Parental health, smoking, alcohol and substance misuse.

- Domestic abuse and neglect.
- Poverty, deprivation and housing or home environment factors.
- Barriers to accessing appropriate and timely support.
- Communication and information sharing between agencies.

Reviews highlighted that vulnerabilities frequently coexist and can create cumulative risk, particularly for families experiencing deprivation. The findings reinforce the importance of early intervention, prevention, effective multi-agency working and targeted support for vulnerable children and families, alongside continued partnership focus on information sharing and access to services.

The DDSCP maintains regular liaison with the Derby and Derbyshire Safeguarding Adults Boards through shared membership, officer links and the exchange of assurance, learning and emerging themes. This supports a coordinated approach to issues affecting both children and adults, including domestic abuse, exploitation, neglect, transitional safeguarding, parental vulnerabilities and risks that affect whole families. Relevant learning from reviews is shared across the partnerships to inform procedures, workforce development, quality assurance and strategic priorities, with matters requiring joint action or escalation taken through the appropriate governance arrangements. During the year, the Derbyshire Safeguarding Adults Board established a Learning Themes Library, bringing together key learning from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Abuse-Related Death Reviews and LeDeR reviews across Derby and Derbyshire. This provides a shared resource for identifying recurring themes, reducing duplication and supporting coordinated improvement across the children's and adults' safeguarding systems.

During the year, the partnership strengthened independent scrutiny, reviewed subgroup effectiveness, developed revised quality assurance arrangements and considered how governance and business support could be streamlined without weakening accountability.

How we will address identified gaps

- Introduce standard subgroup reporting that links activity to intended outcomes and evidence.
- Use the lived experiences of children and families, alongside performance data and thematic analysis, to identify partnership-wide strengths, risks, trends and inequalities.
- Use Executive Board and Chief Officer Group assurance routes to track actions, risks and unresolved barriers.
- Publish clear governance documents and links alongside the final report.

4. How evidence shaped our priorities

Priorities were informed by safeguarding reviews, multi-agency audits, performance information, practitioner intelligence, independent scrutiny, national learning and the experiences of children and families. Domestic abuse, child neglect and online harms appeared repeatedly across this evidence and required focused partnership action. Partners also recognised the increasing impact of digital technologies on children's lives, reflected in substantial partnership activity relating to online safety, exploitation and digital resilience.

Evidence	What it told us	How it shaped action
Reviews and rapid reviews	Recurring themes included engagement, professional curiosity, parental vulnerabilities, cumulative harm, early help, information sharing and escalation.	Practice briefings, best practice guides, procedures, training and action plans.
Quality assurance and audits	Strengths were evident, but practice varied in routine enquiry, contingency planning, use of tools, perpetrator engagement and recording.	Revised QA Strategy, re-audit plans, targeted practitioner learning and management oversight.
Performance and intelligence	Domestic abuse and child neglect remained prominent in statutory activity; online risks continued to change.	Three strategic priorities and revised performance reporting.
Children and families	Feedback highlighted the importance of direct engagement, accessible communication and support that reflects lived experience.	Keeping Babies Safe developments, service-user input to audit and planned young-scrutineer arrangements.
Independent scrutiny	Ambition was strong, but progress, impact and capacity needed to be more visible.	Formal scrutiny workplan, governance review and sharper subgroup reporting.



5. Priorities

Child Neglect

Child neglect is a key partnership priority because of its potential for significant and long-term impact on children. It is also a recurring theme within safeguarding review activity and wider partnership learning. During 2025/2026, child neglect featured in local and out-of-area reviews. The Child Neglect Thematic Group provides strategic oversight of prevention, early recognition, assessment and response.

What did we do?

- Developed a Child Neglect Strategy and delivery plan for 2025-2028.
- Developed performance and proxy measures with links to Public Health and needs assessment evidence.
- Produced shared resources, including a chronology, pre-screening tool, draft practitioner handbook, conversation starters and draft Graded Care Profile guidance.
- Reviewed the Graded Care Profile to strengthen the child's lived experience, SEND, cultural sensitivity and strengths-based practice (to be launched in 2026/2027).
- Embedded learning from safeguarding reviews and considered online harms, poverty, dental neglect, obesity and educational neglect.

