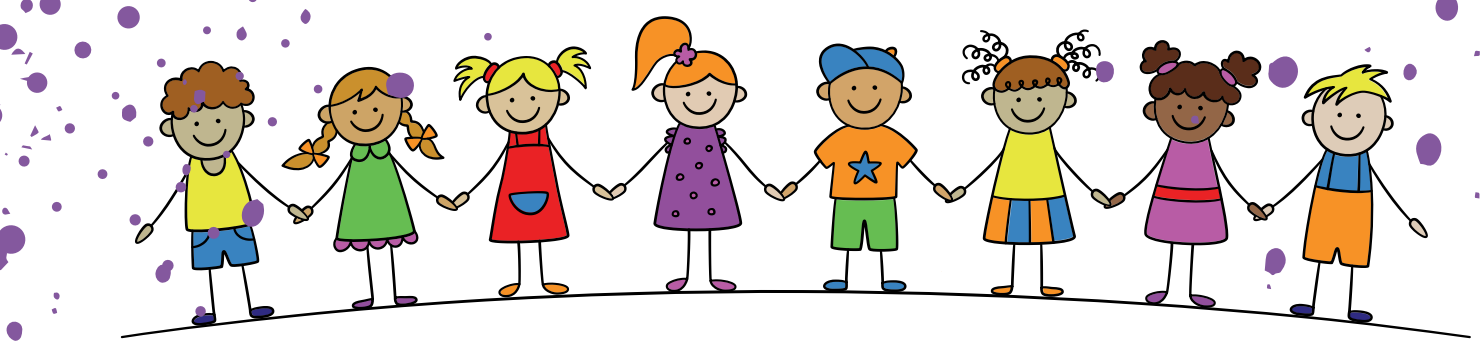
Durham
Safeguarding Children Partnership

Durham Safeguarding Children Partnership

Annual Report 2025/2026



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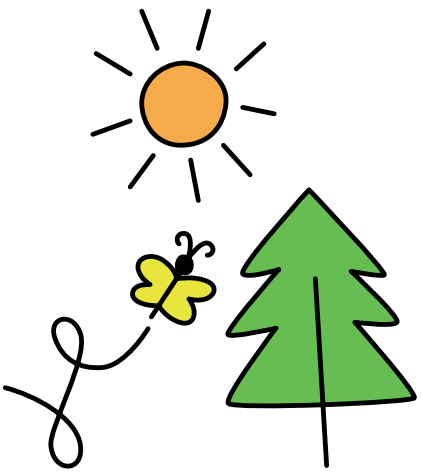
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1 Introduction

Welcome to the Durham Safeguarding Children Partnership (DSCP) 2025-2026 annual report. This report provides an overview of DSCP activity to keep children safe and well, reflecting our achievements and learning over the past year, and our next steps for the year ahead.

Partnership working is at the heart of everything we do and the DSCP values discussion and challenge from all partners. This allows us to build on our strengths, identify learning and improve practice so that children, young people and babies in Durham stay safe and well, and succeed and achieve in their homes, schools and communities.

Safeguarding has remained a priority for all partner agencies over the past year. We have seen strong attendance and participation in the work of our sub-groups, leading to several achievements and proud moments that are shared in this report.

National changes to how children are kept safe and well through multi-agency working are continuing at a pace. March 2026 saw the release of the revised Working Together to Safeguard Children Statutory Guidance alongside the Families First Partnership Programme Guidance. These key documents will continue to drive our work with children, families and each other over the coming year.

The partnership has also seen change as we waved goodbye to John Pearce, Corporate Director of Children's Services, representing the Local Authority as the Delegate Safeguarding Partner, and we welcomed Rachel Farnham into this role. Rachel comes with a wealth of knowledge and experience from her previous role as Head of Service in Children's Social Care in Durham. We also welcomed Richard Scott, Director of Nursing, North-East and North Cumbria Integrated Care Board as the Delegate Safeguarding Partner for Health.

As always, we would like to thank all our partners in a variety of roles who support children, young people, and their parents/carers every day. We are immensely grateful for all that you, our workforce, do across the county, day to day – thank you!



Richard Scott
Director of Nursing
North East & North Cumbria Integrated Care Board



Nicola Lawrence
Detective Chief Superintendent
Durham Constabulary



Rachel Farnham
Corporate Director
Durham Children and Young People Service



Samantha Allan
Chief Executive
North East & North Cumbria Integrated Care Board



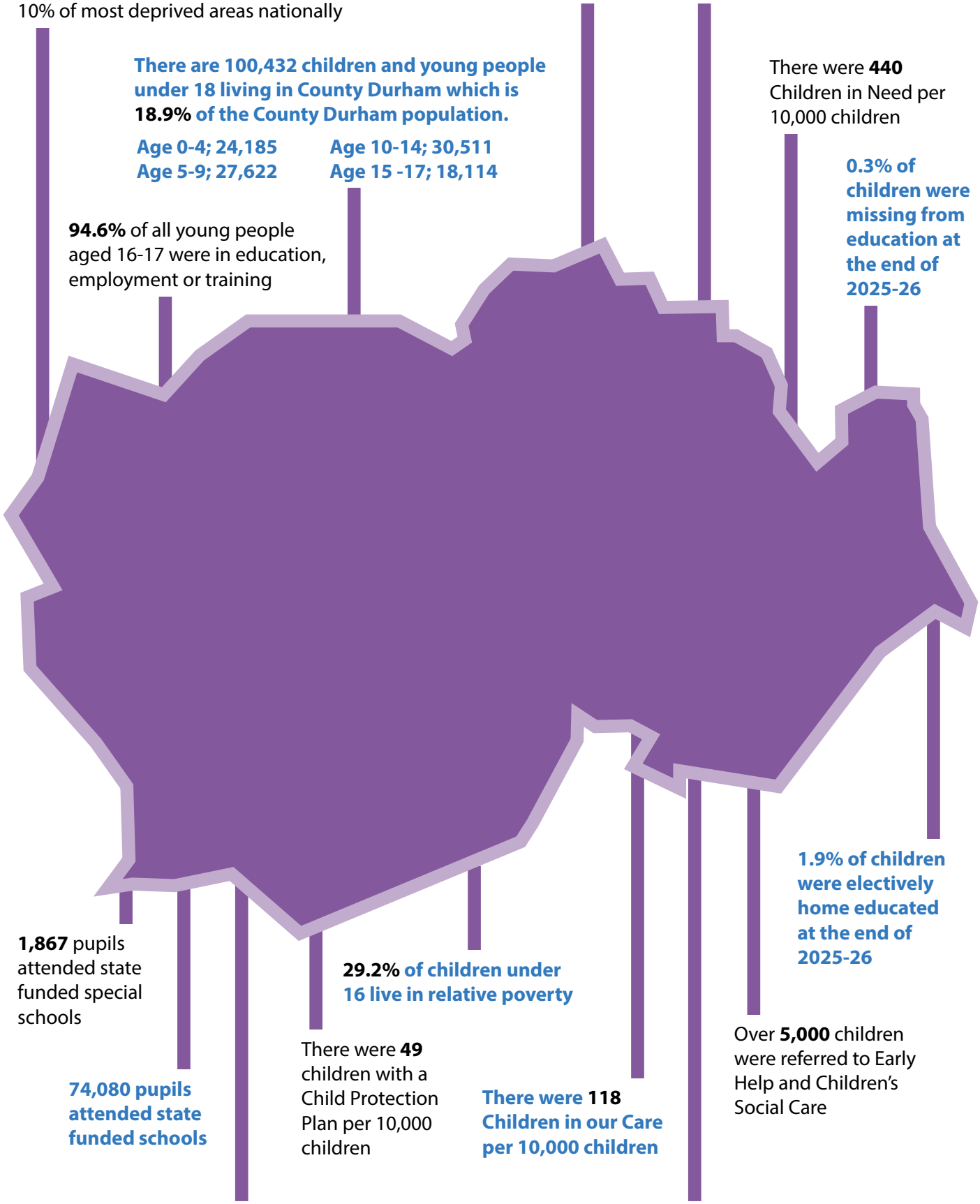
Rachel Bacon
Chief Constable
Durham Constabulary



John Hewitt
Chief Executive Officer
Durham County Council



2 Children and Young People in County Durham



Schools in County Durham

272 Schools

208 Primary Schools

31 Secondary Schools

12 Independent Schools

2 Pupil Referral Units

45 Alternative Providers, including 3 registered provisions

10 Nurseries

9 Special Schools

136 Academy Schools



122 Local Authority Maintained Schools

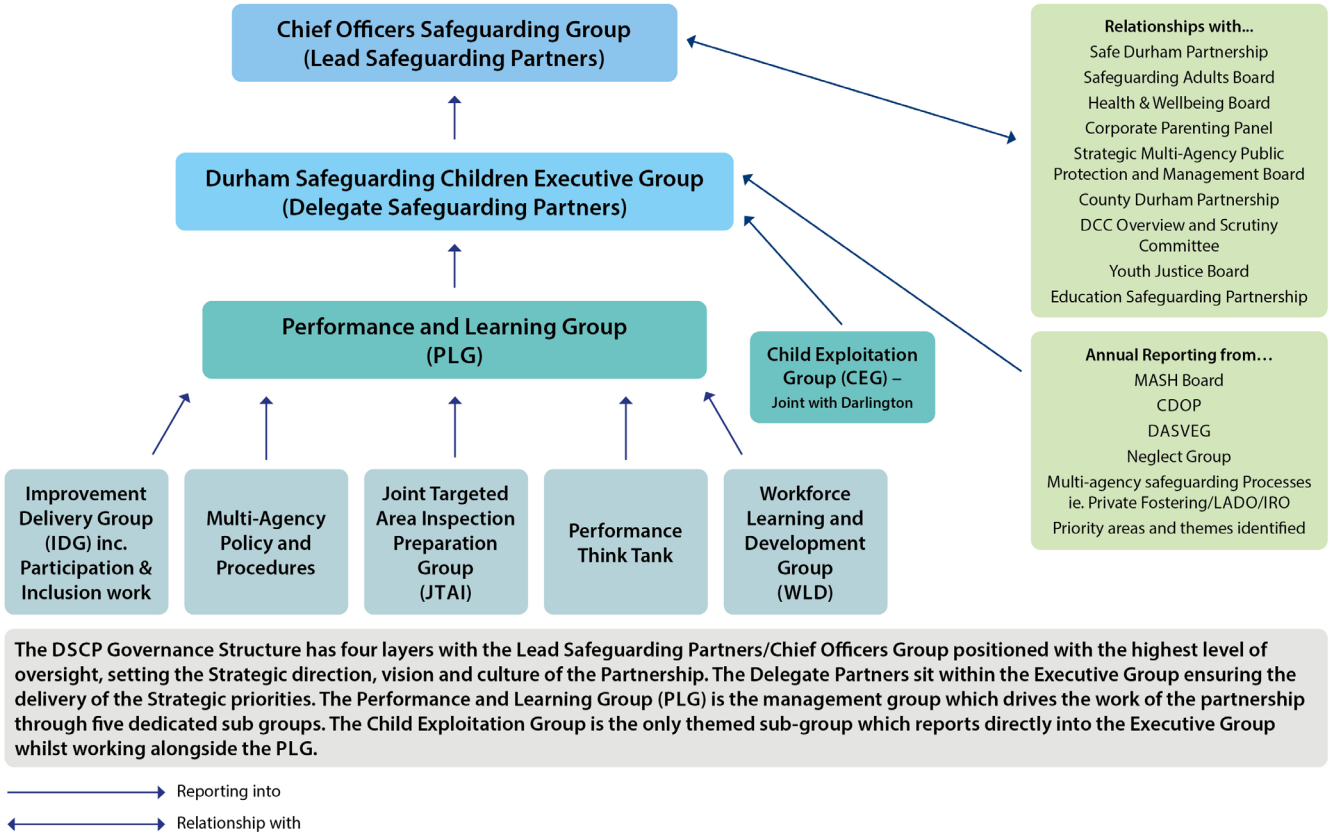
3 About Durham Safeguarding Children Partnership

The Durham Safeguarding Children Partnership (DSCP) is a statutory, multi-agency partnership coordinated by a Business Unit, which oversees children's safeguarding across the Durham County Council area.

The role of the DSCP is to gain assurance that local safeguarding arrangements with partners are working effectively to keep children in Durham safe and well.

How the DSCP is Structured:

Durham Safeguarding Children Partnership Structure



The DSCP Governance Structure has four layers with the Lead Safeguarding Partners/Chief Officers Group positioned with the highest level of oversight, setting the Strategic direction, vision and culture of the Partnership. The Delegate Partners sit within the Executive Group ensuring the delivery of the Strategic priorities. The Performance and Learning Group (PLG) is the management group which drives the work of the partnership through five dedicated sub groups. The Child Exploitation Group is the only themed sub-group which reports directly into the Executive Group whilst working alongside the PLG.

The DSCP Structure has four layers:

The Lead Safeguarding Partners (LSP)/Chief Officer Group holds the highest level of oversight, setting the strategic vision, direction and culture of the partnership. This group is made up of the head of each statutory safeguarding agency and includes members from the Adults Safeguarding Board. For the Local Authority (council), the LSP is the Chief Executive Officer. For Integrated Care Boards (Health) the LSP is the Chief Executive and for Police the LSP is the Chief Officer of Police.

