Surrey Safeguarding Children Board
Annual Report 2016 – 2017

Foreword SSCB Independent Chair

Elaine Coleridge Smith

I am delighted to present the Surrey Safeguarding Children Board (SSCB) 2016 – 2017 annual report.

During the period of this report the Surrey Safeguarding Children Board (SSCB) has continued to carry out its statutory functions under Regulation 5 of the Local Safeguarding Children Board to enable it to achieve its objectives under section 14 of the Children Act 2004 to:

a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Surrey Safeguarding Children Board and Partners are committed to ensuring that the most vulnerable children and their families are supported. The engagement and quality of work across the partnership has developed positively, and this benefits the improvement journey being undertaken in Surrey. As with all change, the impact of these improvements will take time to establish, however there are three areas of work where partners have worked together to drive positive improvements and changes for children in Surrey.

- Child sexual exploitation is now nationally recognised as a significant risk to the safety of children. Surrey partners have worked well together and have developed robust services to better manage this ongoing issue.
- Surrey partners are all in agreement that Early Help is essential in protecting and safeguarding children. Much of this work is driven through Children and Young People's Partnership and the development of a joint commissioning strategy (to take effect from April 2017)
- During this period the Multi-agency Safeguarding Hub (MASH) for Surrey was launched in October 2016 and was overseen by the MASH Executive Board.

Supporting all of this is the Multi Agency Levels of Need document (threshold document) which was developed by SSCB to provide a framework for professionals who are working with children and their families. This document was revised and ready for the launch of the MASH in October 2016.

In addition a new SSCB website was launched in May 2016. This has made a significant difference to the capacity, efficiency and effectiveness of the team, as well as improving communications with professionals and the public.

In November 2016 the SSCB held a very successful conference entitled “Beneath the Radar” to educate, empower and develop practitioners’ confidence through a range of specialist speakers and workshops.

Following on from the 2015 Ofsted inspection report that judged Surrey children’s services inadequate, and the 2015 Ofsted inspection report that judged the Surrey Safeguarding Children Board as requires improvement, key partners have collaborated on a demanding improvement journey. Overseen by the Surrey Improvement Board, key partners have developed an extremely robust partnership that has driven a number of fundamental and positive changes to service delivery. Surrey children’s services have worked to develop a whole-system vision that drives strengths-based practice across the Children, Schools and Families (CSF) directorate. Safer Surrey has been endorsed by partners who share the belief that children and families have the strengths, resources and ability to recover from adversities. SSCB is pleased to see the partnership working together to achieve better outcomes for children and young people through the development of the Safer Surrey approach.

This year’s annual report is in three parts and provides you with:

- Insights into the Journey of the child through the safeguarding system
- A themed analysis against Business Plan priorities
- SSCB information and development

I hope you enjoy reading the report and find it an informative picture of Safeguarding across Surrey. My thanks go to all the Chairs and members of the SSCB groups and to all partners and practitioners within the children’s workforce who work tirelessly to improve practice and protect the children in Surrey.

Elaine Coleridge Smith
Surrey Safeguarding Children Board

Introduction

Surrey is a large county with around 280,000 0-19 year olds. As at 31 March 2017 there were approximately 4,896 children in need, of which 886 are Looked After Children and 842 were subject to a child protection plan. There are an estimated 28,000 children who are living in poverty, yet whilst Surrey has one of the lowest rates of child deprivation in the UK, there remain large numbers of children who persistently experience poorer outcomes than their peers.

This year Surrey partners have faced the ongoing pressure of increasing demand, high cost of statutory provision and reduction in government funding. This is placing financial strain on the system and needs to be addressed together to ensure all our public services are financially sustainable.

Who we are and what we do?

The SSCB is the partnership body responsible for coordinating and ensuring the effectiveness of the work of services in Surrey to protect, safeguard and promote the welfare of children. Board members are senior representatives from all the main agencies and organisations in Surrey with responsibility for keeping children safe.

We coordinate local work by:

- Delivering a multi-agency Business Plan, which outlines how we intend to tackle priority safeguarding issues together
- Developing robust policies and procedures
- Participating in the planning and commissioning of services for children in Surrey
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done

surrey safeguarding CHILDREN BOARD

We ensure the effectiveness of local work by:

- Monitoring, challenging, scrutinising and supporting what is done by partner agencies to safeguard and promote the welfare of children
- Undertaking serious case reviews and other multi-agency case reviews, audits and qualitative reviews and sharing learning opportunities
- Collecting and analysing information about child deaths, and sharing learning from these deaths.
- Publishing an Annual Report on the effectiveness and impact of local arrangements to safeguard and promote the welfare of children in Surrey.

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Chapter 1

The Journey of the child through the safeguarding system in Surrey

The Early Help Partnership

During 2014 Surrey Safeguarding Children Board (SSCB) partners agreed an Early Help Strategy designed to respond to the needs and demands presented by vulnerable children and families. The implementation of this strategy led to some difficulties within the partnership and the work was 're-launched' with a new team in 2016.

The need to reform the Early Help offer in Surrey followed the Ofsted Safeguarding inspection and the subsequent department for education improvement notice requiring the development of a "collaborative and cohesive early help offer delivered by partners

> ***"Early Help means providing support as soon as a problem emerges, at any point in a child's life, from foundation years through to the teenage years. Providing Early Help is more effective in promoting the welfare of children than reacting later."***
> ***(Working Together to Safeguard Children, HM Government, March 2015)***

In 2014 – 2015 there were five 'front doors' allowing access to safeguarding services for children in Surrey. This system led to an inconsistent response for children, as the application of thresholds varied within each area as did the overall experience and quality of information received.

The establishment of a co-located MASH and four Early Help Coordination Hubs has been challenging however the programme 'went live' as planned on 5 October 2016 and is being followed by a planned transition phase, anticipating the need for further support and adjustment. SSCB has been impressed by the radically improved focus, leadership and partnership work demonstrated during this period of significant change.

What's working well?

- Surrey Children's Schools and Families (CSF) have made considerable effort to engage effectively with partners. Senior leaders have communicated effectively with partners through regular updates and newsletters. The refreshed CSF leadership team has demonstrated a real willingness to work in partnership, to be challenged and to respond appropriately.
- Stakeholder events have been held in each borough and district to bring together local agencies and partners to develop the local Early Help offer
- A range of the council's own early help services have been brought together under one umbrella to be known as Surrey Family Services. The new service is to be launched on 2 May 2017

- Four Early Help Coordination Hubs have been established in order to both co-ordinate and, in a small number of cases deliver, Early Help packages of support.
- The MASH and Early Help Coordination Hubs 'went live' as planned on 5 October 2016.

What are we worried about?

- Demand has exceeded expectations within the MASH, and there has been considerable challenge within the Early Help Coordination Hubs (EHCH) in meeting these demands.
- In light of the financial pressures faced by Surrey County Council, the Early Help service is based on targeted needs only. This makes it difficult to deliver a true Early Help and preventative service.
- Confidence in the Early Help system and a shared understanding of thresholds is not yet fully developed.
- The demand for multi-agency basic and enhanced safeguarding training, including an understanding of Thresholds, is increasingly high. This is putting considerable pressure on the SSCB training team.

What do we want to see in 2017 – 2018?

- Surrey has a huge range of preventative Early Help services across statutory, voluntary, community and faith sector partners, however these are not always well coordinated or effectively engaged in the Early Help partnership. Efforts should be made to build on current arrangements and maximise the choices available by the whole range of Early Help providers.
- Plans are being discussed to develop local early help advisory groups in each borough and district and continue to work with local partners to build and oversee the local EH offer. SSCB supports this approach.
- Plans are being discussed to develop a more co-ordinated and coherent early help offer using family hubs as a single point of entry into local early help services. SSCB supports this approach.
- SSCB would like to ensure the development and implementation of a strengths based approach to practice. The roll out of Signs of Safety to accelerate practice improvement throughout Surrey Family Services and within the wider partnership is to be encouraged.

Case Story

A mother and her children had fled domestic violence becoming homeless and were living in one room with a family friend. The Early Help practitioner became involved and supported the mother - firstly by referring her to local domestic abuse services and then by supporting her to obtain a non-molestation order at court.

The worker supported mum to secure housing and to apply for benefits and funding for a nursery place for her youngest child. Further debt counselling was accessed to help mum with her finances.

A referral was made to and accepted by CAMHS for one of the children. Mum and children are now doing well, are housed, managing financially and mum is starting to look for work.