What difference did this make?

- A clearer partnership framework and shared strategic direction are now in place.
- Practice resources give agencies a more consistent basis for recognising and responding to neglect.
- The revised approach places greater emphasis on how neglect interacts with domestic abuse, SEND, poverty, culture and wider family circumstances.

What next?

- Implement and embed the strategy, revised Graded Care Profile and supporting resources.
- Test earlier recognition, quality of assessment, consistency of tool use and the visibility of children's lived experiences.
- Seek feedback from practitioners, children and families and respond to variation between agencies.

Domestic abuse

The Domestic Abuse Thematic Group coordinates activity, assurance and challenge for children who experience domestic abuse. Its focus is recognising children as victims in their own right and strengthening early identification, information sharing, assessment and support.

What did we do?

- Completed and promoted the Domestic Abuse Handbook for professionals.
- Strengthened Stopping Domestic Abuse Together (SDAT) and transition arrangements to Operation Encompass.
- Reviewed multi-agency procedures and developed a child domestic abuse partnership dashboard.
- Improved education engagement and reviewed notification processes, risk assessment and mapping.
- Used audit and review learning to produce a seven-minute briefing and other practitioner resources.

What difference did this make?

- Police performance information showed improved timeliness of notifications to education settings.
- Changes to notifications improved the information provided to education settings.
- Audit findings were translated into accessible learning for practitioners and managers.
- The group established the infrastructure needed to benchmark practice and track progress.

What next?

- Evaluate use and impact of the Domestic Abuse Handbook through a practitioner survey.
- Update the handbook and multi-agency procedures in response to feedback and learning.
- Publish updated Operation Encompass guidance and develop a training video.
- Use dashboard, audit and feedback evidence to assess consistency and outcomes for children.

Online harms

Online harms is a cross-cutting safeguarding issue. Following RACOG governance changes, it will be embedded across relevant DDSCP and wider partnership work rather than overseen through a standalone thematic board.

What did we do?

- Updated the Safeguarding Children from Online Harms procedure to reflect legislative change and emerging risks, including financially motivated sexual extortion and AI-generated abuse material.
- Asked education partners about their main concerns and developed briefings on parent engagement, online bullying and sharing nudes or semi-nudes.
- Produced a neurodivergent-friendly Healthier Screentime infographic and briefing.
- Worked with the NSPCC on workshops about safer online environments, parental controls and new technology.
- Supported police and education activity on financially motivated extortion, including guidance, training and improved recording.

What difference did this make?

- Emerging risks were translated into updated procedures, practical briefings and workforce development.
- Education feedback directly shaped resources for schools, professionals, parents and carers.
- Police activity strengthened the focus on recording, guidance and professional awareness of financially motivated extortion.

What next?

- Confirm clear oversight and assurance routes following governance changes.
- Embed online harms within priority workplans, subgroup reporting and quality assurance.
- Strengthen local data and intelligence and agree a coordinated response to online scares, challenges and hoaxes.
- Evaluate whether resources and training support earlier identification and more consistent support.

6. Learning, improvement and quality assurance

Learning from reviews

During 2025/26, the [CSPR and Action Planning Subgroup](#) coordinated five rapid reviews. Two resulted in decisions to initiate local child safeguarding practice reviews that were not concluded within the reporting period.

Recurring learning themes

- Complete holistic, evidence-based assessment and planning jointly with children, families and professionals.
- Engage children and parents with persistence, curiosity and respectful language, and use management oversight where engagement is difficult.
- See and hear children directly, recognise vulnerability in adolescents and avoid treating harmful experiences as “typical teenage behaviour”.
- Respond at the earliest opportunity and coordinate help when concerns first emerge.
- Understand how domestic abuse, mental health and substance use can affect parenting capacity while keeping the focus on the child.
- Do not assume children living away from parents are automatically safe; maintain robust placement and reunification planning.
- Use chronologies and shared information to identify cumulative harm and escalation.
- Recognise links between physical health, mental health, neurodiversity and safeguarding and seek specialist input where needed.

What changed in response?