LSPs are responsible for holding their own agencies to account and are jointly responsible for the involvement of all relevant agencies in progressing local arrangements and learning. In Durham we are proud to have strong working relationships with a clear commitment to build on our strengths and think creatively about how to improve practice.

The Executive Group (Delegate Safeguarding Partners)

The Delegate Safeguarding Partners (DSPs) sit within the Executive Group and are responsible for driving forward the strategic priorities of the partnership. The Executive Group escalates any risks to the Lead Safeguarding Partners.

For the Local Authority the DSP is the Corporate Director of Children and Young Peoples Services. For the Integrated Care Board, the DSP is the Director of Nursing and for Police the DSP is the Detective Chief Superintendent.

The Chair of the Executive Group changes every 12 months to reflect the partnership approach to safeguarding. For 2025-26 the chair has been Nicola Lawrence, Detective Chief Superintendent of Police.



Performance and Learning Group (PLG)

This is the management group which monitors the performance and impact of partners, as required by Working Together 2026. The group actions any improvements identified by the Executive Group and co-ordinates learning for the partnership, including learning from local and national reviews. During 2025-26 the group has been chaired by Children's Social Care.

The PLG drives the work of the partnership through five sub-groups:

1. Improvement Delivery Group (IDG)

2. Multi-Agency Policies and Procedures Group (MAP)

3. Joint Targeted Area Inspection Preparation Group (JTAI)

4. Performance Think Tank Group

5. Workforce Learning and Development Group (WLD)

Each sub-group has a yearly work plan linked to priorities in the DSCP Strategic Business Plan. Sub-groups report to the PLG or other relevant groups such as the Strategic Child Exploitation Group (CEG).

Strategic Child Exploitation Group (CEG)

Harm Outside the Home is a priority area for the DSCP. The Strategic CEG Group is responsible for agreeing, reviewing and improving the response of all partners to Harm Outside the Home through a yearly work plan. This is held jointly with Darlington. Strategic CEG reports directly to the Executive Group and is chaired by Durham Constabulary (police).

The DSCP Business Unit

The DSCP Business Unit is responsible for the management of and support to the wider partnership. This is an established team that is well regarded by the partnership.

What we do

Quality assurance is at the heart of everything we do, using frameworks that measure progress and impact.

The Business Unit identifies and responds to emerging safeguarding issues highlighted through local and national learning from serious incidents.

We share learning with partners to raise awareness and create resources, toolkits, guidance and procedures to support multi-agency practice. We have a strong, well attended multi-agency training offer linked to our priorities.

The Business Unit reviews multi-agency practice and meetings to be assured that children and young people are being kept safe and well and we analyse multi-agency data and intelligence to inform service planning.

We involve children, young people and their parents/carers in co-creating plans and resources. We review and maintain the DSCP website so that information available to families and practitioners is relevant and reflects our priorities and emerging themes.

Our Vision and Values

Our vision and values are simple, it's about 'Keeping Children Safe' as safeguarding is everyone's responsibility. This is supported by our Three Core Values:

1. Tenacity

2. Curiosity

3. Openness

How we achieve it

- Manage the DSCP Strategic Business Plan (2025-2027) which has four priority areas
- Celebrate and share good practice, e.g. through Appreciative Inquiry
- Challenge each other and learn from practice through the learning cycle
- Apply our Quality Assurance Framework which is aligned to The Association of Safeguarding Partners (TASP) Multi-Agency Child Safeguarding (MACS) framework
- Oversee the Complex and Organised Abuse process
- Support subgroups
- Manage and review serious incidents and Local Child Safeguarding Practice Reviews
- Facilitate reflective discussions to explore learning when criteria for a serious incident aren't met
- Share information and learning through the DSCP Website, DSCP Newsletter and partner communications

4 Achievements 2025-2026

a) Performance and Learning Group

Activity

- Oversight of Performance Think Tank data to direct further exploration
- Considered referrals for learning from serious incidents and learning from practice
- Oversight of action plans for learning from Rapid Reviews
- Oversight of key learning briefings to share local learning from serious incidents
- Attended scoping and review meetings jointly with Delegate Safeguarding Partners to consider partnership priorities and refine key lines of enquiry for the Improvement Delivery Group (IDG)
- Oversight of action plans from IDG project work
- Multi-agency assurance week planning and observations
- Development Day planning and feedback
- Safeguarding week planning and feedback



Received Updates from

- Workforce Learning and Development Group
- Performance Think Tank
- Improvement Delivery Group
- JTAI Preparation Group
- Multi-Agency Procedures Group

Other items discussed

- Response to the National Sexual Abuse Report and proposed action plan for the Executive Group
- Child Safeguarding Practice Review (CSPR) Panel: Guidance for Safeguarding Partners 2025
- Child Safeguarding Practice Review Panel: Learning Support and Capability Project by Research in Practice and the Vulnerability, Knowledge and Practice Programme
- Association of Directors of Children's Services (ADCS) Complex Needs Project and Board
- Casey Report National Audit on Group-Based Child Sexual Exploitation and Abuse
- Sudden Unexpected Death in Infancy (SUDI) Campaign
- Annual Report feedback from National Panel
- Children's Social Care Inspecting Local Authority Childrens Services (ILACS) feedback
- His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) state of policing annual inspection feedback
- His Majesty's Inspectorate of Probation (HMIP)'s national inspection feedback
- Local Authority Designated Officer (LADO) senior nominated officer meetings
- Voluntary, Community and Social Enterprise Safeguarding Report – Durham Community Action
- HMIP national inspection improvement plan
- Quality Assurance Framework
- Role of Partners in Child and Family Assessments and Planning briefing
- Self-harm pathway

Wider evidence of impact can be found in the DSCP sub-groups section of this report.

DSCP sub-groups

b) Improvement Delivery Group (IDG)

The Improvement Delivery Group manages improvement work in the DSCP. The Executive Group and Performance and Learning Group direct the focus of the work via scoping meetings.

Members are drawn from across the partnership. Meetings are chaired by the Improving Practice Manager in the DSCP. The IDG considers multi-agency practice issues linked to the DSCP's current priorities:

Priorities

Priority 1
Harm Outside the Home

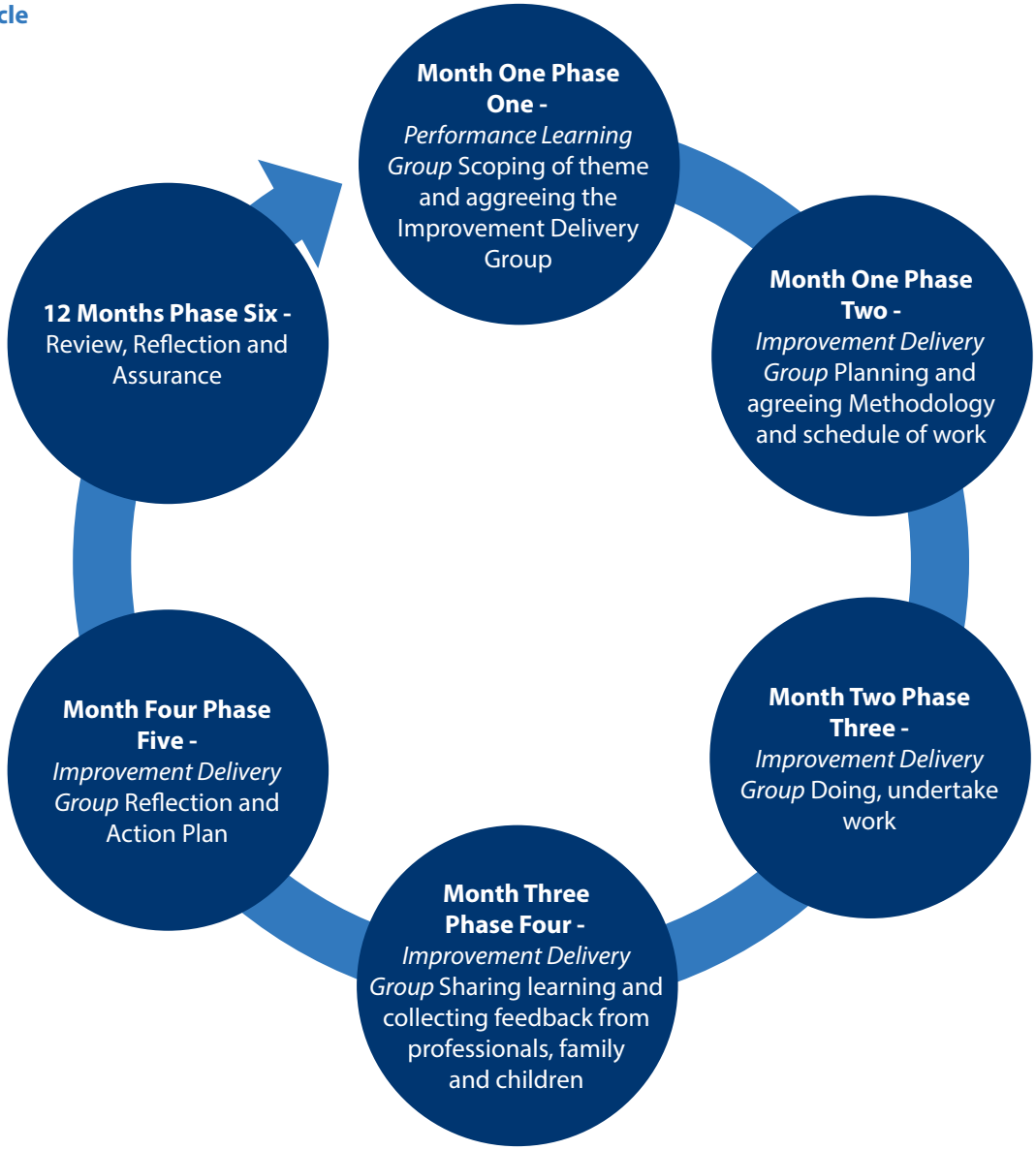
Priority 2
Safeguarding Through Early identification and Intervention

Priority 3
Trauma Informed Practice

Priority 4
Working Together and Towards Reform Action Plan

The IDG considers the strengths and challenges in frontline practice with children and families and makes recommendations to improve multi agency working. Each priority runs sequentially to one another, however using the learning cycle below they interlink and overlap when offering assurance and feedback.

Learning Cycle



The IDG listens to the experiences of children, parents and carers, wider family and practitioners to inform our work. We co-produce plans and resources with children, families and practitioners so that practice improvement is grounded in lived experience and is more likely to make a difference.

Key Achievements 2025 – 2027 Business Plan

Priority One: Harm Outside the Home (HOTH)

Why is this a priority?

We recognise that children and young people at risk of Harm Outside the Home (HOTH) aren't always visible to practitioners. We need to strengthen our approach with partners, children and families to:

- raise awareness of HOTH
- understand the 'Durham offer' for HOTH so children at risk are identified and supported
- identify and act on places and people of concern to better disrupt exploitation
- ensure young people are supported when they move from children to adult services

Cycle 1: (April 2025 – July 2025)

Scope



Question: What is the 'Durham Offer' for Harm Outside the Home?

Key Line of Enquiry: Look at gaps in the Durham Offer regarding HOTH, develop the Durham Offer and promote good practice currently happening in Durham.

Method

Single agency self-assessment to inform mapping of the multi-agency offer.

This question and key line of enquiry links to Priority 1, Outcome 1.2 of the DSCP Strategic Business Plan 2025-2027.

Key Findings

This cycle continues the work from Priority 2 of the 2023-2025 Business Plan, which explored the existing offer for Harm Outside the Home. Findings showed that there was no consistent offer across Durham.

This cycle looked at how to fill the gaps. As this was a large piece of work, we focused on creating resources for parents and children, community guardians (who are the 'eyes and ears' in local areas) and practitioners, using participation and engagement groups to consult with children, young people and parents.

Progress so far (6 months review)

- Online training has been developed for licensees, hotels and other community guardians, to raise awareness of HOTH with local businesses.
- Practitioner Guide to HOTH has been co-created with IDG members for practitioners in universal services to complement the existing Multi-Agency Harm Outside the Home Procedures. It is hosted on the DSCP website.
- The Practitioner HOTH page of the DSCP website has been updated to reflect the work of the IDG so that information and resources align with this. This has been accessed 520 times from April 2025-26
- Parent/Carer Guide to HOTH has been developed with input from parents and hosted on the DSCP website.
- Parents/carers have had input to the content and design of the Parents HOTH page on the DSCP website, so that the content and layout work better for them. This page has been accessed 94 times from April 2025-26
- Children and young people aged 9-13 years have been consulted on the design and content of the Children and Young People's HOTH page on the DSCP website and their views have shaped this. The DSCP website will be moving to a different platform later in the year to make it more user friendly and the children's views will inform this. The Children and Young People's page has been accessed 122 times from April 2025-26
- A poster aimed at parents has been created and shared via the DSCP Newsletter, local family hubs and GP surgeries.
- Lanyard cards with QR codes (how to 'get help' and 'share concerns') have been shared with police (200 copies) and community safety wardens (50 copies)

Next steps

Resources will continue to be shared and promoted. Actions from this IDG cycle are being reviewed through Strategic CEG. Phase 6 (12 months review) will complete the learning cycle. Assurance will be sought about the impact of the work on partner's practice.

Priority Two: Early Identification and Intervention

Why is this a priority?

Local and national learning tells us that risks to children and young people are sometimes missed or identified too late, leading to harm that could be prevented. Learning highlights the need for better funded and more effective early intervention and support to reduce the likelihood of children and families experiencing crises.