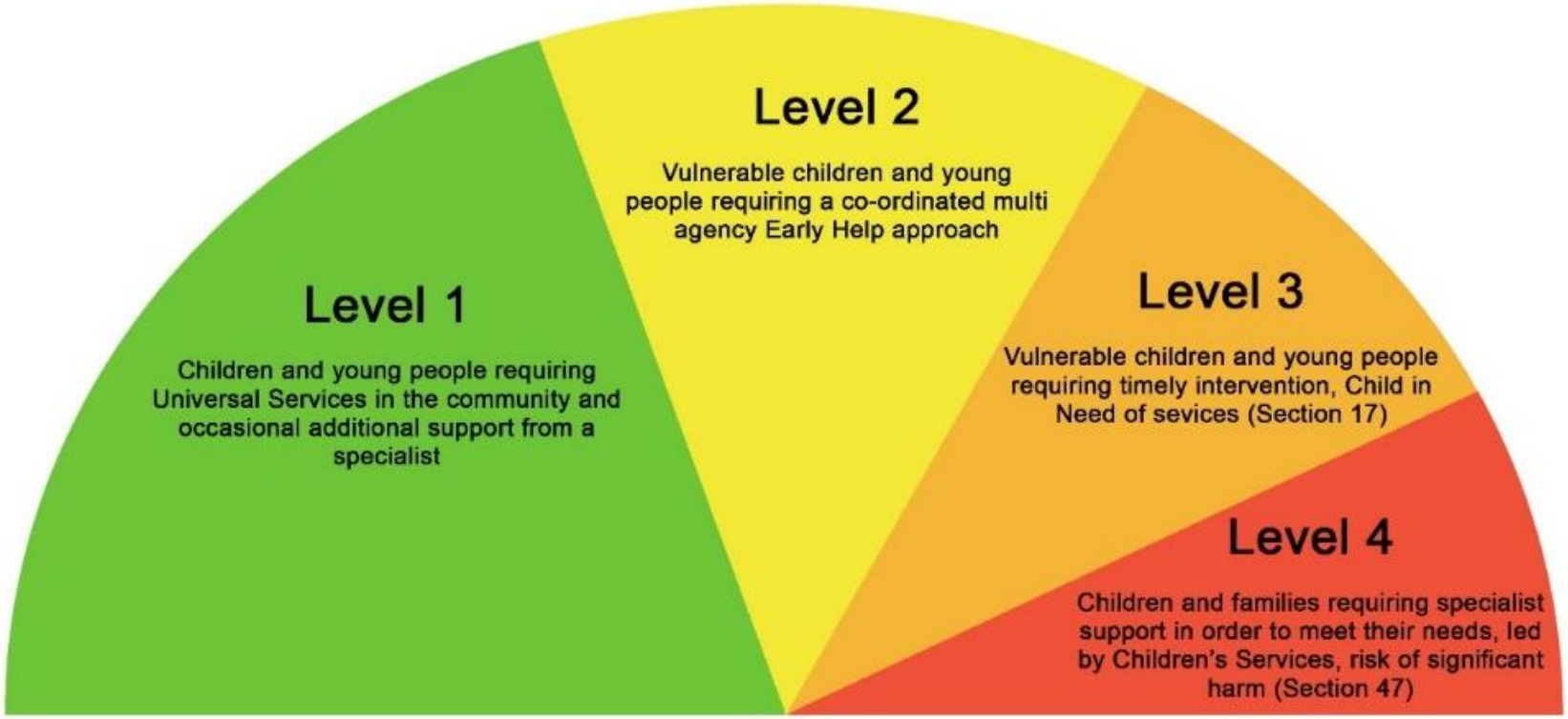
The MASH (Multi Agency Safeguarding Hub)

The MASH, is a multi-agency partnership that went live on 5 October 2016. The four key partner agencies - Children's Schools and Families, Adult Social Care, Surrey Police and Surrey wide Health services agreed and approved a programme plan required to deliver a co-located single Multi-Agency Safeguarding Hub for adults and children and an early help coordination service for children.

The MASH is intended to significantly improve the sharing of information between agencies. Co-locating colleagues with other safeguarding partners in the MASH is expected to improve the sharing of information and help to protect the most vulnerable children from harm, neglect and abuse. As the MASH develops it is expected that improved data analysis will help identify risk factors and enable better prediction of potential vulnerability, allowing support to be targeted accordingly.

What's working well?

- The MASH has achieved the centralisation of the previous four referral points.



- The MASH has achieved co-location of children's services, police, health and education. This has enabled a central team to review thresholds to ensure they are consistent and accurate across Surrey. This way of working supported and enhanced information sharing between partners and improved joint information gathering.
- The MASH is appropriately supporting vulnerable children using the 'windscreen mode', as part of the agreed Surrey Levels of Need. The Levels of Need document enables the MASH to make the most appropriate decision at the earliest opportunity and avoids a family being referred to more intensive intervention when it is unnecessary.

- The performance of the MASH has become increasingly stable and is continuing to improve. All key indicators are reporting at a safe and acceptable level.
- Performance data is overseen by single agency leadership teams as well as the Surrey Safeguarding Children Board and the Surrey Improvement Board.
- In January 2017, the first multi-agency decision-making forum was held to facilitate information sharing and disclosure decisions for the Child Sex Offender Disclosure Scheme (CSODS) and Domestic Violence Disclosure Schemes (DVDS) – Sara's Law and Clare's Law respectively. This was the first such meeting and further work will continue to embed and streamline the DVDS and CSODS processes in the MASH.

What are we worried about?

- The aim of the MASH is to significantly improve the sharing of information between agencies, improve decision-making by taking a more holistic view and therefore help to protect the most vulnerable children and adults from harm, neglect and abuse. Access to a common IT system remains a challenge. The IT system (The Early Help Module MASH case management system) does not provide a common platform for all partners to use and this impacts on referrals. This requires on-going exploration.
- There remains an inconsistent approach to data sharing and risk assessment across the partnership.
- Demand has exceeded expectations and financial agreements between the partners have yet to be established placing the MASH at risk of future funding difficulties. The Children's Services element of the MASH may not be financially sustainable in the future. The budget will need to be considered carefully in the context of the wider resourcing of the front door, through to assessment and intervention and Early Help.
- The current location of the MASH needs to be improved to accommodate the number of staff engaged in this work.
- Management oversight in Children's Services has been problematic due to changes in staffing and structure. This is being effectively addressed through the piloting of a new supervision policy and templates.

What do we want to see in 2017 – 2018?

- Whilst there are a number of areas that require further development, the SSCB is impressed by the establishment of the MASH and recognises that the teams at both operational and strategic level provide a good basis for ongoing development.

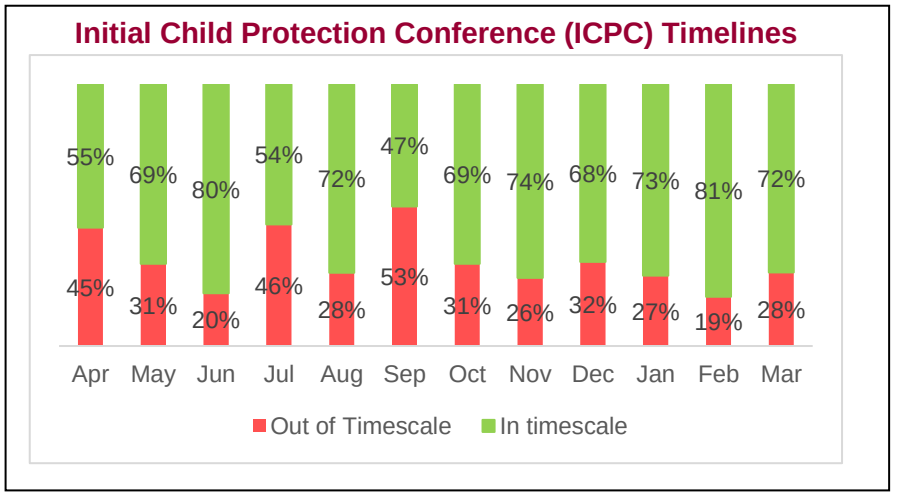
- Delivery of multi-agency projects will always be challenging due to the variations in culture, governance, prioritisation, authorisation routes and decision making processes inherent in the partnership agencies. The requirement for effective communication and stakeholder engagement cannot be overestimated.
- Multi-agency working should be further enhanced by refining information sharing processes with partners, especially schools, and broadening the range of partners who receive feedback on MASH decisions.
- Although a great deal of work has been undertaken by the partnership to agree processes for the MASH enquiry process and information sharing outside the formal mash enquiry, SSCB would like to see this further developed. In particular, there needs to be agreement regarding processes for sharing information from police reports and a process to feedback to health and school colleagues as well as the third sector on the outcome of a MASH enquiry they have contributed to.
- During the next few months the MASH Development Plan should be finalised to allow the discontinuation of the current governance arrangements. The final plan should include an agreed staffing structure and associated budget.