- DDSCP serious incident notification and review guidance was strengthened in line with updated national guidance.
- [Seven-minute briefings](#) and best practice guides were produced and circulated.
- Action planning and assurance arrangements were reviewed to require clearer evidence of completion and impact.
- Review learning informed the Child Neglect Strategy, [Domestic Abuse Handbook](#), substance use protocol, procedures and the learning programme.

Quality assurance

What did we do?

- Completed a multi-agency domestic abuse audit focused on babies and infants under three on child protection plans.
- Worked with the NSPCC on a Child Sexual Abuse Snapshot review.
- Reviewed use of Police Protection powers, child protection medical peer review and contingency planning after reunification.
- Completed the Section 11 self-assessment and reviewed the Quality Assurance Strategy.

What difference did this make?

- Audit identified positive pre-birth assessment, safety planning and trauma-informed practice alongside areas for improvement.
- Joint decision-making about Police Protection powers became more timely and consistent.
- Contingency planning assurance identified strengths in partnership working and safety planning and highlighted communication, recording and specialist support gaps.
- Section 11 returns provided a high level of assurance across five standards.

What next?

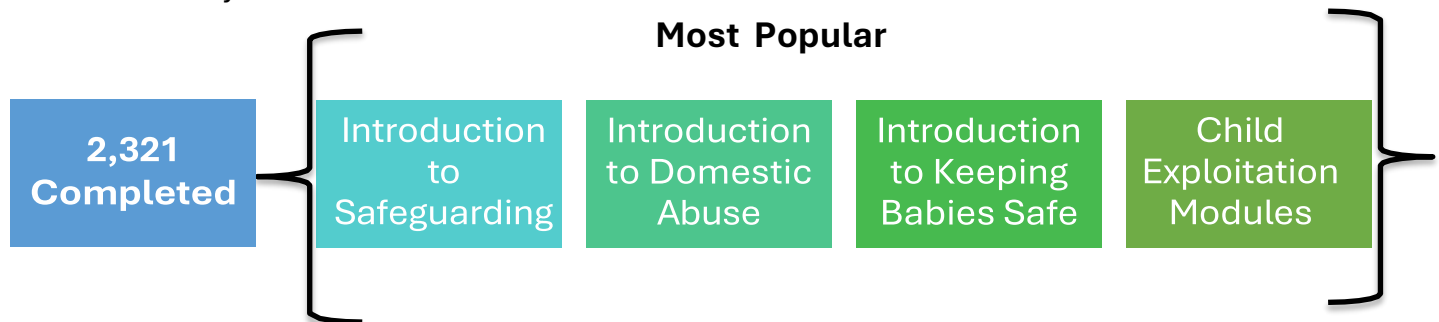
- Use a tiered QA approach that draws on agency assurance and adds value through multi-agency work.
- Re-audit priority areas and track whether learning changes practice.
- Use the lived experiences of children and families, alongside performance data and thematic analysis, to identify partnership-wide strengths, risks, trends and inequalities.

Learning and organisational development

During 2025/2026, the DDSCP Learning and Organisational Development (LOD) Group delivered a [comprehensive multi-agency programme](#) informed by local and national safeguarding reviews, quality assurance activity, and partnership priorities. The programme supported practitioners to strengthen their safeguarding knowledge, skills and confidence, helping to improve outcomes for children and families.



Separately, the DDSCP continued to develop its e-learning offer, improving accessibility and flexibility for learners.



Evaluation feedback reported improved confidence, stronger professional curiosity, earlier recognition and improvements in assessment. The next step is to supplement self-reported feedback with follow-up evidence from supervision, audit and practice.

7. Voice of children and families

The partnership increasingly uses children's and families' experiences to inform priorities, assurance and practice improvement.

What we heard and how it was used

Who was heard	What we learned	What changed or will change
460 parents of babies under six months through the safer sleep survey	Many recalled and reported using the three safer sleep messages; antenatal discussion remained important.	Findings informed co-sleeping and bed-sharing work, safer sleep messages, Never Ever Shake Your Baby and early years roadshows.
Parents and carers through the domestic abuse audit	Support should be sequenced around child and adult victims, with perpetrator accountability and stronger attention to children's voices.	Learning informed briefings, guidance and workforce development.
Children, young people and families through local authority participation routes	Place, relationships, accessible communication, family networks and community support matter.	Feedback informed Families First development and service improvement.
Children and young people through education and partner activity	Children want their experiences to influence decisions and services, not only be recorded.	Young-scrutineer proposals and clearer "You said / We did" reporting are planned.