Cycle 1: August 2025 - November 2025

Scope



Question: Are all practitioners across agencies in Durham confident at identifying risk?

Key Line of Enquiry: Look at exploring where the gaps are in confidence and identifying risk, understand what the barriers are and what practitioners feel is needed to provide support and increase confidence.

Method

Survey and Focus Groups.

This question and key line of enquiry links to Priority 2, Outcome 2.1 of the DSCP Strategic Business Plan 2025-2027.

Key Findings

Practitioners and managers in our sample felt most confident identifying risks around Neglect and Physical Harm and least confident identifying risks around Sexual Abuse, Harm Outside the Home and Cumulative Harm.

Confidence increased due to training and experience, curious questioning, multi-agency working and information sharing.

Challenges included family and system factors, e.g. difficulties engaging families, having difficult conversations with confidence, children not being old enough or able to speak out, poor information sharing and lack of knowledge.

Practitioners valued tools such as the Graded Care Profile, Signs of Safety Mapping tool, chronologies and the Domestic Abuse Stalking and Honour Based Violence (DASH) risk assessment tool, but weren't always clear where to find them.

The most useful forms of help and support were training, examples of good practice and resources/toolkits.

System barriers include misunderstandings about information sharing and each other's roles and responsibilities, having space to slow down thinking, and limited support when thresholds aren't met.

Progress

There are overlaps with findings from this cycle of work and other work streams, meaning many actions are already being progressed elsewhere.

Children's Social Care Reforms 'Test and Learns' will address many of the system barriers identified. Consent and information sharing is being addressed via the 'Front Door' Test and Learn and the Information Sharing Duty.

Child Sexual Abuse in the Family Environment has been the focus of the JTAI preparation group in this reporting period (see JTAI section for more information).

An Intra-familial Sexual Abuse Task and Finish Group was set up in response to the National Child Safeguarding Practice Review Panel's report **"I wanted them all to notice"** to guide strategic planning in this area. Multi-agency procedures are being developed, and training is now available via the **DSCP Training Programme**.

Resources have been produced and shared to support practitioners and parents to identify and act on the signs of Harm Outside the Home (see Priority One above).

Durham has clear information sharing guidance and training that outlines when and how information can be shared. This has been re-circulated to partners and will be re-visited under the Information Sharing Duty later this year.

Next steps

- Create resource for practitioners to help us better understand each other's roles and responsibilities
- Consult with partners on the design of the practitioner section of the DSCP website

The action plan will be reviewed at 6 and 12 months to review progress towards actions and the impact of this on practice with children and families.

Priority Three: Trauma Informed Practice

Why is this a priority?

Local and national reviews have highlighted the need to understand complex trauma, including how unaddressed trauma can lead to family relationships breaking down.

The DSCP wants to improve identification and understanding of the impact trauma has on our children, young people, parents and carers.

Cycle 1: December 2025 – March 2026

Scope

Question: Do practitioners understand what a trauma informed response is towards children and families?

Key Line of Enquiry: To what extent do practitioners show a clear understanding of and use of principles of trauma informed practice in their conversations and interactions with children and families?

Method

Focus groups to reflect on a case study, incorporating parents with lived experience of trauma.

Feedback from the focus groups was very positive across services who attended:

Waythrough (Drug and Alcohol service)

> "It was really good! I think due to having various different services in one room [it] helped get everyone's different views and opinions. It was really informative, and I took a lot away from it!"

Early Help

> "I liked how we were on a table with a complete mix of professionals from different areas, as everyone brought in their experiences…it was also good they used the videos of real parents, who talked about their experiences, as it makes you reflect more…"

Harrogate and District Foundation Trust (Health)

> "…I felt that day was very beneficial for my role. I have discussed this workshop within my team and encouraged if there are further workshops [being] run to try and attend. The presentation and videos were emotive which I think if they were played to all agencies in training…would benefit practitioners understanding and how services users and families are affected regardless of their situation."

Key Findings

Strengths

Many practitioners could articulate what it means to be trauma informed, especially around empathy, understanding and kind language.

Some practitioners are aware of professional bias and how this can affect decision making when we hold pre-conceived ideas about people.

When practice is good, parents tell us it is supportive, empathic, strengths focused and non-judgmental.

Practitioners do 'get' trauma informed practice when they have time to slow down their thinking.

Practitioners are motivated and willing to learn more

Practitioners generally know what helpful and unhelpful responses look like, however there are some barriers to practicing in trauma informed ways, such as:

- capacity issues
- tight timescales for parents to change
- 'one-size fits all approach' to planning
- confusion about information sharing and consent



Learning

The role of class in our bias, and how we perceive and respond to this.

Risk averse practice is still evident, meaning strengths sometimes go unacknowledged or missed.

Being trauma informed isn't just about being kind – we need to have conversations about the worries in honest and compassionate ways.

What we write and how we talk to and about families doesn't always align. We need to be mindful of what we say, all the time.

We need to be trauma informed from our earliest conversations and in all our interactions – with families and each other.

Issues around communication and ensuring that families understand what is asked of them and what is happening. This needs to be adapted to the individual so they understand it.

There is still some confusion across services around information sharing and consent.

Practice isn't always consistent - there are some different ideas about what it means to be trauma informed across different services.

Managers need to have the chance to reflect and ensure they are practicing in trauma informed ways too as this impacts on decision making and supervision.

Lived experience adds a different, important lens and allows for more reflection and learning.

Multi-agency training is valued as a space for practitioners to see situations through a different lens and learn more about each other's roles.

Next steps

An action plan has been created. It includes some recommendations from the CSPR's National Review **Protecting All Vulnerable Babies Better** which was relevant to this priority and our findings.

The plan focuses on alignment by promoting the working definition of Trauma Informed Practice and creating a Partnership Trauma Informed Pledge; review of policies and procedures; creation of a partnership Trauma Informed Toolkit to be hosted on the DSCP website and review of training so it takes a graded approach and is informed by lived experience.

The action plan will be reviewed at 6 and 12 months to review progress towards actions and the impact of this on practice with children, young people and families.

Priority Four: Working Together and Towards Reform Action Plan

Priority 4 was not part of the Improvement and Delivery Group Learning Cycle. It was a standalone action plan developed in response to Working Together 2023 and the Children's Social Care Reforms.

Achievements include the publication of the Multi-Agency Safeguarding Arrangements (MASA) and clarification of the roles and responsibilities of the Lead and Delegate Partners. Information Sharing agreements were established and a process for reporting and learning when a Care Leaver dies.

Any outstanding actions were superseded by the changes made to Working Together 2026 which have been reviewed and overseen by the Performance and Learning Group.

Actions relating to Children's Social Care Reform have evolved in line with the Families First Partnership Programme Guidance and progress is overseen by the Durham County Council (DCC) Transformation Programme and the relevant programme boards.

A key area of focus has been how we strengthen the role of education across the partnership.

Four Focus Groups were held in January 2026, with invites to early years, schools and colleges, to explore how the partnership can best include education as a partner in our Multi-Agency Safeguarding Arrangements.

We explored how the DSCP and education currently communicate with each other, what already works well and what could be improved. Attendees were impressed with the offer from the DSCP, including our free multi-agency training offer, our input into Designated Safeguarding Lead (DSL) networks and our monthly newsletter.

All sub-groups within the DSCP have education in attendance. These representatives are all from the Local Authority however it was felt that communication with education colleagues was generally good, and people are aware of the Single Points of Contact (SPOCs).

Suggestions for improving education's input to decision making and planning in the partnership included using surveys and making better use of existing forums such as the DSL network, headteacher briefings and Community of Learning (COL) meetings.

Key Achievements from the 2023 – 2025 Business Plan (at 12 months)

Priority One: Domestic Abuse

Keeping children and young people safe from domestic abuse was a priority for the DSCP in 2023-2025 as domestic abuse was the main reason that children and young people were referred to Children's Social Care.

Cycle 2: August 2024 - November 2024



Question: What is the impact of early interventions on domestic abuse?

Key Line of Enquiry: Look at the journey of a family to understand those early stages and opportunities for support, i.e. Early help, Education, Health, Early Years Provision.

Method
Deep dive audit.

Key findings and areas for development are outlined in the DSCP Annual Report 2024-2025, page 12.

Phase 6 (January 2026) completed the learning cycle. The IDG reviewed the action plan and sought assurance from partners on the work completed.

Progress (12 months review)

In the 12 months since the work was completed, we have:

- Appointed a Practice Lead for Domestic Abuse in Children's Social Care, who has been in post for over 6 months. This is helping partners to think differently about how they understand domestic abuse through a trauma informed lens and partner with children and non-abusing parents (see 'Impact' below for more information about the difference this is making)
- Refreshed Operation Encompass work - Statutory guidance for Operation Encompass was released in November 2025 and identifies police as the lead for this work. Operation Encompass is in the process of becoming a partnership agreement between Police, Public Health and Harbour (Durham's commissioned Domestic Abuse service), who all remain committed to the model
- Ensured that children are recognised as victims of domestic abuse when they see, hear or experience it. Domestic Abuse training for partners has been re-written to reflect this
- Continued to promote Tier 1 information sharing guidance and training.

What difference has this made?

Domestic Abuse Refresher Course for managers in Children's Social Care has prompted deeper discussion around domestic abuse, intersectionality, trauma, risk assessment and safety planning. This is leading to changes in how practitioners' partner with the non-abusing parent.

Good practice example

An abuser with bail conditions to not contact the victim turned up to the family home. Mum allowed him into the home to keep him calm after he demanded entry. This was recognised by services as mum attempting to keep the children safe rather than practitioners framing this as 'failure to protect'. Mum then called the police, and dad was arrested for breach of bail. The children were kept safe from harm.

Following training, request for consultations from the Practice Lead for Domestic Abuse have doubled. The Practice Lead for Domestic Abuse is seeing evidence of the training influencing practice in assessments and managers reinforcing that safety planning should not be the sole responsibility of the non-abusing parent.

There are plans to look at domestic abuse focussed expertise for Durham's new front door, in the multi-agency safeguarding teams and the 'Keeping Families Together' service.

The focus for 2025-26 with partners was a training needs analysis to understand strengths and gaps in practice, meaning less training was delivered to partners during this time. 20% of responses to the training needs analysis were from partners. The training has now been updated, and this will be rolled out over the rest of the year to partners such as Waythrough (drug and alcohol service) and health.

Domestic abuse is no longer a priority for the DSCP Business Plan 2025-2027, however development work continues to be driven and monitored via DASVEG, which reports into the Executive Group. The Improving Practice Manager from the DSCP Business Unit also attends DASVEG.

Priority Four: Mental Health and Wellbeing

Cycle 2: April 2024 – July 2024

Although mental health isn't the main reason children are referred to Children's Social Care, mental health difficulties for parents, children and young people was a common factor in many referrals in this timeframe and was identified as an issue in all local learning.



Question: What are the barriers to accessing mental health services earlier, before families are in crisis? What are we doing around prevention, and to promote good mental health for children and families?

Key Line of Enquiry: How do we identify families for support at the earliest opportunity, looking at the journey of a family that have gone into crisis and whether there was an opportunity to offer any intervention or support at an earlier opportunity to prevent families reaching crisis point.



Method

Multi-agency deep dive audit. Survey of children, young people, parents and carers.

Key findings and areas for development are outlined in the DSCP Annual Report 2024-2025, page 14.

Phase 6 (November 2025) completed the learning cycle. The IDG reviewed the action plan and sought assurance from partners on the work completed.

Progress (12 months review)

In the 12 months since the work was completed, we have:

- completed a mapping exercise with the Mental Health and Wellbeing Board to explore what support is available and where children, families and practitioners can find information about mental health and wellbeing
- developed a communication plan to raise awareness of information sharing
- co-produced a Children and Young People Self-Harm Pathway for practitioners which was launched in January 2026
- produced an Appreciative Inquiry training resource with a young person with lived experience - 'Supporting Young People with Mental Health Concerns', focused on strengths in practice and 'take aways' for learning
- developed and launched guidance on Managing Professional Differences and Mutual Challenge and Voice of the Child and Lived Experience.

Mental Health and Wellbeing is no longer a priority for the DSCP Business Plan 2025-2027.

Development work continues to be driven and monitored by the Children and Young People's Mental Health Reference Group, which the DSCP attend.

c) Joint Targeted Area Inspection (JTAI) Preparation Group

JTAI is an inspection framework to evaluate the effectiveness of multi-agency approaches to safeguarding unborn babies, children and young people.

JTAI's are conducted jointly by Ofsted, Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and His Majesty's Inspectorate of Probation (HMIP) by carrying out a 'deep dive' into specific safeguarding themes.

During 2025-26 the themes for inspection were **'the multi-agency response to identification of initial need and risk'** and **'the multi-agency response to child sexual abuse in the family environment'.**

JTAI evaluation criteria are used to identify areas of strong practice, and areas that we may need to focus on to improve service delivery. We do this alongside existing workstreams and partnership groups, such as the Intra-familial Child Sexual Abuse Task and Finish Group, to support reflective discussion, have a line of sight into practice, and guide next steps that will positively impact on children, young people and families.

During 2025-26 assurance activity of referrals into the 'Front Door' was conducted which complimented the JTAI framework for the identification of initial need and risk. This included dip sampling and understanding our preparedness relating to child level data lists.

The JTAI Preparation Group has considered the framework for child sexual abuse in the family environment. An audit of multi-agency practice was held in November 2025 to better understand partners' responses to sexual abuse. All children were either at risk of or had been subjected to sexual abuse in the family environment.