Child Protection Services in Surrey

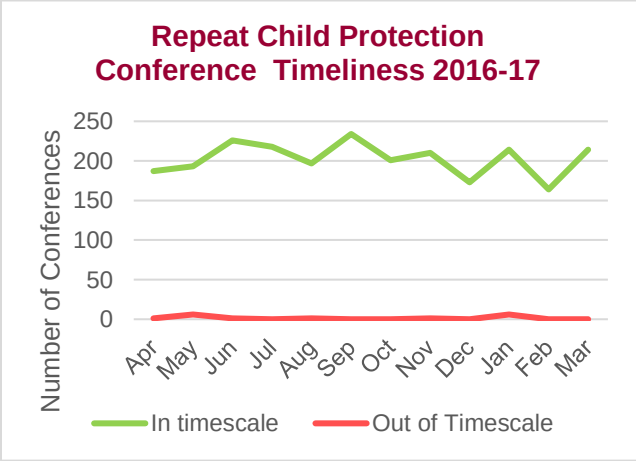
Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, which includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm. The Director of Children's Services and Lead Member for Children's Services in Surrey are the key points of professional and political accountability, with responsibility for the effective delivery of these functions.

Under the Children Act 1989, Surrey Children's Services are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local agencies, including the Police and health services, also have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

Category of Need	2015-16	2016-17
Emotional Abuse	231	190
Multiple	31	58
Neglect	559	553
Physical Abuse	25	11
Sexual Abuse	35	30
Grand Total	**881**	**842**



Child Protection Plan per 10,000	Statistical Neighbour	Surrey	Surrey
	2015-16	2015-16	2016-17
CPP Rate per 10,000	37	34.36	32.84



Repeat Child Protection Plans	Statistical Neighbour	Surrey	Surrey
	2015-16	2015-16	2016-17
Repeat CPP			313
Total CPP			1346
Percentage	**19.00%**	**23.10%**	**23.25%**

What's working well?

- During the period of this report there has been growing evidence of improvement in both social work and multi agency practice, There remains much more to do to raise practice quality across the county for all children. Partnership working is stronger and there is a greater sense of partners owning the necessary system wide improvement.
- Changes made by the Director of Children's Services to the senior Children's Schools and Families (CSF) leadership team were well received across the partnership and are having a positive effect. Clear leadership expectations, including a much stronger culture of performance and accountability is evident.
- Changes in CSF leadership has led to an improvement of management oversight and monitoring and this has contributed to the positive trend being observed
- In October 2016 the decision was made to strengthen practice through the implementation of the 'Safer Surrey' approach to strength based practice. The impact on services provided for children is encouraging with signs of more timely and better quality practice
- 'Safer Surrey' sets out clearly what good looks like and contributes to the delivery of a consistent approach to casework as part of the improvement journey. SSCB is supporting practitioners to achieve this standard through focused training and learning and the ongoing delivery of multi agency workshops introducing the 'Levels of Need / Safer Surrey' approach
- There is now a more robust system in place to check the variability in case-load numbers and to investigate, understand and take necessary action where specific workers are holding a high number of cases.
- There has been a gradual but significant increase in the timeliness of Initial Child Protection Conferences (ICPCs). This is an encouraging early sign that actions being taken in this area are having a positive impact.
- The Ofsted review held in January 2017 noted that 'Timeliness of Child Protection (CP) reviews has been an area of strength in Surrey, with consistently high performance'.
- During the period of this report re-referral rates have gradually reduced, as have average case-loads for Child Protection, Children Looked After and Assessment teams.
- Regular case file audits by Children's Services provide increasingly accurate performance data. This has been supported by data from health and Police colleagues, and multi-agency audits completed by the SSCB Quality Assurance team. The Ofsted inspectors were encouraged by improvements in performance management and quality assurance
- Considerable work has taken place to ensure that the voice of the child is captured in a Child Protection Conference using the Signs of Safety. Children are invited to the Child Protection (CP) Conference through the social work team from the age of 12 yrs upwards.

Children below the age of 12 are encouraged to work with their social worker in the most inclusive way in order to obtain a sense of their wishes and feelings. Where the voice of the child is not present in the social work report to the conference a challenge to the team is raised by the CP Chair.

- The Ofsted visit in January 2017 supported the SSCB's opinion that the passion and knowledge of children that staff have as a real strength. Ofsted noted clear evidence of a drive to improve across our services, good understanding of the priorities for improvement are and evidence that Children's Services understood what needed to be done to improve further.

What are we worried about?

- The quality of our practice across Surrey remains variable and in particular there is more work to do on supervision, management oversight and information sharing across the partnership. In particular the timeliness of Initial Child Protection Conferences continues to fluctuate and the attendance by partners at conferences remains variable.

- Partners ability keep pace with rising demands at the same time as managing financial pressures will be seriously tested over the next year placing increased pressure on both statutory and universal services.
- The impact of changing pressures such as the continued increase in the number of Care Proceedings and the rise in Unaccompanied Asylum Seeking Children continues to be a challenge across the partnership.
- Recruitment and retention of experienced staff continues to challenge the partnership. In particular a large number of vacant social work posts are covered by experienced locums

What do we want to see in 2017 – 2018?

- SSCB would like to see partners continuing to focus on the positive shift in culture brought about through new leadership initiatives. In particular SSCB would encourage the following:
  - The Safer Surrey implementation group (chaired by the Assistant Director, Children's Services) should build on the implementation plan for Signs of Safety as part of the wider Safer Surrey framework.

- Work should continue to ensure that the Safer Surrey model is used across the partnership, and appropriate ongoing training to help fully embed this approach into practice
- The introduction of 'Communities of Practice' should be extended to the wider partnership. This should be progressed through local areas and local Safeguarding Groups.
- The work of the successfully increased Assessed and Supported Year in Employment (ASYE) Social Work Academy should continue to support the recruitment of newly qualified social workers.

Looked After Children

A 'Looked After Child' is a child or young person under the age of 18 who is being looked after by their local authority. They might be living:

- with foster parents;
- at home with their parents under the supervision of children's services;
- in residential children's homes; or
- Other residential settings like schools or secure units.

All Members of Surrey County Council have responsibility as corporate parents to ensure the wellbeing of our children in care, supported by all partners with statutory responsibility for services for children.

What's working well?

- Overall there has been some positive progress in 2016, with evidence of improvements in the priority areas for action identified for the year including Child Sexual Exploitation (CSE) and missing children, and Unaccompanied Asylum Seeking Children (UASC).
- The Corporate Parenting Board, is effective in overseeing services for Looked After Children and Care Leavers and monitoring their impact. The Board is a multi-agency partnership, with representatives from Members, council officers and partner agencies, who meet bi-monthly to progress this work.
- More children have remained with their carer for at least two years, more care leavers are living in suitable accommodation, and more young people over 18 are being supported to "stay put" with their foster carers in stable, supportive homes.

- There has also been excellent evidence of practitioners knowing the children they support well and using the Safer Surrey practice tools to ensure their voice is heard.
- Positive efforts have been made to ensure looked after children and care leavers have a voice and opportunity to tell professionals what they think of their services
- Looked After Children are one of the key vulnerable groups likely to be affected by child sexual exploitation (CSE). Partners have worked well together to improve procedures for responding to CSE cases and provide support and training for front line workers, multi-agency arrangements have been put in place to oversee CSE planning including disruption activity against perpetrators.
- The Safer Surrey approach encourages social workers to have meaningful conversations with their young people which is starting to be reflected in the recording of their wishes and feelings in pre meeting review reports.
- Signs of Safety is being embedded across social work teams and Independent Reviewing Officers (IROs) are starting to use this within looked after review meetings.
- The views of looked after children and care leavers consistently influence the decisions made in Surrey that impact on their lives. The Children's Rights Team works with young people to ensure their voices are heard in a variety of ways.

As of December 2016 there were:

- 903 looked after children, up from 779 in 2015 and 793 in 2014
- 479 care leavers who were entitled to ongoing support until the age of 21, or 25 when in higher education.

Of the 903 children looked after, there were:

- 153 Unaccompanied Asylum Seeking Children, up from 124 in 2015 and 113 in 2014
- 122 with a Special Educational Need or Disability (13.5% of the total)

Of the 479 care leavers there were:

- 159 Unaccompanied Asylum Seeking Children

What are we worried about?

- Despite efforts to date from staff and colleagues in partner agencies there remain too many children placed out of county.
- There have been some improvements in the delivery of health care services but further actions are required, including ensuring care leavers have easier access to their full health histories.
- Audit and quality assurance activities, including Ofsted monitoring visits, show there are still inconsistencies in practice quality that need to be addressed
- The increasingly challenging context in which looked after children and care leavers services are delivered can't be ignored. Demands for services continue to increase and at the same time financial constraints tighten.