Commitments for 2026/27

- Develop safe and supported young-scrutineer arrangements.
- Involve young people in reviewing the accessibility and child focus of the annual report.
- Build participation into thematic priority plans and assurance reports.
- Publish clear examples showing how feedback changed a decision, resource, service or outcome.
- Protect confidentiality and avoid identifiable case detail.

8. Independent scrutiny

A permanent Independent Scrutineer commenced in June 2025. Early work included induction, observation of governance and thematic groups, involvement in review and audit activity, and engagement with regional and national scrutiny networks.

Strengths identified

- A mature partnership with engaged senior leaders and committed multi-agency participation.
- Positive senior representation and elected-member oversight.
- Openness and transparency in rapid review activity.
- Substantial multi-agency contribution to the domestic abuse audit, including some parent and carer feedback.

Challenge and areas for development

- Reduce the volume and complexity of activity and ensure expectations are realistic within available capacity.
- Clarify decision-making authority and improve consistency of agency representation.
- Make progress against thematic workplans and intended outcomes more visible.
- Strengthen standard subgroup reporting, agenda discipline and evidence of impact.
- Ensure governance changes do not weaken accountability during wider reform.

How partners responded

- Agreed a formal scrutiny workplan and routine reporting to Executive Board and Chief Officer Group.
- Revised the scrutiny strategy and strengthened reference to education involvement.
- Prioritised scrutiny across child neglect, domestic abuse, online harms, governance, Families First and significant incidents.
- Reviewed subgroup structures and reporting expectations.
- Continued to consider whether scrutiny capacity is proportionate to the breadth of work.

9. Leadership, accountability and partner contribution

Leadership and oversight

Lead and Delegated Safeguarding Partners exercised oversight through the Chief Officer Group and Executive Board. Agendas included priorities, review learning, risk, independent scrutiny, finance, Families First, quality assurance and national reform. Standardised reporting and the risk register will be used to track unresolved issues and provide escalation routes.

Education as a strategic partner

Education is visible at both strategic and operational levels with representatives included in the Chief Officer Group and Executive Board. Across the area there are 569 schools and 46 trusts, many based outside the local authority area. Members contributed through subgroup meetings, task and finish activity, audits, policy development, training, review activity and dissemination of safeguarding updates. The subgroup structure was reviewed to respond to capacity, and the two education subgroups were merged reducing meetings from eight to four per year. Achieving representative engagement across such a diverse sector remains challenging and requires continued partner support.

- Education representatives contributed to Chief Officer Group, Executive Board, education subgroups and thematic work.
- Education partners helped shape child protection safeguarding template policy, child neglect tools, Operation Encompass notifications, including clarification of notification routes where children are not in school, online harms resources, school-GP communication and a school safeguarding audit.
- The proposed joint education subgroup will reduce meetings while requiring monitoring to ensure the education voice remains representative across a large and diverse footprint.

Partner and relevant agency contribution

Partners and relevant agencies contributed leadership, data, policy expertise, review activity, audit, training delivery, dissemination and frontline intelligence. The partnership expects relevant agencies to provide role-appropriate training, supervision, representation, participation in audit and reliable learning records.

Accountability in 2026/27

- Use subgroup workplans that state intended outcomes, measures and owners.
- Report exceptions, barriers and decisions required, not only completed activity.
- Triangulate performance data with audit, feedback, scrutiny and practice evidence.
- Escalate risks that threaten statutory safeguarding arrangements.

10. National reforms and system resilience

The partnership considered the implications of NHS restructuring, Integrated Care Board safeguarding structural reforms, policing changes and wider organisational restructuring across safeguarding partners. Chief Officers agreed that senior-level representation remained essential to maintain safeguarding leadership, accountability and effective decision-making during this period. The partnership will continue to maintain oversight as the organisational landscape evolves.

Families First

The partnership supported development of Families First arrangements across Derby and Derbyshire. Local work covered family help, family group decision-making, multi-agency child protection, information sharing, workforce development and participation.