There were several strengths and some areas for further learning identified through the audit activity under five broad themes:

- Initial response and acting on risk
- Assessment
- Planning
- Child's voice
- Leadership

Strengths included:

- Strong, timely response at initial referral
- Assessments were balanced, holistic and focused on worries and impact on children
- There was evidence of good practice between several agencies, for example, police and youth justice in relation to the Harmful Sexual Behaviour pathway; Children's Social Care and Education worked well together when understanding signs and attending meetings
- Agencies worked well to ensure appropriate inter-agency and multi-agency challenge
- Direct work helped to build trusting relationships. Responding to needs and the use of intermediaries showed strengths relating to the child voice.

The following recommendations reflect our learning. These are being progressed by the Intra-Familial Child Sexual Abuse Task and Finish Group:

- Earlier consideration and a more in-depth understanding of the lived experience of brothers and sisters
- Recording to better reflect work that has taken place and the rationale for decision making
- A review of the Elective Home Education procedure
- Create guidance about roles and responsibilities across different health trusts to ensure the most appropriate representation at meetings
- Development of a local procedure for Intra-Familial Child Sexual Abuse
- Roll out multi-agency Intra-familial Child Sexual Abuse training
- In the coming year, the JTAI Preparation Group will continue to explore 'the multi-agency response to identification of initial need and risk' alongside the new inspection framework which will be announced by the Summer of 2026.

d) Strategic Child Exploitation Group

The Strategic Child Exploitation Group (CEG) has joint governance with Darlington Safeguarding Partnership. Strategic CEG is accountable to the Executive Group.

Vision

Durham and Darlington Safeguarding partners are committed to protecting all children and young people. We recognise that as children grow and develop, they may face Harm Outside the Home (HOTH), from emerging worries to significant harm. Our goal is to ensure every agency understands their role and works together to provide a co-ordinated, effective response to prevent all forms of child exploitation.

The Strategic CEG action plan 2025-2026 has four priorities, linked to the DSCP Business Plan 2025-2027.

Key Achievements

Priority 1: Increased awareness of HOTH - All partners will strengthen their identification of and response to children and young people at risk of HOTH, from the earliest opportunity

The National Audit on Group-based Child Sexual Exploitation and Abuse report highlighted that crime data held by Durham police for contact child sexual abuse cases was higher than the number of assessments completed by Children's Social Care in Durham.

An audit took place to explore the difference in the data and found that, when counting the crimes, there were multiple victims rather than one, and some crimes were adults reporting historical abuse, which helped to explain the difference.

The report outlined three recurring themes, which the strategic CEG action plan is helping to address:

- The need to improve system processes around data gathering, information sharing and staff training
- The ability to identify risk factors and recognise signs of grooming and exploitation
- The need to collect data and information on perpetrators, including on ethnicity and culture.

Education

Awareness raising took place with Designated Safeguarding Leads and teaching staff at the Durham Education Safeguarding Conference to highlight that Harm Outside the Home doesn't stop at the school gates and joint action can allow us to spot the signs and act earlier.

These discussions led to further offers of consultations and support. 75% of young people in Durham who are at moderate or significant risk of being exploited are educated in a specialist or an Alternative Provision. This could be unintentionally increasing risks to them by connecting children and young people who are being exploited, increasing grooming opportunities and reinforcing harmful norms in friendship/peer groups.

Alternative Providers do not always receive the full picture about the circumstances of young people in their provision to help them manage the risks. Exploitation, Risk and Associated Safeguarding Engagement (ERASE) is Durham's specialist Child Exploitation team. Since the team was first created, they have evolved to support children and young people at risk of all forms of exploitation. ERASE has delivered training to over 50 Alternative Providers to help them:

- complete the Child Exploitation Matrix to identify young people at risk
- share locality intelligence and information about children and young people who are linked outside of school

- manage people and places of concern, including risks from other young people
- help with safety planning in school
- create school space risk assessments to reduce the risk of exploitation in school

Training and awareness raising sessions with education providers has led to better relationships with schools and more requests for support from schools to help them support individual children and young people.

Following feedback from education partners that practitioners need more training on how to best respond to online risks, the DSCP has commissioned training from police colleagues to address this issue. This training will be available from April 2026.

Police

In December 2025, the DSCP delivered training to 22 designated police officers in the MASH undertaking work on screening/decision making, disclosures and strategy meetings, to raise awareness of types of exploitation, grooming models, spotting the signs, information sharing, professional curiosity and cumulative harm. This was well received by attendees.

Child Exploitation Vulnerability Triage (CEVT) meetings are chaired by police and currently take place three times per week. This allows children and young people at risk of HOTH to be identified earlier so the right support can be put in place at the right time. The ERASE team manager is part of the 'Front Door' Test and Learn (Children's Social Care Reforms) so that an earlier offer of support is made when HOTH is identified, which includes seeking support from police.

Durham Police were inspected on their safeguarding arrangements in January 2026. Inspectors found strong leadership and governance, where child protection was seen to be a force priority. Inspectors highlighted positive identification of child sexual and criminal exploitation and good investigation plans, solid partnership working with strong management oversight and daily risk management, good initial Threat, Harm, Risk, Investigation, Vulnerability and Engagement (THRIVE) assessments and an absence of victim blaming language.

Sports clubs

Rise North-East has created a specific template to support sports clubs to review their spaces and be more aware of where and from whom children and young people could be at greater risk of exploitation. This is being piloted with a view to sharing it with other partners so they can produce similar templates specific to their setting.

Community Guardians

A training package has been created by the DSCP to raise awareness of Harm Outside the Home with community guardians such as taxi drivers when they apply for a licence. This will be promoted by the licencing team over the next year as part of the DSCP's training offer.

Priority 2: The 'Durham Offer' related to HOTH is clear and understood - Children/young people, parents, carers and practitioners are aware of how they can raise a concern or seek support:

Practitioners

The Multi-Agency Harm Outside the Home Procedures have been agreed and endorsed. These procedures are complemented by guidance for practitioners in universal services that were developed through the Improvement Delivery Group Cycle 1 (April 2025–July 2025). Please see the Improvement Delivery Group section of this report for more information about key achievements linked to this work.

Parents and Carers

Parents and carers have shared their experience of services supporting them and their children, which will be used to support learning and drive service improvement across the partnership.

Parents and carers shared they feel most supported when services take the time to get to know them and their children, when they offer practical and emotional support and when they are kept informed of investigations.

Parents and carers also described challenges such as feeling unheard and overwhelmed, worries about their children being criminalised or excluded from school rather than being seen and supported as victims, long waiting lists for neurodiversity assessments and children's struggles being dismissed as behavioural rather than due to developmental difficulties or trauma.

Children and young people

Young people (both male and female) who attend Alternative Provision have told us their views about exploitation and how they feel they should be supported.

Young people shared that they don't like the term 'exploitation', and they don't see themselves as being exploited. They often feel targeted for their behaviour whereas the behaviour of adults is ignored. They lack confidence in reporting concerns to police as in their experience it doesn't always lead to action. They speak to parents rather than professionals such as teachers as they feel parents listen and help them whereas they fear professionals might contact police or children's social care.

Young people felt trust in police could be improved if police spent time getting to know them and focused more on the adults causing harm. Some young people would speak to their doctor (GP) or friends if they were struggling with their mental health. Young people want safe spaces to spend time, where they don't get moved on.

The views of these young people contrast to younger children who are not being exploited. Younger children show greater trust in professionals (including police) and are more open to conversations about exploitation using this language.

The challenges that young people and parents have described mirror some areas for improvement from the police safeguarding inspection in January 2026:

- Improvements are needed in assessing risk, making appropriate referrals and capturing evidence for online child sexual abuse investigations
- Some investigations for contact child sexual exploitation are not completed in a timely way, and breaches of bail are not always acted on
- Child victims of criminal exploitation are not always viewed as a 'child first', with a focus on proving offences against the child/young person rather than seeing them as a victim.

Priority Three: Targeted Approach to Places and Spaces and People of Concern - Relevant partners will develop and share intelligence, pursue and prosecute perpetrators and disrupt exploitation activity within communities

A Stakeholder Group has been created to drive forward actions around spaces and places and people of concern at an operational level. This group will feed into Strategic CEG and The Safe Durham Partnership so that the relevant strategic groups have oversight of the work.

The Operational Child Exploitation Group continues to take place monthly in the North, East and South of the county and is attended by relevant partners and the lead practitioner for the child/young person. Operational CEG has oversight of all children and young people assessed as high risk of exploitation and the disruption plans in place to protect them. Any emerging issues at a locality level are escalated to strategic CEG for consideration.

An audit of the Operational Child Exploitation Group took place in summer 2025 and identified the following good practice:

- recognising trauma and the voice of the child was well recorded
- language used was non-victim blaming
- there was evidence of rapport building with young people
- there was good use of protective orders to keep children and young people safe

A good practice example was identified during the audit of Operational CEG. This led to a multi-agency Appreciative Inquiry: 'Learning from Good Practice: Missing and Exploitation' which was recorded and shared as a celebration of practice and a learning resource. We explored good practice around information sharing, disruption, relationship building and cross-boundary working, which are recurring themes locally and nationally.

Attempts have been made to correlate police data with partners' data, such as community safety teams and information from Return Home Interviews, to better identify 'hot spots' where exploitation is taking place in communities. However, due to limitations in data sets and recording, there are challenges in accessing and cross referencing this information. The focus for 2026-2027 will shift to online enabled exploitation, to explore patterns and trends that can assist with disruption.

Priority Four: Young People are supported to transition to adult services

Membership of Operational and Strategic CEG has been expanded to include Adult Safeguarding, to bring their expertise to support with protocols and pathways for young people as they move into adult services.

Next steps

The Improvement Delivery Group will meet from April 2026 to progress a joint protocol to support young people as they move from children to adult services. Young people who have been subjected to Harm Outside the Home will be consulted on what does and doesn't work for them and what they feel they need, so their views are considered and acted on.

As part of the Children's Social Care Reforms, a Family Help HOTH Test and Learn team has been agreed to improve the early identification of and offer of support for children and young people at risk of exploitation, before the risk to them increases. This will progress over the next year to inform learning around future practice.

Insights from young people and their parents/carers will continue to inform the Strategic CEG action plan, including a renewed focus on early identification and intervention and working alongside parents and carers to keep children and young people safe and well.

Multi-agency 'People of Concern' meetings will take place to help partners share information and use police and civil powers to frustrate and disrupt the actions of people who wish to exploit children, so that the source of Harm Outside the Home can be better addressed.

e) Workforce Learning and Development

The Workforce Learning and Development Group (WLD) is a sub-group of the Performance and Learning Group (PLG), with overarching responsibility for ensuring that learning from local and national learning is effectively embedded into multi-agency training across the partnership. In 2025-26 the group was chaired by Harrogate and District Foundation Trust (HDFT).

The WLD group ensures that training is delivered to a consistently high standard and that robust monitoring and evaluation processes are in place to assess its effectiveness and impact.

Key Achievements 2025 – 26

The WLD group has maintained strong and consistent representation from all key partner agencies, enabling effective collaboration and contribution to another highly successful year of multi-agency training delivery.

The group has demonstrated a clear and focused approach to embedding learning from safeguarding practice reviews, ensuring that the training offer reflects both local priorities and national developments.

A significant achievement this year was the streamlining of the training offer. This reduced duplication across multi-agency training while complementing single-agency provision, resulting in a more coherent, accessible, and efficient programme for practitioners.

WLD has continued to draw on both local expertise and national specialists, ensuring a well-rounded offer that combines local context with broader national safeguarding issues.

Training Delivery and Reach

Despite a more streamlined offer, engagement has continued to grow, reflecting both the quality and relevance of the training provided:

- **21,572 course completions in 2025-26.** This is a 7.5% increase on 2024-25 and a 45.8% increase from 2023-24

Breakdown of delivery

- **17,060** eLearning completions (Me-Learning platform)
- **1,187** completions via face-to-face and MS Teams sessions
- **2,438** Safeguarding Week attendees
- **599** Development Day completions
- **288** bespoke training attendees

This sustained growth demonstrates strong partnership engagement and the accessibility of the training offer across a range of formats.

To find out more information on training and breakdown of agencies, please see the training section of this report.

Safeguarding Week 2025

WLD led the successful planning and delivery of Safeguarding Week 2025, centred on the theme 'Identification of Risk Across the System'.

The programme focused on 4 key areas:

- Child Sexual Abuse
- Harm Outside the Home
- Domestic Abuse
- Cumulative Harm

A total of **16 high-quality briefings** were delivered during the week commencing 17 November 2025, each lasting between one and two hours.

Attendance increased significantly, with a **138% rise compared to the previous year:**

- **2,438 attendees in 2025-26**, compared to **1,021 in 2024-25**

WLD ensured that sessions were both impactful and engaging by sourcing expert facilitators from across the partnership and nationally. Importantly, the inclusion of **lived experience speakers** across all sub-themes provided powerful insight and enhanced the depth and relevance of learning.

DSCP Development Day

WLD also shaped the focus of the DSCP Development Day, ensuring it was firmly grounded in **learning from serious incidents and child deaths**.

To maximise reach and impact:

- The initial session targeted **managers and safeguarding leads**, with 188 attendees
- Learning was then cascaded within organisations, resulting in **411 practitioners** receiving training through their managers

This cascading model significantly extended the reach of the training and supported the embedding of learning into frontline practice.

What difference has this made?