What do we want to see in 2017 – 2018?

- SSCB would like to see the wider improvement made in Children's Services and across the partnership arena through our Children's Improvement Plan embedded in practice

- Work needs to progress reduce the number of incidents where Looked After Children go missing.
- Ongoing work to gather and collate more systematically the views of the children and young people - either in preparation for or after their review meetings, is required.
- The views of younger children, unaccompanied asylum seeking young people and young people with special educational needs and disabilities (SEND) need to be considered in a more robust way.

Safeguarding across the Health Economy

Surrey Wide Clinical Commissioning Groups (CCGs)

The 6 Surrey CCGs continue to work through collaborative commissioning arrangements to ensure safeguarding remains a priority. As part of these collaborative arrangements Guildford and Waverley CCG host the County wide safeguarding team and take the lead for safeguarding on behalf of the 6 CCGs. Legislation and national guidance sets out health's safeguarding responsibilities, requiring the Governing Body to oversee a clear policy and regular reporting to ensure that the CCG meets its statutory duties. These activities help to assess if improvements are embedded through the system from the strategic level to front-line practice.

Throughout the last year there have been a number of significant developments:

What's working well?

- In support of the Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (June 2015) for both safeguarding children and adults and to support quality improvements across the Surrey health economy, Guildford and Waverley NHS CCG has developed a clear safeguarding governance framework with a clear process for monitoring safeguarding compliance of services that are commissioned and reporting to each Surrey CCG.
- Through collaborative working between CCGs, health providers and sub groups of the Safeguarding Boards, NHS Guildford and Waverley CCG have continued to seek and test implementation of referral pathways into Multi-agency Safeguarding Hubs (MASH), Early Help, child sexual abuse exploitation process, Prevent, Mental Capacity Act, Care Act 2014 and multi-agency information sharing through single and multi-agency forums and audit programmes.
- From 1st October 2016 the County wide Safeguarding children and adults teams became fully integrated, now known as Surrey Wide CCG Safeguarding Team. The team, whilst maintaining its individual statutory obligations, work closely to identify key areas of interface between children and adult safeguarding, reflecting a "Think Family" approach.

- Throughout the last year Guildford and Waverley CCG has overseen health's contribution to the ongoing development of Surreys MASH and Early Help Programme. Interim arrangements have been made to ensure the presence of health professionals within the MASH and there has been appropriate representation at the Executive Board and the other board structures that drive the development.
- The safeguarding team continue to undertake an annual Safeguarding Deep Dive Audit across the health economy, including member practices. The 2016 deep dive demonstrated a number of areas of improvement in health's response and engagement with the LSCB priorities and the embedding into practice lessons from serious case reviews (SCRs).
- Appointment has been made to the posts of County wide Designated GP Safeguarding Children and the Named GP Safeguarding Children. These roles are hosted by Guildford and Waverley CCG and will be undertaken on behalf of the 6 Surrey CCGs. This has resulted in an increase in capacity and will allow for enhanced support for GP practices in their safeguarding work.

What are we worried about?

- Throughout the coming year change at both health provider and commissioner level will continue. With ongoing change there is the need to continually monitor safeguarding arrangements and seek assurance that these remain a priority.
- In the year 2016-2017 the re-procurement of children's community health services was undertaken. As from 1st April 2017 there will be a new children's community provider. Services will be delivered through a partnership between three existing Surrey health providers. Guildford and Waverley CCG is working closely with the current and new provider to monitor and have oversight to ensure a smooth transfer.
- In line with national requirements across Surrey the last year has seen the ongoing development of Sustainability and Transformation Plans (STPs). Every health and care system in England is now required to produce a Sustainability and Transformation Plan (STP), showing how health and care services will evolve and become sustainable over the next five years and will deliver the aims of the NHS Five Year Forward View. Such developments provides a focus for meeting the needs of the local population and driving changes to improve the quality of care, the health and wellbeing of the local population and the efficiency of services. They must also be financially sustainable. Within Surrey there are 3 STPs. The ongoing changes will require influence, scrutiny and oversight to ensure the continuation of a robust safeguarding governance arrangements.

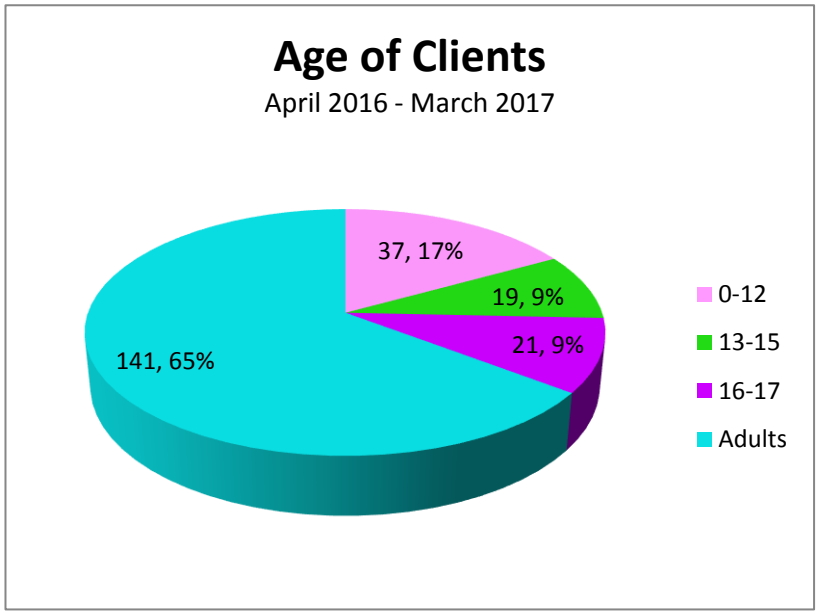
What do we want to see in 2017 – 2018?

- The last year has seen a number of changes across the health economy. As these shape and embed there is a need for clarity regarding how the safeguarding systems will operate within these changing arrangements.
- Health partners have contributed to a number of safeguarding developments through collaborative arrangements. Developments include the Surrey MASH, Early Help, child sexual abuse exploitation processes and responses to neglect. There is a need to continue to develop systems to evidence the difference such developments are making for children.
- Work with partners to develop the future multiagency structures and ways of working that demonstrate how it is safeguarding and promoting the welfare of children including ongoing scrutiny of safeguarding arrangements as arrangements across commissioners and providers take shape
- Ongoing implementation of the CCG safeguarding governance framework to provide assurance that health organisations are meeting their statutory safeguarding requirements and the SSCB priorities are embedded within their work.

Sexual Assault Referral Centre (SARC) Paediatric Service

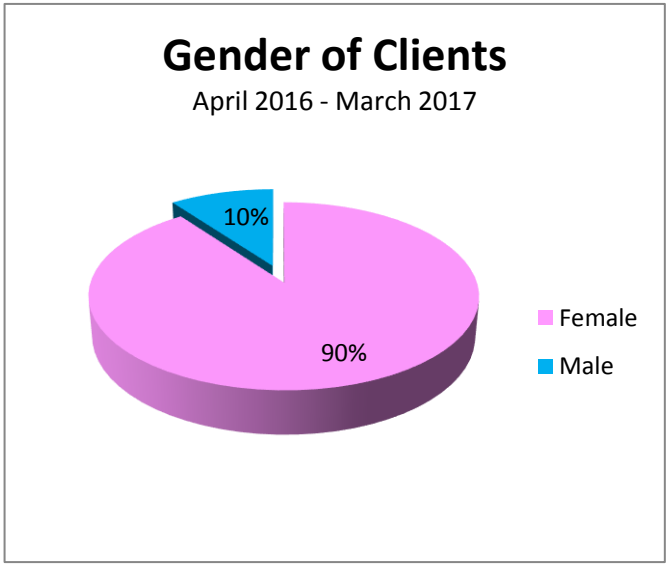
The SARC Paediatric Service is currently run by Care UK and community paediatricians provide input to the service. From 1 June 2017 Mountain Healthcare will take over the running of the service.