Local direction described by partners

Area	Derby emphasis	Derbyshire emphasis
Family help	Locality-based conversations, mapping services, team around the school and co-produced assessment.	Prevention, earlier support, relational practice and partners equipped to lead early help assessment.
Family networks	Family Alliance, family group decision-making and peer support.	Family Solutions Meetings, stronger family networks and support for safe reunification.
Multi-agency child protection	Options appraisal and co-production of a central team and Lead Child Protection Practitioner role.	Planned locality trial and strengthened child protection management capacity.
Voice and workforce	Insight from families with lived experience and place-based community support.	Child and family voice, common practice, high support and high challenge.

Local Government Reorganisation

The partnership considered the potential implications of Local Government Reorganisation for safeguarding leadership, governance, workforce capacity, partner engagement, information sharing and resources. A specific risk register entry was established to support ongoing oversight, alongside safeguarding impact, transition and business continuity planning, assurance from safeguarding partners, review of governance and Terms of Reference, and escalation where changes could affect effective safeguarding arrangements.

System resilience

- Maintain safeguarding leadership and delegated authority during ICB/NHS reform, policing change and Local Government Reorganisation.
- Use safeguarding impact assessment, transition planning, business continuity and partner assurance to manage change.
- Complete the full Threshold Document review and align procedures with new arrangements.
- Keep online harms visible through clear reporting and assurance routes.
- Use scrutiny to test whether reform improves practice and experiences for children and families.

11. Funding and resources

Core partnership funding is provided equally by the four statutory safeguarding partners, with an additional contribution from Probation. Financial reporting is provided to the Executive Board and Chief Officer Group.

During 2025/26, partners reviewed staffing and subgroup arrangements because contributions had remained unchanged since 2019 while employment costs and partnership activity increased. The proposed structure reduces the business unit from 9.68 FTE to 8 FTE, consolidates support functions and aligns capacity to statutory responsibilities, priorities, reviews, learning, policies and quality assurance.

Assurance

- The revised model is projected to remain within the existing funding envelope until 2028/29, supported in the short term by reserves from vacancies.
- Longer-term sustainability will be supported through ongoing review of funding, partner contributions and capacity.
- Partners must monitor whether resources remain sufficient for statutory functions, scrutiny, quality assurance and evidence of impact.

12. Priorities and improvement plan for 2026/27

The plan below focuses on intended difference and evidence, so progress can be reported consistently during the year.

Priority	Key action	Intended difference	Evidence and assurance	Lead route
Child neglect	Implement strategy, revised Graded Care Profile and resources.	Earlier, more consistent recognition and child-centred planning.	Audit, performance measures, tool use and feedback.	Neglect Group / Executive Board
Domestic abuse	Update handbook and procedures; implement Operation Encompass guidance and training.	More timely information sharing and stronger child-centred response.	Notification quality, audit and feedback.	Domestic Abuse Group / Executive Board
Online harms	Embed online harms and confirm reporting and escalation routes.	Online risks remain visible and emerging issues receive coordinated responses.	Workplan reports, intelligence and assurance.	Relevant groups / Executive Board
Families First	Align thresholds, family help, child protection, workforce and procedures.	Earlier, coordinated help and clearer pathways.	Milestones, audit, pathway data and feedback.	Families First governance / Chief Officers Group
Learning and Quality Assurance	Track recommendations and test change in practice.	Learning is embedded and sustained.	Action assurance, re-audit, practice evidence and scrutiny.	CSPR and quality assurance groups
Data and fairness	Strengthen analysis by age, ethnicity, disability, SEND, deprivation, geography and circumstances.	Unequal experiences are better understood and acted upon.	Dashboard analysis, actions and follow-up.	Quality Assurance Group / Executive Board

Priority	Key action	Intended difference	Evidence and assurance	Lead route
Voice and participation	Develop young-scrutineer and “You said / We did” approaches.	Children and families visibly influence priorities and improvement.	Participation evidence and examples of changed decisions.	Executive Board/Scrutineer / participation routes
System resilience	Maintain oversight of organisational change, resources and funding.	Leadership and accountability remain effective during change.	Risk register, partner assurance, scrutiny and finance reports.	Chief Officers Group / Executive Board