The work of the Workforce Learning and Development Group (WLD) during 2025–26 has resulted in clear and measurable improvements across the partnership. This has contributed to improved practitioner confidence, more consistent multi-agency working, and a greater focus on identifying and responding to risk, supporting better outcomes for children, young people, and families.

Improved practice and decision-making

By embedding learning from local and national Child Safeguarding Practice Reviews into training, evaluations and feedback show a strengthened understanding of risk and enhanced practitioner's ability to respond effectively.

Strengthened the quality and consistency across multi-agency working

The streamlined, accessible training offer, has reduced duplication and ensured that key safeguarding messages are consistently communicated across all partner agencies. WLD is hoping to see more aligned and co-ordinated multi-agency responses with an increase in confidence.

Increased engagement and participation in learning

The continued year-on-year rise in course completions demonstrates a strong commitment to learning across the partnership. Increased attendance, particularly during Safeguarding Week and face to face sessions, shows that the training offer is relevant, accessible, and valued by practitioners.

Enhanced reach and impact of learning and learning from safeguarding reviews directly informs practice

Innovative approaches such as cascade training following the Development Day have extended the reach of learning beyond those directly attending sessions. This has ensured that key messages are embedded more widely within teams and reflected in day-to-day practice.

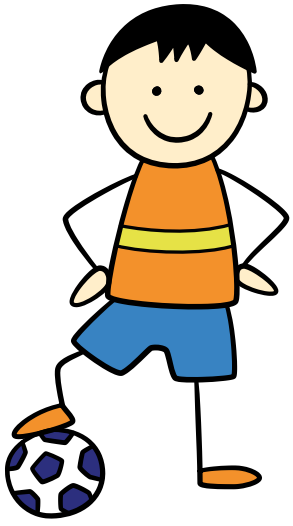
Stronger voice of lived experience

The inclusion of lived experience speakers has deepened practitioners' understanding of the real impact of safeguarding issues, making learning more meaningful and practice more child centred.

f) Multi-Agency Policy and Procedures (MAP) Group

This subgroup creates and updates policy, procedures and practice guidance to support practitioners working with children, young people and families across the partnership. The group is chaired by health (TEWV). 2025-26 has been another busy year, with the following chapters and guides published or updated:

- Child Exploitation (including Child Sexual Exploitation and Criminal Exploitation)
- Children with Disabilities/Complex Needs
- Pre-birth
- Recognising Abuse and Neglect
- Initiating Section 47 Enquiries
- Diversity, Inclusion and Anti-racist Practice
- Allegations Against Staff or Volunteers
- Domestic Abuse
- Child Sexual Abuse in the Family Environment
- Harmful Sexual Behaviour
- Child of Parents with Learning Disabilities
- Online Safety: Children Exposed to Abuse through Digital Media
- Guidance for Safe Recruitment, Selection and Retention for Staff and Volunteers
- Radicalisation, Terrorist and Extremist Ideology



The following Local Resources have been updated or created in line with local and national learning:

- Threshold Guidance
- A Practitioner's Quick Guide to Cumulative Harm
- Managing Professional Differences and Mutual Challenge
- Durham Virtual School: Supporting Children in our Care in their Early Years
- Whole Family Approach

g) Performance Think Tank

The DSCP Performance Think Tank gathers information and data from partners to monitor multi-agency child safeguarding arrangements. The group is chaired by the Performance and Programme Co-ordinator in the DSCP. During 2025-26, the Think Tank focused on 11 themes relating to safeguarding practice. Three of these eleven were linked specifically to the DSCP Business Plan priorities.

The Think Tank facilitates qualitative and quantitative input, discussion and challenge from our partners, including Children's Social Care, Integrated Care Board, Police, Harrogate District Foundation NHS Trust, County Durham and Darlington NHS Foundation Trust, Tees Esk and Wear Valley NHS Foundation Trust, Probation and Prison Service, Harbour, Public Health, Waythrough, Education (including Durham Works, 16+), Virtual School, Early Years, Housing and Voluntary Sector. The group uses this information and discussion to consider the impact or the 'so what' question in relation to our work.

Data and information provided by partners through the performance model allows themes to be explored through a multi-agency lens, including:

- **Elective Home Education:** analysis led to improved practice via an agreement with the Durham Association of Secondary Heads (DASH), where it has been identified that elective home education is deemed as 'unsuitable'.
- **Multi-agency discussion at the front door:** a dip sample was completed to consider the impact of discussions on outcomes for children. The sample concluded that there was a breadth of discussion with a range of partners which led to the right help for children and young people.
- **Family networks:** following discussion relating to child protection plans, a dip sample was completed to understand the quality of information provided by partners at initial referral/contact. Following this (and linking with developments in Family Group Decision Making) a series of briefings on identifying family networks from the earliest opportunity are planned for delivery across the partnership.
- **Young people presenting as homeless:** triangulation of data with housing, police and children's social care has been carried out to understand the timeliness of response and engagement with young people.
- **Families living in temporary accommodation:** data highlighted the prevalence of this issue. The Think Tank discussed the impact of this in their agencies so we can better identify, understand and develop the pathway so families are supported at the right time.

During 2025-26 we reviewed the Think Tank process and received positive feedback on the benefits of the group, including:

> "Collective focus on priority areas"

> "The coming together of multiple services generates strong discussion and valuable actions that support children and help the council improve its services. It's encouraging to see the range of topics being explored and how external agencies are involved to create a more joined up approach"

> "Multi-agency approach and space to meet to discuss issues/trends"

Next steps

The Think Tank will continue to build on existing strengths and refine the processes in line with feedback to ensure discussions are focused on emerging issues across the partnership.

In response to local and national learning, the performance model will be developed during 2026-27 to include a focus on neglect and child sexual abuse. The DSCP Quality Assurance Framework has been further developed with clearer links to assurance models, including the performance model. This will allow us to better align our learning and focus our work to ensure an effective partnership.

h) Golden Threads

The DSCP has several 'Golden Threads' guiding our work as a partnership.

Golden Threads - that weave through everything we do...

Child's voice and lived experience
Working together across partners and boundaries
Whole family approach recognising networks, father's roles and hidden males
Cultural Competence
Reflective practice
Signs of Safety



Child and Family's Voice and Lived Experience

Listening to and acting on what children, young people and their families tell us is at the centre of what the DSCP does and the resources we produce, particularly through the Improvement Delivery Group. The detail of this participation work is threaded throughout this report. The following is a summary of the work undertaken:

Children, young people and their parents/carers who are part of existing participation groups across the partnership have been involved in reviewing the content and design of the DSCP website as we prepare to move to a new platform later in the year. They have helped shape resources we produce for them so that these work for them, for example the Parent Guide to Harm Outside the Home.

Young people who attend Alternative Provision have shared their views about exploitation, policing and who they would and wouldn't speak to if they had any worries. Parents and carers of children and young people who have been exploited have shared their views on what services do that does and doesn't help. This feedback will continue to shape the strategic CEG action plan as we move into 2027.

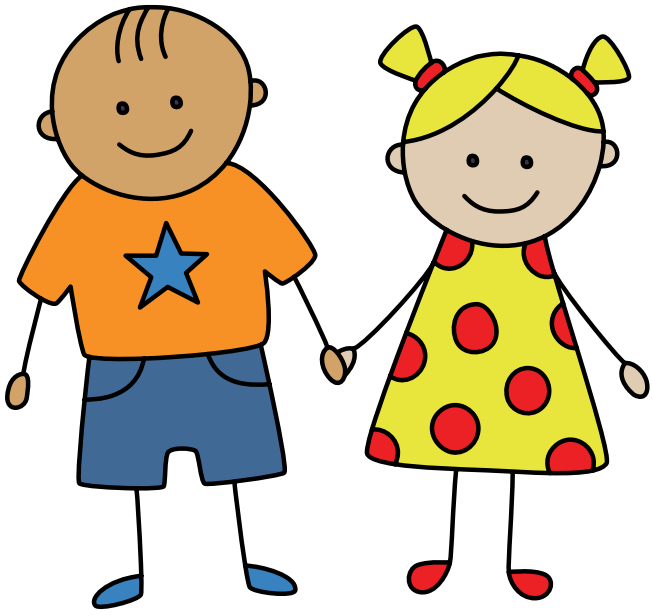
Mum and dads have shared their experiences of stress and trauma to support reflection and learning in our focus groups around Trauma Informed Practice. Many practitioners shared that this was the most impactful part of the focus groups for them and the inclusion of parents with lived experience will be taken forward into the wider partnership training offer for Trauma Informed Practice.

A young person and his mum have taken part in an Appreciative Inquiry to celebrate and share how services worked well with them and the difference this made so that other practitioners can be inspired and learn from this.

Parents have shared their views about multi-agency meetings and support during Assurance week, so that learning considers the family's perspective alongside practitioner observations.

Young people will be sharing their experiences of moving from children to adult services to support culture change within services and help us to provide information around transitions and transitional safeguarding in a way that suits them best.

A Durham care experienced young person completed a work placement with the DSCP from July until September 2025 to support him to gain skills and insight into working in a safeguarding setting. He reviewed the Children and Young People's section of our website so that this will be more child and young person friendly. This young person has since been successfully employed as a care leaver ambassador in the care leavers service.



Whole family approach, recognising networks, father's role and hidden males

In Durham, we promote a 'whole family' approach to working with children, young people and families. This includes actively considering how partners can better involve dads and male carers and identify and involve members of the wider family network, such as grandparents, aunts, uncles, family friends, neighbours and community supports.

The DSCP attends and contributes to the 'Dads and Male Carers Project Group' led by Early Help. This allows us to share information and learning relating to dads, promote father inclusive practice and involve dads in our development work in the DSCP.

The Families First Partnership Programme Guide was published in March 2026 and highlights the importance of and expectations around Family Group Decision Making so that families can create unique plans that work for them.

The DSCP undertook a dip sample in March 2026 looking at how family networks are identified and explored by key partners as we want to identify important people to the child and their parents/carers from the earliest opportunity. Findings showed that partners are attempting to explore networks however they could benefit from asking more specific questions about who people are and how they help.

Sessions will be offered to partners over the rest of the year to raise awareness around the importance of family networks and provide tips to help them continue to identify important people and the role that they play in helping children and their parents/carers.

Cultural humility

Working Together to Safeguard Children 2026 highlights the importance of anti-racist, anti-discriminatory, culturally aware practice and the need for services to actively challenge discrimination and bias when they come across this.

The population in County Durham is mainly White British however Durham has an established Gypsy, Roma, Traveller community and the number of people of Global Majority Heritage is increasing. Many communities across the county have a proud working-class history whilst struggling with high levels of poverty and deprivation.

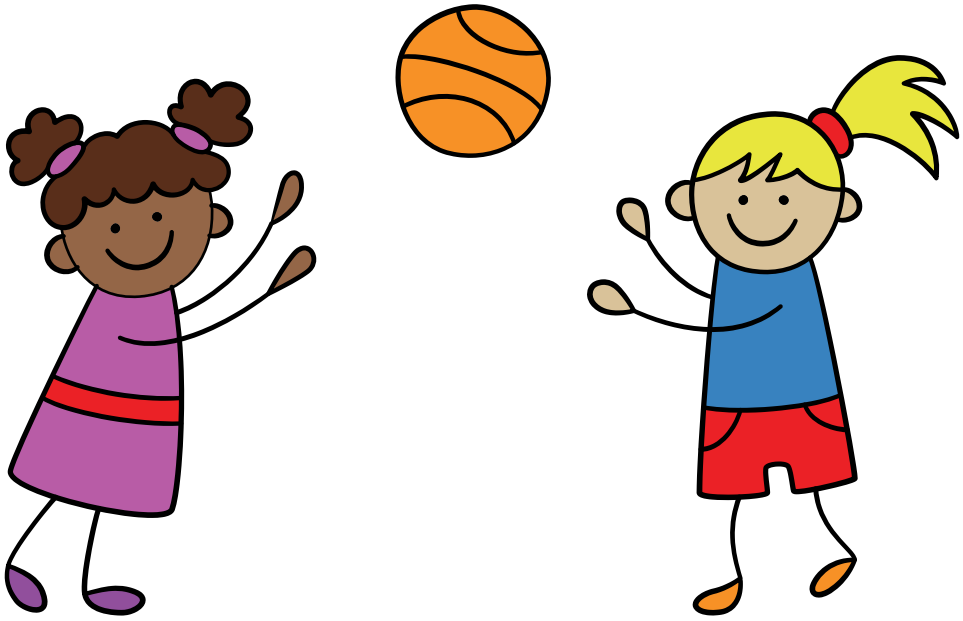
The DSCP therefore continues to consider cultural humility and intersectionality in our learning and workstreams. The DSCP has a strong training offer around anti-racist practice and Gypsy, Roma, Traveller cultural awareness. Findings from the Trauma Informed Practice Improvement Delivery Group have highlighted the role of class in our bias and this will be addressed in the next steps linked to this work.

How we Practice in Durham

'How we Practice in Durham' is our key practice model across the partnership, combining 'Signs of Safety' with trauma informed, relational practice.

The model continues to evolve to align with national changes to how children are helped and protected. Family networks are central to 'How we Practice in Durham' and the Children's Social Care reforms and are covered elsewhere in this report.

Learning over the past year has highlighted the need to strengthen some aspects of multi-agency working across the partnership. The DSCP has produced and promoted resources such as The Role of Partners in Child and Family Assessments: A Shared Responsibility to complement 'How we Practice in Durham', raise awareness and offer tips on working together and supporting the lead practitioner.