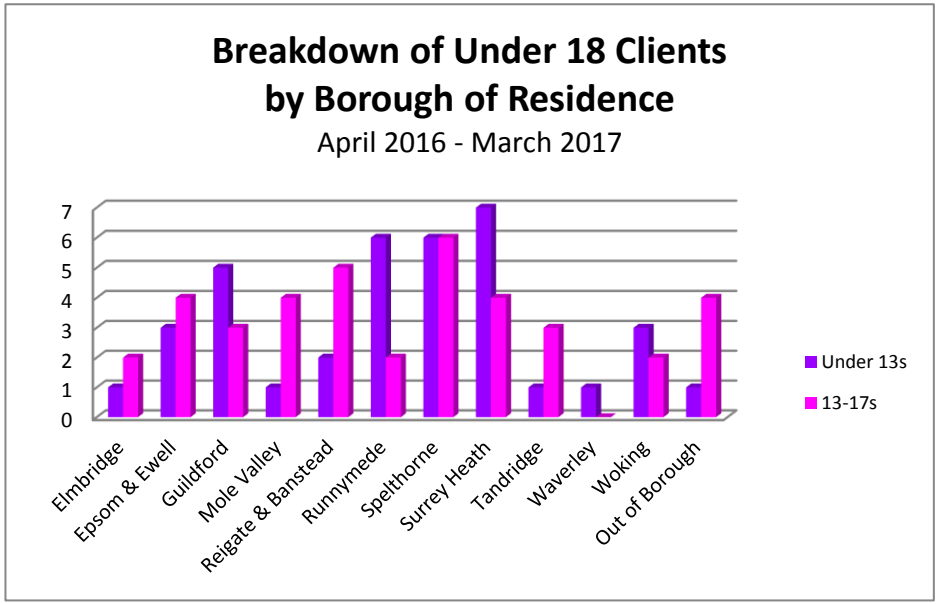
The centre will see all children who live within Surrey, or who have a Surrey GP, or if the offence occurred within the Surrey Police area, and have been the victim of a sexual assault or abuse, either as acute or non-recent (historic abuse) cases.



What's working well?

- The SARC sits under the Sexual Exploitation and Assault Management Board (SEAMB) ensuring improved links to the SSCB.
- Throughout the year there has been an active marketing campaign with all agencies to raise awareness of the Surrey SARC, and there have been many tours for colleagues from other agencies so that they are aware of the SARC's services and are comfortable referring children to the SARC.
- All children have a CSE screening tool completed and all under 18s are referred to Children Services.
- The Child ISVA (Independent Sexual Violence Adviser) post is a valuable addition to the service. The Child ISVA provides both emotional and practical support for the child and their family, and works in partnership with agencies and professionals to ensure that the needs of the child are fully met.
- All children are referred to STARS: Sexual Trauma Assessment Recovery Service, which is a specialist CAMHS team. They are able to focus on the needs and wellbeing of children who have been affected by sexual abuse, and they offer group work and if needed direct 1:1 therapeutic support. There has been recent significant recruitment to the STARS team so they now have several therapists with different specialism.
- The SARC also sees children with concerns about Female Genital Mutilation, in line with new national standards





What are we worried about:

- Over the last year, there has been significant work with Genitourinary (GU) partners to ensure that children referred by the SARC are seen in age appropriate clinics for ongoing support.

Work is ongoing with NHSE and the new provider, Central and North West London NHS Foundation Trust to ensure that this level and type of support is maintained in locations that are accessible to SARC clients.

- Previous Health Needs Assessments have highlighted the low number of child referrals to the SARC in Surrey. The number of referrals does not correlate with the number of child rapes, sexual assaults and sexual abuse reported to Surrey Police. Work is ongoing through SEAMB to address this.
- The Child ISVA post was vacant for 6 months during this period, but has now been filled with the replacement due to start in April 2017.

What do we want to see in 2017 – 2018?

- Mountain Healthcare will be the new provider for the Surrey SARC from June 17 and has a different proposed acute paediatric model. Discussions are ongoing with NHSE and the new provider to ensure that a safe paediatric service continues through the transition.
- There needs to be greater awareness of the role of the SARC with all multiagency partners: More invitations to visit the SARC will be sent to other agencies, so that tours can be organised to raise awareness of the support we can offer.
- We need to ensure we hear the child's voice fully and develop improved specific feedback for the under 13 years who attend the SARC. Feedback has been received previously from 13-18 year olds via STARS and this has been valuable when planning our services.

Emotional wellbeing and mental health support in Surrey

Promoting emotional wellbeing and good mental health is one of five priorities of Surrey's Health and Wellbeing Board, with the outcome that more children and young people will be emotionally healthy and resilient. Health and Wellbeing Board Strategy.

Following a period of extensive public engagement undertaken jointly by the Clinical Commissioning Groups and Surrey County Council, a decision was made to invest an extra £2.3 million – a 30% increase – into the mental health and wellbeing services for Surrey children and young people.

What is working well?

- Surrey has a well attended partnership CAMHS Strategy Board and has developed strong joint commissioning governance.

- As from 1st April, 2016 contracts for a new Surrey Child and Adolescent Mental Health Service (CAMHS) were awarded to Surrey & Borders Partnership NHS Foundation Trust (SABP)
- The new service is commissioned to:
  - Be available between 8am – 8pm Monday to Friday and 9 – 12pm on Saturday
  - Reduce waiting times for assessment and treatment
  - Ensure children receive the right service at the right time
  - Work closely with parents or carers so they are better informed of children's needs and progress
  - Offer support on the telephone or through face to face contact
  - Be accessible from schools, GP practices, youth clubs and voluntary, community and faith sector organisations
  - Provide a brand new Behavioural, Emotional and Neurodevelopmental (BEN) pathway for Attention Deficit Hyperactivity Disorder (ADHD), high functioning Autistic Spectrum Disorder (ASD) and other neurodevelopmental conditions for 6-18 year olds and support to parents.
- A Single Point of Access for all referrals, called CAMHS One Stop, has been operational from 1st April 2016.
- A "no wrong door" approach i.e. all children, young people and families will be supported to find the right help at the right time.
- 364 out of 393 (92%) of Surrey schools have had contact with their Primary Mental Health Worker either for one to one support or have received training improving access to emotional wellbeing and mental health and building resilience.
- CAMHS Rights and Participation Team have delivered training to schools and acute hospitals and are now due to deliver training to GP's and the Police.
- Everybody's Business training was well attended in 2016-2017 with outcomes showing better understanding of mental health and emotional wellbeing by all participants. A further 10 courses now commissioned for 2017-2018.
- The Hope Service achieved SABP Care Excellence accreditation in 2017.
- The Surrey Targeted Mental Health offer takes a whole school approach, focusing upon mental health awareness and attachment training. This continues to be well received by over 89% of Surrey schools.

What are we worried about?

- The new Surrey Child and Adolescent Mental Health Service (CAMHS) has revised the threshold criteria for acceptance into CAMHS and volumes are expected to increase significantly
- Challenges facing recruitment across Surrey has contributed to ongoing difficulties with recruitment of Band 6 Mental Health Nurses and other roles in CAMHS.
- Some young people in Tier 4 (adolescent Psychiatric Hospital) are experiencing difficulties identifying suitable placements on discharge this has led to extended bed days.
- Young people have said that during a mental health crisis requiring admission to an inpatient unit, they would prefer to be placed locally where their family can visit and support their recovery
- The arrangements for out of county tier 3 and 4 admissions have had some unintended negative consequences including increased lengths of stay, difficulties accessing care where placement is rare or complex and a higher numbers of complaints and concerns raised by families and stakeholders

What needs to happen?

- The Health and Wellbeing Board should continue to provide robust executive leadership in regard to the delivery of the Surrey Transformation Plan.
- CCG led commissioning arrangements, including evidence of operational implementation of the plan being undertaken by the 'CAMHS Joint Commissioning and Transformation Board' should continue to be overseen by the Health and Wellbeing Board.
- Work must be undertaken with partners to identify suitable placements for Tier 4 young people, both on admission and on discharge from the service

Safer Surrey

The Safer Surrey approach is a strength-based approach that works on the belief that children and their families have the strengths, resources and ability to recover from adversities. It has its roots in solution focused practice and creates a common language used by all professionals from universal services through to child protection.

Safer Surrey invests power in children and families to help themselves, and puts practitioners in the role of supporting and helping them rather than as directors of change. The approach encourages professionals to support and reinforce child and family functioning rather than focus on individual or family deficits.

What's working well?

- Safer Surrey provides the overarching framework for all strength based practice across the whole Children's, Schools and Families directorate.
- There is an appetite across the County from Children, Schools & Families, and partner agencies to adopt a unifying approach that unites professional, supports the work they do with children and families, creates a common language and focuses on improving outcomes
- The Children, Schools and Families (CSF) has decided to introduce Signs of Safety as a practice model that will strengthen the way they work with children and families. Signs of Safety will be introduced as a 2 year implementation programme.
- Investment in Practice coaches to support managers to deliver Safer Surrey on the ground is a positive move.
- In January 2017 Ofsted noted that where Signs of Safety was being used as part of Safer Surrey that there was evidence of a positive impact on practice.
- Integrated working with the SSCB training team is well developed.

What are we worried about?

- The Signs of Safety model which is part of the Safer Surrey approach is being used as a way of developing significant improvement in practice across Children's, Schools and Families directorate. Whilst this is commendable, the service is still grappling with financial and workforce issues that could impact negatively.

- CSF must continue to work closely with partners on the wider Safer Surrey approach and the specific Signs of Safety model. The full engagement of partners will help deliver the programme with the necessary pace required.
- 1,500 staff across CSF will receive training by March 2018 to help them to incorporate the Signs of Safety model into their practice. 150 practice leads within CSF will also be trained to support the embedding of Signs of Safety into practice.
- There remains the danger that the Signs of Safety practice model will be confused with the wider Safer Surrey Approach and ongoing multi agency training must be maintained.
- There is a need to be very clear that the purpose of Signs of Safety is to help practitioners to achieve the higher level aims of Safer Surrey.

What do we want to see in 2017 – 2018?

- Following positive discussions about Safer Surrey at the Children & Young People's Partnership Board and the SSCB the first stage of embedding Safer Surrey more widely is to raise and maintain awareness. This is being achieved through a series of half day briefings and training. SSCB suggests that it is important to continue with this work until the new way of working is well embedded.
- Half day briefings for partner agencies will be delivered from September 2017.
- There is clearly real enthusiasm for the approach and this must be built on. The partnership needs to determine more precisely how it can work together in order to embed Safer Surrey at scale and across the whole system.
- The draft Signs of Safety implementation plan must be finalised and ready for implementation in early 2017.
- The plan for CSF to develop a skills framework and toolkit for leadership and management is a welcome development.

Serious Case Reviews

LSCBs are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected and a child has died or suffered significant harm and there are concerns about how professionals may have worked together.

The purpose of an SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

What's working well?

- The Surrey Strategic Case Review Group (SCRG) is a sub group of the SSCB. Membership reflects the partnership, and invitations to participate in reviews are both appropriate and relevant.
- The process of review, recommendation, and follow up training is well delivered by this group under the chair of Kerry Randle – North East Area Education Officer.
- Between April 2016 and March 2017 SCRG received 17 referrals for consideration.
- Information was also received from another LSCB about an (SCR) that involves Surrey agencies.
- Five SCR's and two partnership reviews were initiated during this period.
- One SCR was published during this period: SCR Child AA
- In addition to the SCRs initiated during the period, there were three reviews ongoing; SCR Child BB, SCR/DHR Child CC, and SCR Child FF.
- It is anticipated that SCR Child BB is going to be published by summer 2017.
- SCR/DHR Child CC is currently with the Home Office for quality assurance prior to publication in June 2017.
- SCR Child FF, is being considered by SCR National Panel following a request from the Independent chair not to publish.
- The SSCB incorporates the learning from each review into its core training modules. In addition, the training team provides regular 2-hour briefings summarising the learning from reviews and audits. Those briefings also explore barriers to learning and steps to improve practice.

What are we worried about?

- The number of cases being referred to the SCRG is gradually increasing. This could be seen as a positive move as professionals become more confident to share concerns around practice.
- During this period some reviews had links to Child Sexual Exploitation or Abuse. The Surrey Sexual Exploitation and Assault Management Board was established in part as a response and has been proactive in responding to the changes in practice required by these reviews. (see below for the CSE report)
- During this period several cases of 'Neglect' were shared with the SCRG. SSCB work on neglect is considered further in this report.

What do we want to see in 2017 – 2018?

- SSCB welcomes the referrals to the SCRG and would like to encourage staff to continue with this practice.
- SSCB would like to see the SCRG supporting local consideration of cases that do not meet the criteria for SCR. The introduction of multi agency appreciative enquiries has been suggested and would be supported.
- SSCB would like to see consideration of 'Best Practice' cases and would ask SCRG how best to develop this.

Chapter 2

Addressing our Priorities

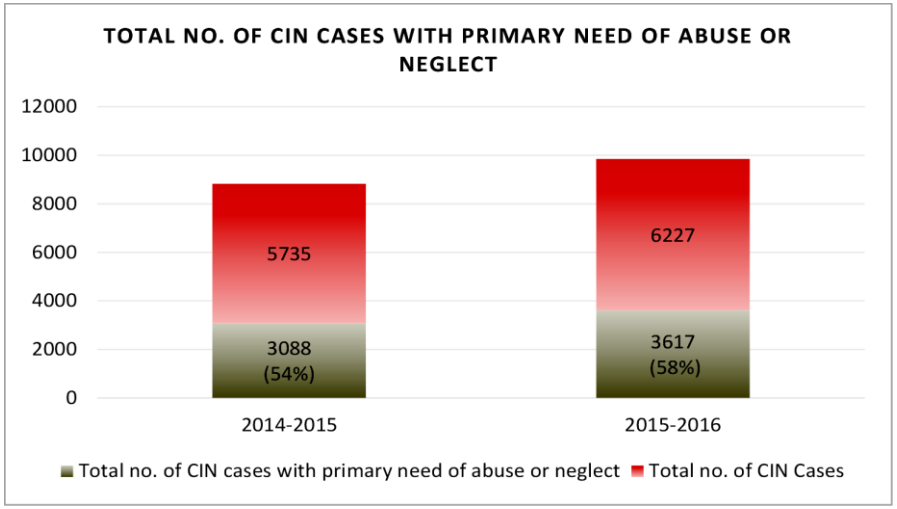
Neglect

Working Together 2015 defines neglect as:
'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.'

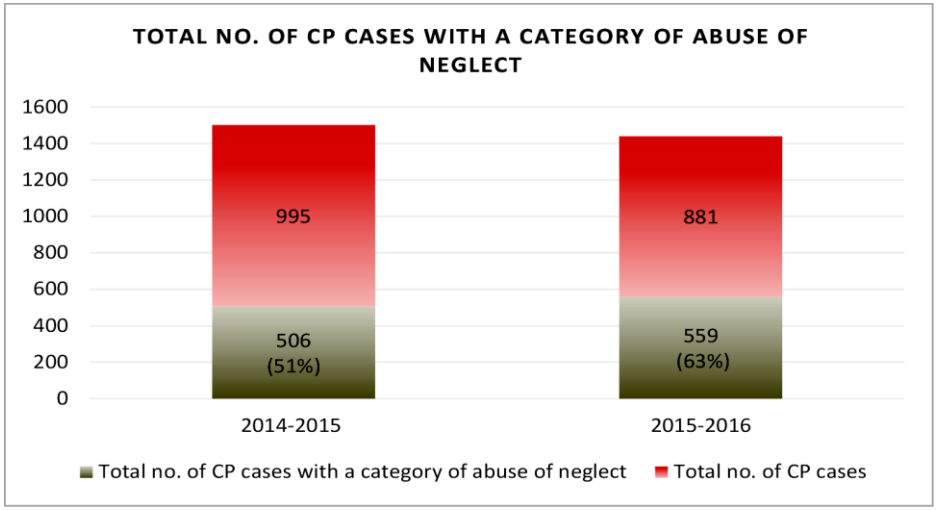
For most children and young people Surrey is a good place to grow up – the economy is doing well and many households benefit from higher than average socio-economic circumstances. Most children and young people are safe, well educated, experience good health and have good leisure and employment opportunities.

However, deprivation exists in Surrey and there are groups of children and young people who experience poorer outcomes. Around 10% of children and young people live in poverty with pockets of poverty often close to the most affluent areas.

The Department of Education 2015 – 2016 Child in Need census showed that nationally abuse or neglect are the most common primary need at assessment for children in need. As at 31st March 2016 50.6% of children in need across England had abuse or neglect as their primary need compared to a higher percentage of 58% in Surrey. Neglect is one of the four key priorities for Surrey Safeguarding Children Board (SSCB) in 2016 – 2017.



Total number of CIN cases with primary need of abuse or neglect in Surrey



Total number of CP cases with a category of abuse of neglect in Surrey

What's working well?

- There is an appetite across all partners to adopt a unifying approach that supports the work we do with children and families including the use of a common language. To help with this Safer Surrey is currently being embedded across Children, Schools and Families and the wider partnership.
- The problem of Neglect is recognised in Surrey and partners have begun work under the SSCB to develop an action plan along with a neglect tool kit and guidance.
- A SSCB multi agency audit confirmed that families received relevant support from various agencies including Children Services, schools and health. Coordinated multiagency support also appeared to result in better outcomes in some children's cases.
- Families are generally signposted consistently to relevant services where they can benefit from support including outreach providers and counselling services.
- Evidence suggests that relevant actions are taken for unborn children to ensure that the child is safe when born. Good examples of multiagency work and special considerations made to explore safer options to keep mum and child together were seen in the SSCB neglect audit.
- SSCB Quality Assurance group has been very active during this period. The group has supported work through
    - the completion of a Surrey Neglect profile
    - the completion of a Neglect Audit
    - the completion of a Multi-Agency Challenge event

What are we worried about?