5 Scrutiny

The DSCP has an Independent Scrutineer who provides oversight and accountability for the work undertaken by way of reports to relevant strategic committees and partnerships.

The Partnership Business Manager and Independent Scrutineer communicate so there is a clear link between the subgroups and the Executive Group. This allows risks, opportunities and themes to be highlighted to the Executive Group and challenge, direction and opportunities to be shared with subgroups.

The role of the Independent Scrutineer is outlined in **Working Together 2026** page 37.

Overview and assurance from Durham's Independent Scrutineer can be found at the end of this report.



6 Learning and Improvement Work

The DSCP is committed to working together to protect children and young people from the risk of serious harm and abuse.

The DSCP Business Unit continues to horizon scan national documents and reviews, recording themes from learning to better understand the national picture alongside local learning. This means we are better prepared to respond to any emerging risks or threats.

a) Learning from Reviews

The DSCP has an established Serious Incident Notification/Child Safeguarding Practice Review Panel within the Performance and Learning Group (PLG) with representation from key agencies such as children's social care, police, ICB, health trusts, education, housing, early help, probation and prison service, youth justice service and public health. The independent scrutineer attends panel meetings and legal and media reps are aligned to input where necessary.

The SIN/CSPR panel manages all multi-agency learning activity in line with the **DSCP Learning Together Model**. The panel coordinates the outcomes of all reviews and thematic audits and oversees action plans where learning has identified that frontline practice could be strengthened.

Between April 2025 and March 2026, the panel received several referrals to be considered for Serious Incident Notification and review. All children were discussed by the panel and recommendations made to the Delegate Safeguarding Partners for any final decisions.

Where criteria were not met, other processes such as reflective discussion and a learning review were progressed instead.

Serious Incident Notifications were made for eight children and young people. Six progressed to Rapid Review and two related to children in our care, where no safeguarding concerns were identified therefore no rapid review was required.

All six Rapid Reviews were thorough. Reviews were well attended, information was shared appropriately, and single and multi-agency learning was identified in each review. It was agreed that all necessary information was obtained to understand learning through each Rapid Review, meaning a statutory Local Child Safeguarding Practice Review was not recommended. Positive feedback was received from the national panel in response to these Rapid Reviews.

Information sharing, professional curiosity, multi-agency working and family networks are recurring themes from our local learning, with neglect and vulnerable pre-school children re-emerging as an issue locally. Horizon scanning suggests that this mirrors the national picture too.

Following all reviews, learning is shared within PLG, actions and measures are agreed, and plans are reviewed at 6 and 12 months for assurance and evidence of impact.

Key learning is shared with the wider partnership through briefings, Lunch and Learns and updates to procedures and guidance. Themes inform the multi-agency training programme, development days and safeguarding week.

a) Case study - Noah

Understanding the young person and what happened

Baby Noah's birth was traumatic. He was delivered by forceps, leaving him with injuries to his face. From the first day he was born, Noah was a baby with a sore head, he cried often and it's likely that he was a baby in pain. Noah was 9 weeks old when he was taken to hospital due to concerns about serious non-accidental injuries, including a fractured skull and bleeding on his brain, which meant he needed intensive care. Further scans showed that Noah had old injuries to his skull and ribs.

The explanation that Noah's parents gave was not consistent with his injuries and both parents were arrested on suspicion of Section 18 Wounding. The family were not known to safeguarding or wider support services in the lead up to this incident, so the review focused on the approach taken by universal services involved with the family in the 12 months leading up to the incident.

What worked well

- **Relationships** Mum had a good relationship with school staff involved with her oldest child. School also had a relationship with gran. Both mum and dad attended ante-natal appointments together
- **Professional curiosity** Practitioners asked appropriate questions based on what they knew at the time, and they explored wellbeing, mental health and domestic abuse during their visits

- **Working Together** There was good collaboration between midwives and the hospital around Noah's birth. Despite challenges with staffing in midwifery and health visiting teams, all post-natal visits were completed with evidence of good discussions
- **Recording** Noah was delivered by forceps and a body map of his injuries was completed and recorded on health systems. The midwife referred to Noah's body map five days after his birth when she noticed bruising on his face. The quality of recording of home visits and contacts by health services was good
- **ICON** There is evidence throughout the review of practitioners from midwifery, health visiting and 111 giving ICON advice, suggesting this practice is well embedded across health services.

The following themes were identified

Theme	What does this mean for our practice?
How we recognise and respond to traumatic births ● Mum described the use of forceps as **'horrendous'.** Delivery by forceps is common so **practitioners may become de-sensitised** to the impact of this ● The **Birth Reflection Service** was offered to mum on the first visit however **mum felt too emotional to take this up at that time**. This would usually be offered from six weeks after birth ● There were **missed opportunities to re-visit support with mum**, such as additional support from the midwife, exploring early help and involving the wider family network.	**Trauma Informed Practice** Traumatised people understandably **find it hard make sense of and retain information** when they are in fight or flight. Practitioners can work in more trauma informed ways by: ● Sharing information in a way **families can best understand** ● **Repeating information** so it's more likely to be retained ● **Re-visiting offers of support** at future visits ● **Including wider family members** in discussions, to help them understand the impact of trauma and provide additional support ● Speaking to parents and wider family about **what is and isn't usual crying following a traumatic birth**, so they know what to expect.
Sharing information and collaborating ● **Staffing challenges** across health services are a national issue. This meant different practitioners were visiting the family. Although this helped with arranging visits it **impacted on information sharing** when issues arose ● There were **missed opportunities to communicate and co-ordinate visits** - neither midwifery nor health visiting had seen the home before baby Noah came home from hospital ● The Health Visitor was aware of the traumatic birth however the **handover could have provided more information** to help the Health Visitor have ongoing conversations about support for mum ● **Information** shared by the family about Noah's traumatic birth as an explanation for bruising to his face **was taken at face value** by first responders, which meant **safeguarding wasn't considered** from the earliest opportunity.	**Staying curious** This is a recurring theme in local reviews. ● When handovers take place, it is important that **practitioners have the right information** to allow them to ask any additional questions and continue to explore support with families ● Health emergencies are understandably an emotional time for families and practitioners. Practitioners still need to **'think the unthinkable'** at these times rather than taking information at face value ● We do this sensitively by listening to what the family is telling us whilst acknowledging that **we need to keep an open mind** about what may have happened ● **Balancing priorities is important** – responding to health emergences is a priority for everyone. Other agencies, e.g. police will have other priorities such as preserving evidence which should be considered too.

Theme	What does this mean for our practice?
Cross boundary challenges - procedures **Bruising in Non-mobile Children Protocol (BINMC)** ● **Durham's BINMC differs to other protocols in neighbouring hospital trusts** regarding the point at which health services make a referral to Children's Social Care ● Had Durham's protocol been followed there would have been an opportunity for a social worker to speak with the family about any additional support and to triangulate information from the health visitor and GP.	**Overcoming challenges** **Bruising in Non-mobile Children Protocol (BINMC)** ● Currently there are no plans for neighbouring hospitals to adopt Durham's protocol as they feel their processes are proportionate ● When families live in Durham, practitioners in neighbouring trusts and authorities should follow the Durham protocol to the best of their ability.
Involving dads and male carers ● There was some good practice in involving dad in ante-natal appointments and ICON information was shared with dad and mum by several practitioners ● Services continued to see mum as the main point of contact. More effort could have been made to speak to dad, e.g. updating him about visits that he missed due to work or attempting to call both parents to rearrange visits.	**Overcoming barriers** Father inclusive practice means holding dads in mind throughout our involvement and finding ways to overcome any barriers to their involvement Practitioners need to make every effort to get phone numbers and email addresses for dads so that both parents are a point of contact. Practitioners should think creatively about how to better include dads, for example: ● Inviting dads directly to meetings rather than via mum ● Visiting/organising meetings at times that suit dads ● Calling dads to get their input/provide updates when they are unavailable for meetings or visits ● Holding hybrid meetings where dads can dial in

What is the DSCP doing?

- A key learning briefing will be shared with partners to summarise learning from the review and what this means for practice, as outlined above
- The DSCP will share learning across the partnership about the impact of traumatic births. The impact of traumatic births will be included in ICON
- The DSCP will continue to raise awareness of the Durham Bruising in Non-Mobile Children Protocol, and promote its use for all families who live in Durham, including when they are treated by a neighbouring health authority
- The DSCP updated the Information Sharing Agreement Guidance in 2024, and full training is available on the DSCP website. This will be updated again when the Information Sharing duty comes into effect
- The DSCP has highlighted the impact of workforce challenges and capacity issues with Lead Safeguarding Partners
- The DSCP will create a resource to help practitioners across the partnership understand each other's roles and responsibilities
- The DSCP will continue to raise awareness of father inclusive practice.

b) Learning from good practice

During 2025-2026 the PLG continued to promote learning from good practice as we recognise that celebrating and learning from what works is as important as learning from incidents. The DSCP recorded and hosted two Appreciative Inquiries that explored good practice:

'Learning from Good Practice: Missing and Exploitation' – this featured the multi-agency team supporting a young person who had been sexually exploited, with a focus on relationship building, information sharing, cross boundary working and disruption.

'Supporting Young People with Mental Health Concerns' – this featured a young person, his mum and their Rapid Response worker reflecting on what services did that was helpful.

c) Other Improvement and Development Work

Sexual Abuse in the Family Environment Task and Finish Group

In November 2024 the Child Safeguarding Practice Review Panel published their national report **'I wanted them all to notice'** focused on protecting children and responding to child sexual abuse within the family environment. In response to this a dedicated Task and Finish group was set up to take forward the recommendations via an action plan.

The group established short and long-term governance arrangements for Intra-familial Child Sexual Abuse to lead on the agreed strategy. The group established a comprehensive multi-agency training offer, updated procedures and developed new guidance to support consistent, best practice across all agencies. The Task and finish group ended in March 2026 and will now form a newly established Strategic Intra-familial Child Sexual Abuse sub-group which will sit within the DSCP governance structure, to ensure that the changes are embedded and measured.

Quality Assurance Framework

During 2025-26 we updated our Quality Assurance Framework. This outlines the methods, processes and planning that will be used to test and assess evidence of partnership safeguarding activity and how our values are put into action to keep children and young people safe.

Awareness raising

The DSCP raises awareness of themes and issues throughout the year to highlight local and national areas of interest or concern, so practitioners and families are better informed to seek help when needed and prevent harm. One way the DSCP achieves this is by attending other meetings so we can work together and share learning, for example:

- Designated Safeguarding Leads meeting (Education)
- DASVEG
- Strategic MAPPA
- Police Child and Family Scrutiny Panel
- Named GP meetings
- MASH Board
- Anti-Slavery Network
- Prevention and Early Help Partnership Meeting
- Children and Young People Mental Health Reference Group
- Dads and Male Carers Project Group



7 Assurance

The DSCP undertakes regular scrutiny of multi-agency safeguarding arrangements. The work is carried out through the Performance and Learning Group sub-groups. Learning is shared with frontline practitioners through training, 'Lunch and Learns', 'Development Days', conferences, partnership meetings and newsletters. The following is an overview of our assurance activity during 2025-26.

a) Assurance week – multi-agency meetings

Assurance week took place from 15-19 September 2025, to learn from best practice and understand areas for development. Across the week, 14 Team Around the Family (TAF) meetings (led by Early help), 5 Child in Need meetings and 2 Core Groups were observed. 19 partners offered to observe meetings. Feedback was sought from parents/carers and children involved.

More meetings were put forward, however due to parents not giving consent for meetings to be observed, or meetings being rearranged this led to some observations being cancelled.

Key Findings

All observed meetings had the Local Authority (early help practitioners or the social worker) as the lead practitioner. This reinforced that we have a culture of the Local Authority taking the lead on early help.

Durham is rightly proud of our early help offer to families however we are trying to move towards partners taking a lead on early help where they have the right knowledge or the best relationship with the child and/or parents/carers. National changes to how children and families are supported through the Family Help model should help support this change as we move into 2026-2027.

Strengths

- Meetings were clearly explained and everyone understood the purpose
- Meetings were child focused and mostly strengths based
- Most parents reported that they felt listened to:

> "I feel like I'm 1000% involved. They listen to me and my children, and they listen to my husband."

- Most parents scaled high when asked how satisfied they were with the meeting:

> "It's all positive. I've had great feedback. X go above and beyond."

Next steps

We want to shift our culture towards a shared responsibility for partners to input into and support assessments, plans and meetings rather than an over-reliance on the lead practitioner to co-ordinate everything.

The Role of Partners in Child and Family Assessments: A Shared Responsibility has been shared with partners through PLG to raise awareness and will be central to bespoke Lunch and Learn sessions on plans and planning for 2026-27.

We will have a continued focus on involving dads and the wider family network, for example through dad's champions, and identifying and involving family networks from the earliest opportunity through partnership sessions on family networks.

b) Use of Restraints

Durham Safeguarding Children Partnership supports independent assurance of the appropriate use of restraint within Aycliffe Secure Centre through annual assurance visits.

At the start of 2025-26, an assurance visit considered the use of restraint. Aycliffe Management and the DSCP subsequently agreed that more frequent independent scrutiny would be helpful, initially moving to quarterly and later monthly reviews to provide additional assurance.

Ofsted conducted both monitoring and full inspections at Aycliffe Secure Centre throughout 2025-26. In July 2025, Ofsted noted that incidents of restraint should be subject to regular scrutiny and, in December 2025, highlighted concerns about restraint practice. DSCP reviews provide independent scrutiny of incident reports, relevant footage and reflective discussions with managers. Observations and points for consideration are shared promptly so that Aycliffe leaders can reflect on practice and determine any action required.

During a further monitoring visit in January 2026, Ofsted reported that the ***"independent oversight arrangements to strengthen children's safeguarding are now in place… This provides leaders and managers with additional assurance and enhances the scrutiny of practice, helping to identify learning points and highlighting what has worked well."***

The reviews also consider whether the physical restraint holds used appear appropriate and consistent with guidance. As part of this independent oversight, the visitor routinely samples CCTV footage alongside relevant documentation, offering an additional perspective and constructive challenge for leaders and managers to consider. Ofsted noted: "However, these improvements are not yet embedded, and their effectiveness to date cannot yet be evidenced." (Ofsted, March 2026)

Since monthly DSCP assurance visits were introduced, constructive professional relationships with Aycliffe managers have continued to develop. Through the review process, the DSCP offers observations and challenge about areas for reflection and examples of effective practice. Aycliffe managers accompany the visits, supporting broader management involvement in considering the feedback and ensuring any changes are embedded consistently in practice.

Following a full inspection in March 2026, Ofsted reported ***"improvements have been made with reviewing physical restraint practices. A multi-agency restraint review panel now meets weekly to review all incidents. This is successful in identifying shortfalls in restraint practice, and action is taken quickly to improve children's experiences."*** (Ofsted, March 2026)

Evidence considered through the monthly DSCP assurance visits indicates that restraint is only used when necessary, for the shortest practicable duration, and not as a routine measure. These observations provide assurance alongside the Centre's own monitoring and improvement arrangements.

The records sampled also indicate increased documentation of de-escalation and lower-level techniques, such as guiding young people away. This is consistent with Ofsted's positive findings about children's experiences and provides some assurance that staff seek to engage meaningfully with young people. Records also refer to reflective discussions with staff and communication with social workers, contributing to oversight of young people's experiences.

The evidence reviewed provides increasing assurance that restraint is being used proportionately and in the least restrictive way possible. Ofsted identified improvement during 2025-26, and the Centre is now rated as 'requires improvement to be good'. Ofsted reported that ***"Children's experiences have improved since the last inspection in December 2025. There is a calm and settled atmosphere throughout the home."*** (Ofsted, April 2026)

In 2026-27, the DSCP will continue regular assurance visits to support Aycliffe Secure Centre's oversight of restraint. The DSCP will also consider restraint data quarterly to assess assurance and highlight any matters requiring further review by the Partnership or consideration by Aycliffe Secure Centre.

8 Training

> My brain is full, my mind is racing, and my heart is full of passion to try to do better. This training has empowered me to be the difference to someone.



> Highly engaging, emotionally impactful, and professionally valuable training delivered by exceptional trainers.

> The training programme is delivering high-quality, impactful learning experiences that support both professional development and improved outcomes for children and young people.

Overview of course completions

Me-Learning (eLearning and recorded briefings) – 17,060

Increase in number of courses from 45 courses in 2024-25 to 54 courses 2025-26 with a 4% decrease in course completions.

Training Programme (face to face and MS Teams delivery) – 1187

Reduction in courses from 14 courses in 2024-25 to 12 courses in 2025-26 with a 72% increase in completions

Safeguarding Week – 24381

Reduction in number of briefings from 21 in 2024-25 to 16 in 2025-26 with a 138% increase in completions.

Development Day and Re-delivery – 188 and 411

188 managers and leads attended and the expectation was for them to re-deliver to the practitioners they supervise. 411 practitioners were trained on the case study by their manager.

Bespoke Training – 288

An increase of 42% in number of people attending bespoke training from 202 in 2024-25 to 288 in 2025-26.

Total

21,572 course completions 2025-26

1,521 more completions than in 2024-25 (20,056 completions)

6,784 more completions than 2023-24 (14,793 completions)

Me-Learning (eLearning)

Our platform continues to be developed which has a mixture of eLearning-built packages and recorded briefings which are relevant to Durham and national arising issues. Most of the courses are less than 1 hour long on a particular safeguarding subject. For example, Dental Neglect, Private Fostering, Learning from Practice Reviews, Adultification Bias.

This offers the practitioners in County Durham opportunities to enhance their professional development and practice knowledge on a wider range of safeguarding topics. Our evaluation analysis suggests practitioners are opting for face-to-face sessions again following the pandemic and this is indicated in the rise in number of completions on the training programme sessions.



Training Programme (Face to face or virtual delivery on MS Team/Zoom)

The training programme was reduced this year as the Workforce Learning and Development Group (DSCP sub-group) identified some duplication and streamlined the face to face and virtual delivery. The number of courses was therefore reduced from 14 to 12.

The group highlighted a gap in Child Sexual Abuse training and sought the 'Train the Trainer' from The Centre of Expertise in Child Sexual Abuse. 12 practitioners from across the partnership were trained to deliver Intra-Familial Child Sexual Abuse – taking a multi-agency approach. This was added to the programme in January 2026 and over 200 practitioners were trained from January until March. Although there was a course reduction, the number of completions increased by 72% as there is now no duplication of training across all platforms.

Safeguarding Week

Our annual safeguarding week took place in November 2025 with an overarching theme of 'Identification of Risk Across the System'. The week focussed on 4 sub-themes:

- Harm Outside the Home
- Child Sexual Abuse
- Domestic Abuse
- Cumulative Harm

The number of sessions across the week reduced from 21 session in 2024-25 to 16, however we commissioned lived experienced speakers across all the 4 sub themes to tell their own story. Although the number of sessions was reduced, there was a 138% increase of 2,438 completions compared with 1,021 in 2024-25.

Development Day and Re-delivery

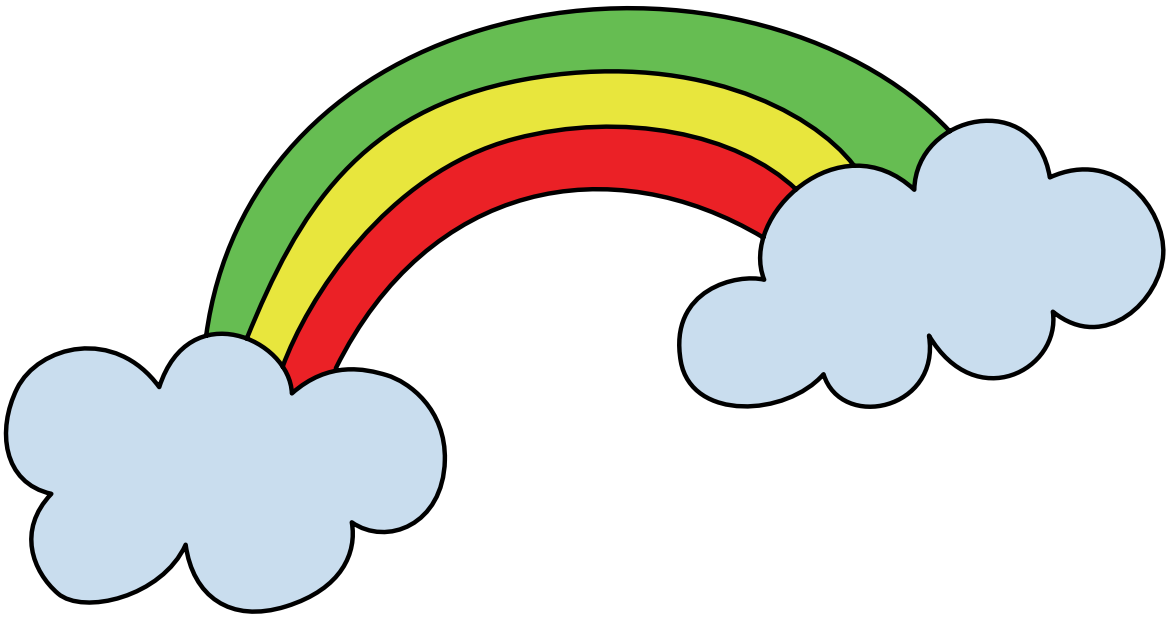
The theme of the day was based on recent serious incidents and child deaths. A case study was used to work through as a multi-agency group. It was an expectation that this would be taken back by attendees and delivered to practitioners in their own organisations.

The initial session was for all partners with case management responsibility, responsibility for overseeing safeguarding of children in their organisation and for anyone supervising practitioners who work with children, young people and families. 188 managers and leads attended the initial session and 411 practitioners were trained on the case study by their managers.

Bespoke Training

288 practitioners completed bespoke training delivered by the DSCP Training and Development Coordinator. Training is tailored and designed to meet the needs of a single agency, and this incorporates multi-agency messages. Bespoke training was delivered to the following:

- Alternative Provision
- Community Centres
- Community Cultural Charity
- Early Years
- Humanitarian Support
- Independent School
- Residential Care
- Schools
- Youth Project



Course Completions by agency across Me-Learning, Training Programme, Safeguarding Week, Development Day and Bespoke

Organisation Name	Total
Alternative Education Provider	870
Colleges (Further Education)	357
Domestic Abuse Service	130
Drug and Alcohol Services	500
DWP	6
Early Years and Childcare (All Nurseries including private nurseries, Out of School Clubs and Childminders)	2399
Faith based	19
Fire Service	26
Integrated Care Board (ICB)	2
Integrated Passenger Transport (Home to School Transport including Taxi Drivers)	1468
LA Adult and Health Services (AHS)	169
LA Children Social Care	3933
LA Early Help (One Point/Family Hubs)	1090
LA Education and Skills	677
LA Foster Carers	425
LA Housing	163
LA Other	757
LA Regeneration and Local Services (ReAL)	48
LA Youth Justice Service	177
NHS Foundation Trusts	1618
Northeast Ambulance Service	4
Police	81
Primary Care	342
Prison Service	51
Private Housing Providers	54
Private Organisations (for profit organisations including Independent Schools, Private Children's Homes and Fostering Agencies)	305
Probation Service	23
Schools	4205
Universities (Higher Education)	33
Voluntary Sector (Community Interest Companies, Registered Charities, Volunteers)	1640
Total	**21, 572**

Learning Gain

Post Course Evaluation

Course content average rating out of 5

Me-Learning – 4.7

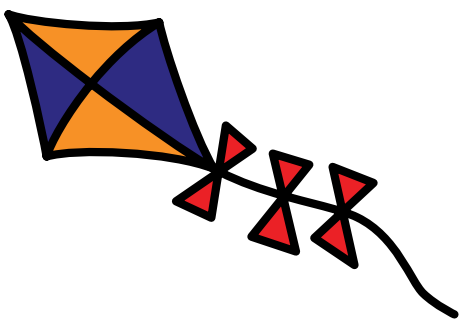
Training Programme – 4.8

Safeguarding Week – 4.8

Development Day – 4.7

Bespoke Training – 4.9

Overall average across all training is 4.8 out of 5

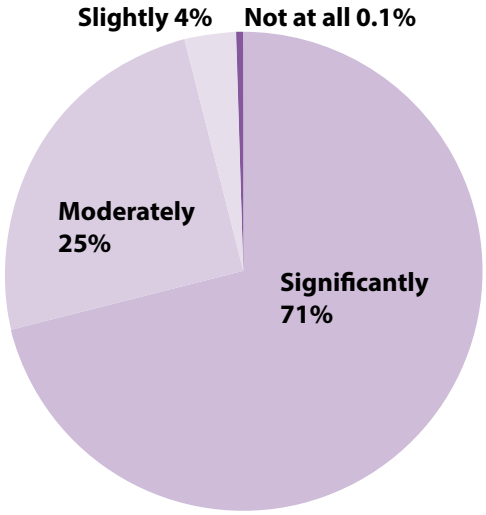


Average level of knowledge on this subject before and after training

1 being limited knowledge and 10 being in depth knowledge.

	Before	After
Me-Learning	5.3	8.8
Training Programme	4.5	8.9
Safeguarding Week	5.7	8.2
Development Day	5.7	8.9
Bespoke	6.5	9.1
Average	**5.5**	**8.8**

Do you think this training will have impact on your practice with children, young people, and families?



Impact analysis summary

The analysis of training feedback demonstrates overwhelmingly positive responses from participants, with consistent themes highlighting the high quality and impact of the courses. Attendees frequently described the training as informative, engaging, and interactive, with praise for the use of group discussions, case studies, and real-life examples that enhanced learning and applicability to practice.

The knowledge and delivery style of trainers were repeatedly identified as a key strength, with many participants noting their expertise, approachability, and ability to create a safe and inclusive learning environment. Feedback also emphasised the practical relevance of the content, with many learners reporting increased confidence and improved understanding of safeguarding issues. Overall, the training is viewed as highly effective, professionally valuable, and in many cases emotionally impactful.

Overview

- The training was extremely well received, with consistently positive feedback from participants.
- Attendees highlighted the course as highly engaging, informative, and impactful.
- Feedback demonstrates a high level of satisfaction across all aspects of delivery and content.
- The training is widely regarded as valuable and relevant to professional practice.

Trainer and Delivery

- Trainers were consistently praised for being knowledgeable, engaging, and highly skilled facilitators.
- The delivery style created a safe and inclusive environment that encouraged participation and discussion.
- Facilitators effectively combined professional expertise with real-life experience, enhancing credibility and impact.