- Surrey has a higher than normal average percentage of children subject to child protection plans for reasons of neglect, (at 31 March 2017 812 children were subject to child protection plans of which 553 were under the category of neglect) the data and other evidence from audits will of course inform the work of the SSCB Neglect group to better understand what can be done differently to prevent children's needs escalating.
- The children's case file review findings suggest that children tend to go through a cycle of improvement and deterioration. Some children came off the CP plan when their situation improved and then moved back to the plan when improvement was not sustained and/or new issues emerged.

- Core groups did not take place regularly in four out of sixteen children's cases and in one case, it was not recorded in LCS
- Some of the recent Serious Case Reviews highlighted the devastating consequences of delayed or appropriate actions for children in CP plan. There were five Serious Case Reviews conducted in Surrey in 2016. Out of those five, two were on a CP plan under the category of neglect. Therefore managing neglect with timely intervention and support are essential for children on a CP plan.
- The audit did not show the use of any specific tools to support practitioners' assessment and identification of neglect, although there is evidence of tools from the Safer Surrey approach being incorporated into some direct work.

Child Sexual Exploitation

Surrey has been on a long journey to improve its response to CSE since the 2014 Ofsted inspection in the period of this report. The SSCB has prioritised improving partnership work by focussing on developing robust multi-agency oversight structures. The Sexual Exploitation and Assault Management Board (SEAMB) is now fully operational, and is providing a tangible sense of direction and purpose. This has been recognised by Ofsted.

The introduction of comprehensive performance information at SEAMB's has enabled the partnership to focus on areas of practice that require the most attention. Based on the information provided, SEAMB has now asked for further work to be done to more effectively identify, refer and assess children at risk of CSE, to provide consistently high quality support to children who reach 18 and require ongoing support as well as to focus more explicitly on children with additional vulnerabilities (including boys, children with care experience, children with additional learning needs/disabilities as well as unaccompanied asylum seeking children).

However, while the strategic oversight has improved markedly, we know that the quality of responses to children at risk of/experiencing CSE still remains variable and requires further improvement. We also know that the voice of the child does not consistently inform interventions. We will therefore continue to work with our partners to ensure that the strategic improvements translate into sustainable practice improvement and demonstrable outcomes for children and their families.

What's working well?

- Governance has been reviewed with the Sexual Exploitation and Assault Management Board overseeing the partnership's CSE work and acting as the statutory SSCB sub-group.

- SSCB agreed and published a new partnership CSE strategy and action plan in Nov 2016.
- The delivery of the agreed action plan is driven effectively by the CSE Delivery Group which reports in to SEAMB. Existing multi-agency delivery structures were praised in the 2016 Ofsted monitoring visit for providing necessary focus and good senior management oversight.
- Awareness raising for professionals, parents, children and the public is ongoing. During this year the Virtual School funded 'Chelsea's choice' in a range of school with high numbers of looked-after children. In addition and as part of Operation Makesafe (led by Surrey Police), partners have been working with taxis, licensed premises and hotels. This will have tangible impacts for children looked after as they use licensed transport provision.
- The improvement work of the partnership has been accelerated by the appointment to the Partnership CSE Co-ordinator post in May 2016. This post is funded by the PCC and sits within the SSCB. It has provided a focal point to facilitate and co-ordinate CSE activity across the partnership
- Disruption of CSE perpetrators has improved significantly in 2016 with increasing numbers of successful prosecutions and issuing of child abduction warning notices.
- Surrey has a range of services available to Children and Young people which include therapeutic interventions (STARS), adolescent specific care (Youth Support Service) and CSE specific care (WISE).
- The introduction of CSE Lead Practitioner Roles in Children's Services and the Youth Support Service has increased organisational knowledge and capacity to support children at risk of/experiencing CSE effectively.
- The introduction of the Lead Practitioners Forum led by the SSCB Partnership CSE Co-ordinator contributes towards the development of a consistent approach across the county.

What are we worried about?

- We know from audits and the peer review that practice standards need to improve as do the supporting structures. The Missing and Exploited Children's Conferences (MAECC) are the key vehicle for overseeing our response to CSE in Surrey. The monthly MAECC meetings are intended to bring together key agencies to agree and co-ordinate actions to support children assessed at medium or high risk the area. Feedback from external reviewers suggests that MAECCs do not strike an appropriate balance between support and disruption, and are not an efficient way of managing CSE risks.

- The number of children on the CSE list has remained static over the last 12 months. We need to continue to assure ourselves that systems to identify and refer children who may be at risk of CSE are effective. This should include improved processes for reporting of referrals and a wider review of existing screening and assessment processes, as well as ongoing awareness raising across the partnership.
- Within the overall number of children identified on the CSE list, there are particular groups of vulnerable children who may be under-represented. These include boys (although the number of boys identified as at risk of CSE has increased to 15% of the MAECC cohort this is still lower than research suggests is appropriate), unaccompanied asylum seeking children and children looked after.
- The SSCB remains concerned about diversity. Whilst there are a range of interventions available, there is an absence of provision for boys or culturally sensitive services for children and parents/carers for black and ethnic minority backgrounds. We also know that a high number of children on the CSE list have SEN. Yet there is an absence of provision specifically tailored to this group.
- Population-wide preventative interventions are recognised as a gap and hence work has been identified to pilot enhanced Personal, Social and Health Education (PSHE) / Relationships and Sex Education (RSE) offer in schools identifying a need for this (drawing on the CSE problem profile).
- To date there has not been a bespoke CSE training plan for staff working in Children's and Family Services (who provide the lead professional roles). This may lead to inconsistent practice identified by Ofsted and our own audits.

What do we want to see in 2017 – 2018?

- Surrey has a mixed economy of provision across the CSE pathway, and further work is required to develop a comprehensive commissioning plan which will enable the partnership to direct funding in a way that complements existing service provision. The development of a commissioning plan could provide an opportunity to develop innovative and effective responses to children with additional vulnerabilities (including children in care or with care experience and SEN) as well as boys and children from black and ethnic minority backgrounds.
- The introduction of revised CSE Delivery structures (supported by revised SSCB CSE Procedures)
- A refreshed SSCB training offer which ensures training materials are up to date and the frequency of training is increased.
- A review of existing identification and screening processes – supported by tailored awareness raising across the partnership. .

Missing Children

When a child or young person goes missing they are at risk. Safeguarding children therefore includes protecting them from this risk. Whilst the majority of children who go missing will return or be located quickly, there are many others who will either be at risk of, or will suffer harm. Their physical and emotional health may suffer as well as their general health, education and social relationships.

Developing a co-ordinated, multi-agency response to support both children and adults going missing is a priority for partners in Surrey. The Adult and Children Safeguarding Boards have worked together to support the development of a new strategy. Approved in January 2017, the strategy outlines the agreed priority actions to support the implantation of robust, co-ordinated multi-agency responses. It includes children missing from children's home, care or educational settings, home and children placed here from another local authority and has been agreed by all partners.

What is going well?

- The Missing Children's Strategy clearly describes what we will do as a partnership to better protect children who go missing. This strategy has been approved by the Sexual Exploitation and Assault Management Board (SEAMB) who will oversee the work.
- A multi-agency Missing Persons Delivery Group has been established and meets on a bi-monthly basis to ensure that the Missing Children's strategy is delivered.
- A 'Missing Problem Profile' is being developed, collating data from a range of agencies, to better understand why children go missing, which children and where they go missing to.
- The Missing Children's Panel meets weekly to review the information from Return Home interviews. This is focussed on ensuring all risks are identified and information collated responded to. It is chaired by Surrey Police and attended by representatives from Police, MASH, Children's Services, YSS and Missing People.
- A new recording process in the MASH has now been implemented and improvement noted. This has been of particular benefit for children living / placed in Surrey and for those children placed within 10 miles of the Surrey border and covered by the Missing People contract).
- Contract Monitoring has been ongoing on a monthly basis with Missing People with a view to focussing their efforts on improving the timeliness of Return Home Interviews, and the number completed.

- Surrey Youth Focus is a membership organisation that aims to significantly improve the lives of young people in Surrey, by encouraging cross sector collaboration to serve young people work involved in all sectors - public, business and education members include over 70 organisations that work with children.

What are we worried about?