Learning and Content

- Participants reported a significant increase in knowledge and understanding following the training.
- The content was described as clear, well-structured, and easy to follow, supporting effective learning.
- Training materials were up to date, relevant, and directly applicable to participants' roles.

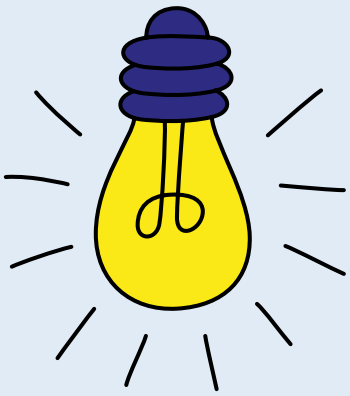
Engagement and Interaction

- The use of interactive methods, including group discussions and case studies, was particularly valued.
- Attendees appreciated the opportunities to share experiences and learn collaboratively with other professionals.
- The training successfully encouraged active participation and critical reflection.

Impact and Outcomes

- Many participants stated the training would positively influence their practice and decision-making.
- The courses were described as thought-provoking, eye-opening, and, in some cases, transformative.
- Feedback indicates the training has strengthened confidence in recognising and responding to safeguarding concerns.

Lightbulb moments



"I have introduced elements of this training into the organisation to raise awareness of certain issues. This has enabled the volunteers to be much more alert and aware of situations what can come up and to ask curious questions."

"Most of us are aware of the basic categories of abuse, but this training covered so many other areas we now need to consider. I had very basic knowledge on cultural and faith-based child abuse, exploitation and the complexities around online abuse. My head is full of new information, and I want to know more. I will go back to my organisation and share what I have learnt with others."

"I am shocked at the level of information shared at the training and how the facilitator keeps up to date with this. I have over 20 years of working in my field and I have learnt so much from today's session, some things which have not been touched on before."

"Every safeguarding training mentions the importance of information sharing and professional curiosity. This training used real life experience to bring it to the forefront of our minds. I am thrilled that Durham have produced an information sharing agreement so that it is clear to all that this is so important and not hide behind data protection regulations as a barrier."

"It takes real skill to be able to deliver training to Managers and DSLs from different organisations who feel they have lot of knowledge on safeguarding. Keeping it relevant to all and engaging is extremely difficult but this course did that and more. The level of engagement, discussion and experience in the room was fantastic. I have made contacts with other agencies and can now pick up the phone to ask for help if needed. Multi-agency safeguarding training at its best!!!"

9 What's Next for the DSCP

Throughout 2026, the DSCP will continue to focus on existing priorities:

Priorities

Priority 1	Priority 2	Priority 3	Priority 4
Harm Outside the Home	Safeguarding Through Early Identification and Intervention	Trauma Informed Practice	Working Together and Towards Reform Action Plan

The current Business Plan can be found here. It outlines the rationale for our priorities, examples of assurance activity and evidence of impact.

As we move into 2027, the DSCP will review the Strategic Business Plan and agree new priorities for 2027-2029, in line with local and national learning.

Learning across the whole system in 2025-26, from our Improvement Delivery Group, JTAI, Performance Think Tank, Rapid Reviews and Assurance Week highlights the following recurring themes:

- Confusion about information sharing and consent
- Misunderstanding of partner's roles and responsibilities
- Variable attendance at meetings
- Reliance on the Local Authority as the Lead Practitioner

The partnership has a well embedded, strong training offer in response to these themes, that receives excellent feedback from attendees. The persistence of these themes suggests that the challenges are systemic rather than solely related to knowledge or skills. Partners have recognised that addressing these issues requires broader cultural and organisational change, supported by strong leadership, clear accountability, and a shared commitment to strengthening multi-agency practice across the partnership.

The DSCP is currently updating our Quality Assurance Framework, due to be published later in 2026. We will implement the principles from The Association of Safeguarding Partners (TASP) Multi Agency Child Safeguarding (MACS) Evaluation Framework, using the Theory of Change to understand our work, how it will lead to change and the outcomes and impact for children, young people and families. This includes a focus on leadership and culture, alongside participation and quality assurance.

The DSCP acknowledges the need to move towards more shared responsibility, particularly in early identification of need, assessment and planning, so that children and families receive the right support, at the right time, from the right practitioners and their network of family and friends.

This is central to Families First Partnership Programme reforms, being led by Children's Social Care, with input from the DSCP Business Unit and a range of partners. A series of 'Test and Learns' have been in place during 2025-26 including the Multi-agency Front Door Test and Learn and the Family Help Test and Learn.



Harm Outside the Home continues to be a key area of focus for the partnership. A new Family Help Harm Outside the Home Test and Learn will commence later in 2026, with the aim of identifying children in need and at risk from HOTH earlier, so that they can be supported before the risk to them increases. Learning from these sites will help to shape and inform future multi-agency service delivery into 2027.

The Families First Partnership Programme Guide 2026 and Working Together to Safeguard Children 2026 both highlight the importance of the voluntary and community sector in offering early help and support to children and families. The DSCP will continue to build

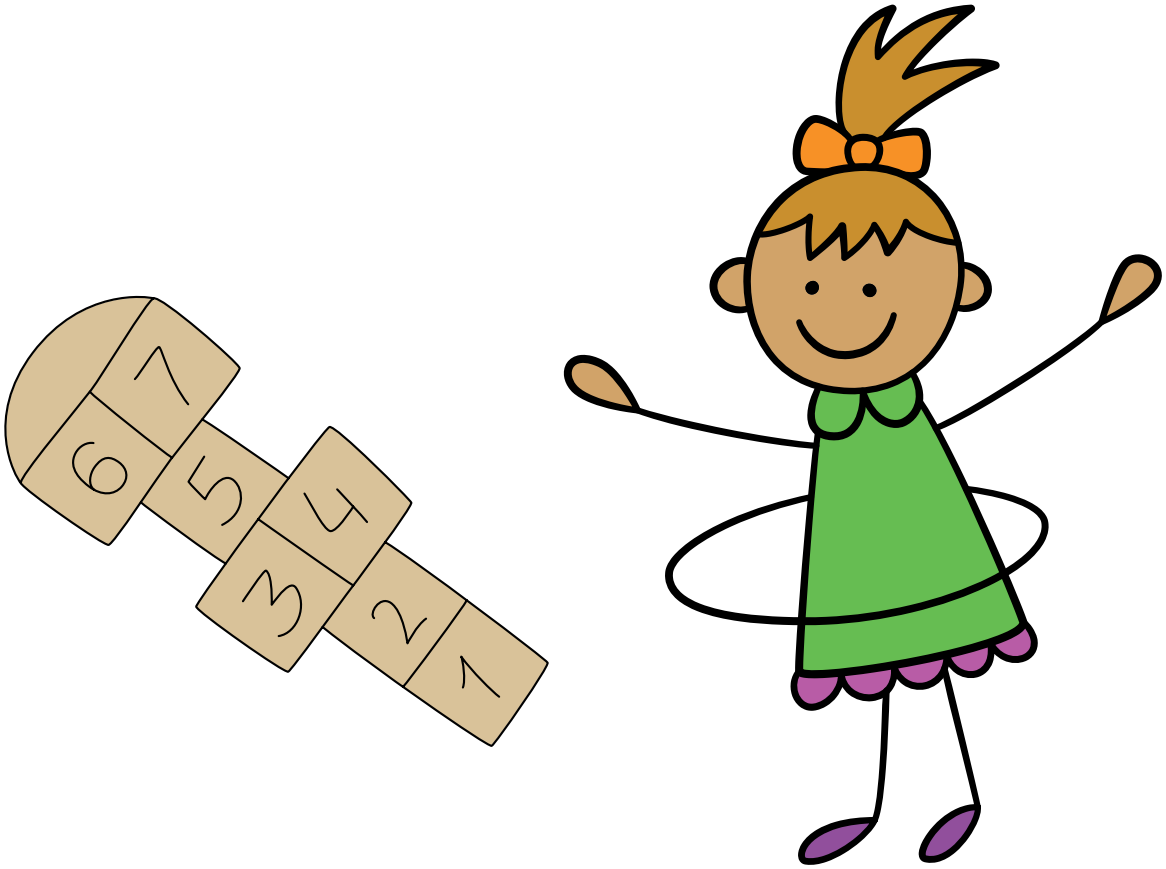
relationships with the voluntary and community sector to strengthen multi-agency arrangements for early intervention, so children and families receive the right support from the services that know them best from the earliest opportunity.

The Information Sharing Duty, as set out in the Children, Schools and Wellbeing Act, is due to come into effect later in 2026, once the act becomes law. This will clarify expectations and the lawful basis for how partners should share information when they are worried about the safety or wellbeing of a child/young person, to better address some of the system barriers to information sharing. The DSCP will update our existing Tier 1 and Tier 2 Information Sharing Agreements to reflect the new duty.

Our Multi-Agency Safeguarding Arrangements (MASA) will be revisited and updated to reflect changes outlined in the Families First Partnership Programme Guide 2026 and Working Together 2026, underpinned by the Children's Wellbeing and Schools Act 2026.

We will create a new neglect strategy to drive forward practice, as this a re-emerging theme locally.

We will take forward recommendations from the Child Safeguarding Practice Review Panel's national report: **Protecting All Vulnerable Babies Better** and **"Why did it take so long to respond?" Child Neglect: A Thematic Analysis**



Overview and Assurance by the DSCP Independent Scrutineer

I am pleased to respond as the Independent Scrutineer to the publication of the Durham Children Safeguarding Partnership Annual Report for 2025-26.

I can give assurance that the partnership structure and practises required of Working Together to Safeguard Children 2023 are embedded and continue to be the basis of the partnership structure and processes. They remain normal business with considerations already in progress to understand the impact of the new 2026 revisions.

This year has seen change within the lead members due to the retirement of the local authority's corporate director of Children and Young People Service and Chief Superintendent Nichola Lawrence from the police taking on the role of chair of the Delegated Safeguarding Partners Executive Group. This was part of the agreed annual rotation of the chair. Whilst there has been pressure on services and significant change within the Integrated Care Board (ICB) attendance and oversight by the delegated statutory partner leads has remained very good with representation in person, at all the planned meetings throughout the year. The Executive Group and supporting sub-groups remain embedded, with good attendance and progress on priorities.

Sadly, there have been several fatal incidents reported that have required notification and rapid reviews following the tragic deaths of children within the county. These multi-agency reviews have been well attended, and I have seen good information exchange, challenge, identification and consideration of the key issues. Feedback from the National Panel on the written review findings have been positive and complimentary. As Independent Scrutineer, I am assured as to their rigor, compliance with statutory obligations and how thorough they have been. Attendees have been eager to identify learning opportunities, and I am sure these reviews will have improved local practice.

Within this reporting period key partners have had external statutory inspections that have been published, the findings of which have been discussed by the Executive Group and wider partnership to share understanding and multi-agency touch points.

The partnership continues to demonstrate strong quality and practice assurance processes and has conducted a multi-agency operational level audit pilot together with two working group sessions to agree on ratings. A multi-agency case file audit was undertaken including an in-person review of findings looking at responses to reports of child sexual assault. Another multi-agency case file audit was conducted in preparation for a Joint Thematic Area Inspection. These audits have enabled the partnership to identify learning themes for improvement together with good practice to promote. The scrutineer took part in each of these audits which were also considered by the Executive Group as part of their assurance process.

The Performance and Learning Group has continued their partnership work in relation to practice delivery against the partnership priorities for 2025-26 with the other sub-groups supporting practice and safeguarding outcomes. The outcomes of the work on the priorities are covered within the report.

The Executive Groups remains keen to ensure that the partnership has the breadth of membership to ensure appropriate representation and commissioned scrutiny of the partnership in how it engages effectively with the wider voluntary and community sector. Whilst this scrutiny was limited, the findings showed that the partnership was well known across the voluntary and community sector, with established and good communication links and a good and valued training offer. The partnership was well regarded for the support it offered. Areas for improvement included increased communication and feedback.

The partnership continues to receive positive feedback on its training offer which has a good take up and completion rate.

The partnership is well sighted on the new Families First Partnership model, and its future implementation plans, and this will continue into the next reporting period. This is a significant opportunity for the statutory partners to deliver a lasting change to how children are supported in the years ahead.

The partnership has continued its efforts to raise awareness via its web site and newsletters. Further assurance was sought regarding the partnerships effective support, links and communication with the education sector. Several workshops took place in January with designated safeguarding leads, head teachers and other representatives, including invites to nursery staff, to discuss and provide feedback on how they felt engaged with the partnership. The results were positive with only minor improvement opportunities identified.



Adrian Green
Independent Scrutineer

Appendix

DSCP Budget 2025-2026

Financial contributions from strategic partners.

Partner	Contribution (£)
Durham County Council	191,604
Integrated Care Board (ICB)	105,135
Durham Constabulary	39,285*
Probation	4,951.06
HDFT	2,680
CDDFT	2,680
Durham County Council additional training/education contribution	4,050
Total	350,385.06

**In addition to the financial contribution Durham Constabulary contribute a Partnership Analyst as a fulltime resource shared between the Durham and Darlington Children and Adults Partnerships*

Income is also generated by the training programme through non-attendance charges, registration fees from profit organisations, and bespoke training charges. For 2025-26 this figure was £11,000.

Durham Safeguarding Children Partnership recognises and is grateful for all contributions including the non-financial contributions which are made from a wide number of partners providing their time and knowledge. These resources are vital to supporting the partnership to deliver on effective multi-agency arrangements.



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