- The month-on-month trend for numbers of return home interviews undertaken, those offered within 48 hours and the recording of episodes and responses on the Children's Services database all show an improvement. This is despite a significant increase in the overall number of missing episodes. Analysis is being undertaken to understand if this increase is a result of changed and improved recording of missing episodes or if there are actually more children going missing,
- Despite raising concerns over 'missing' children and young people, the SSCB has not been able to sufficiently influence the work of partners to reducing the safeguarding risks associated with children missing from home or care. In particular there is concern that:
  - Partners from Children's Services, Police, Health, Education and other services are not yet working effectively together to prevent children from going missing and to act when they do go missing.
  - Data analysing children missing from home, care and education is insufficiently scrutinised within single agencies, and across the partnership.
  - Data analysing return interviews is insufficiently scrutinised and shared across the partnership.
  - SSCB does not receive regular reports from children's homes used by the local authority or within the local authority area on the effectiveness of their measures to prevent children from going missing.
- The 2016 LGA peer review of CSE and Missing and the supplementary review of MAECCs, referenced the poor emphasis on missing in Surrey.
- Ofsted inspectors expressed concerns that the Missing People contract does not provide good value for money and that the take-up of Return Home Interviews is limited, with limited information and variable quality.

What do we want to see in 2017 – 2018?

- A greater strategic focus on 'missing' agenda, underpinned by transparent sharing of data and information with strategic leaders (via SEAMB) to ensure that practice is effective and sustainable.

- Attention needs to focus on those who repeatedly go missing and links should be made with the improvement work being carried out in relation to children missing education, unaccompanied asylum seeking children and responses to children who go missing from placements outside of Surrey.
- Greater transparency about the quality of the existing contract with Missing People – including a focus on efforts to increase both the number and the timeliness of Return Home Interviews. A monthly operational meeting has been established in order for practical considerations to be addressed quickly between partners and Missing People.
- Share findings of the Missing Profile across the partnership with a view to inform strategic responses and resource allocation.
- Use the Missing Problem Profile and work of the Missing Persons Delivery Group to drive improvements in response to unaccompanied children, placed outside of Surrey.

Early Help

Please see Chapter 1.

Domestic Abuse (DA) and MARAC (Multi Agency Risk Assessment Conference)

Seven women a month are killed by a current or former partner and one in five children and young people nationally will live in a household impacted by domestic abuse (DA).

DA can leave children with serious psychological, emotional and physical consequences that may contribute to a chaotic lifestyle involving substance misuse, homelessness, offending behaviour, gang involvement, prostitution or mental health problems. Public Health research indicates that children who have had four or more adverse childhood incidents are 15 times more likely to be a perpetrator of violence, 14 times more likely to be a victim, and are more likely to visit GPs and A&Es and suffer from chronic diseases by the age of 49. Domestic abuse is the most prevalent of these adverse childhood experiences.

What's working well?

- The Surrey DA Strategy (2012 – 2018) focuses on
  - Developing services that maximise prevention, early intervention and provide holistic responses to those affected by DA.

- Developing services and responses that support children, and their families, impacted by DA
- Providing the opportunity to break the cycle of abuse and improve the health and wellbeing of our future generations.

- Work to promote healthy relationships is undertaken as part of all schools PSHE curriculum supported through the Healthy Schools Programme.
- School staff have access to a range of training and development opportunities promoted through the Safeguarding Children Board and Community Safety Board as well as Surrey Domestic Abuse Services (SDAS) Healthy Relationship training.
- The Office of the Police and Crime Commissioner (OPCC) has supported access to drama productions for schools which have focused upon domestic abuse and unhealthy relationships.
- Health commissioners ensure all providers have an identified lead for DA, and procedures to support the identification and referral of DA cases.
- GP Surgeries in East Surrey have been piloting the IRIS system to support earlier identification of patients experiencing DA.
- Surrey Police has refreshed frontline procedures emphasising the need to refer all children associated with a DA incident or family not just those present at the incident
- As part of the 'one front door' for all Children's and Adults Safeguarding concerns Surrey County Council, Surrey Police and Health Partners now refer all children affected by DA at the first incident to the Multi Agency Safeguarding Hub
- Children in care, many of whom have experienced DA, have access to bespoke CAMHS interventions which address these particular needs, through the 3C's Service.
- Surrey Police achieved White Ribbon Status in Partnership with the OPCC and Surrey DA services in December 2016 and continues to recruit White Ribbon Ambassadors across the force. Work is also being done to extend this accreditation to Surrey as a whole county by working with multi-agency partners to get involved in actions supporting the campaign. This campaign specifically supports a clear message that no violence against women or girls will be tolerated.
- HMIC (Her Majesty's Inspectorate of Constabulary) Vulnerability Inspection shows that Surrey Police have gone from inadequate to good within 2 years; with a firm commitment to continuing improvement.
- The MARAC portfolio is now encompassed into the newly formed DA Delivery Group, who will provide strategic oversight.

What are we worried about?

- Domestic abuse is the highest reported violent crime in Surrey and yet numbers show that domestic abuse is still a 'hidden' crime.

The 2015 – 2016 data tells us:

- 14,498 incidents of domestic abuse were reported to Surrey Police involving 6,533 children (5,336 were involved, 448 witnessed, 335 perpetrated, and 414 were victims)
- 650 children on child protection plans and 2,625 children in need had DA as an identified factor. DA is also recognised as a driver for other risks such as CSE and children missing from home and school.
- Surrey Domestic Abuse Services worked with 1,917 new users, who had 2,389 children of which 435 were known to be in contact with children's services
- The Surrey MARACs are risk management meetings where professionals share information on high risk cases of domestic abuse and put in place a risk management plan. The meetings aim to address the safety of the victim/children and review and co-ordinate service provision in high risk domestic abuse cases.
- Between the 13th July 2016 and the 2nd August 2016 all four of the Surrey MARACs were observed by 'SafeLives' in order to inform a thorough review and generate recommendations on where improvements could be made to enhance the effectiveness of MARAC within Surrey.
- Key themes from the review were;
    - the need for greater awareness of MARAC and referrals from agencies other than Police;
    - the consistent attendance by all agencies;
    - Monitoring the impact and effectiveness of the outcomes from a referral.

What do we want to see in 2017 – 2018?

- For the first time in Surrey all children who are identified as experiencing or having previously experienced domestic abuse will be offered support. These responses can include
    - specialist children's DA intervention provided by the outreach services,
    - CAMHS early intervention (jointly commissioned services which have been significantly enhanced in the last year), and
    - DA trained SCC family and youth support workers.
- These services will also support schools with bespoke DA responses where information has been shared by the MASH that a child has witnessed DA or where DA has become apparent through other sources.

- This is a new identification and response pathway and needs to be tested and embedded along with Surrey's other MASH and Early Help processes.
- The GP pilot of the IRIS system to support earlier identification of patients experiencing DA has been well received and would benefit from further rollout across Surrey.
- Whilst MARAC is firmly embedded across Surrey and continues to safeguard children and vulnerable victims of domestic abuse, the rolling programme of oversight and continuous inspection and assessment should continue to support continuous improvement.

Chapter 3

Additional Functions of the Board

Child Death Overview Panel

The SSCB has responsibility for reviewing the deaths of all children who live in Surrey, other than still births or planned terminations that are within the law, through the arrangements of a Child Death Overview Panel (CDOP) which is a sub group of the SSCB (Working Together 2015).

The purpose of the child death review process is to collect and analyse information about the death of each child who normally resides in Surrey with a view to identifying any matters of concern affecting the health, safety, or welfare of children, or any wider public health concerns. The overall purpose of the child death review process is to understand why children die, put in place interventions to protect other children, prevent future deaths and to support families.

Working Together 2015 identifies two inter-related processes for reviewing child deaths. These are:

Rapid Response to the unexpected death of a child, which is carried out by a group of professionals, who come together as soon as possible after a child has died for the purpose of enquiring into and evaluating each unexpected death; and

Review of all child deaths for children up to the age of 18 years when the child who has died would normally be resident in the Surrey Safeguarding Children Board (SSCB) area. This review is undertaken by a designated multi-agency panel.

What's working well?

1. The Rapid Response process is well-embedded within Surrey and there is good engagement by agencies. The Specialist Nurse provides joint training with Surrey Police regarding the rapid response to an unexpected child death. This training has resulted in improved communication and joint working between CDOP and Surrey Police to ensure a timelier and more efficient response to unexpected deaths and the achievement of a joint visit to the family as appropriate.
2. All Professionals have easy access to CDOP information via the CDOP booklet which is updated annually and disseminated to all 5 acute hospitals, community providers, GP, Children's services, Police and the Coronial Service. Surrey CDOP information is also easily

accessible for both professionals and families via the SSCB website. This has resulted in an improvement in the early notification of child deaths, the timely initiation of the rapid response and improved information to support families.

3. Multi-agency information sharing and communication with the Coronial service is a two way process. Post Mortem reports, Regulation 28 reports and responses are shared in a timely manner with CDOP.
4. Surrey CDOP proactively contacts families via the Specialist Nurse to offer them the opportunity to contribute to the child death review process and allow their voice to be heard
5. Surrey CDOP facilitates prompt dissemination of lessons learned from child deaths both locally and nationally to improve outcomes for vulnerable children and families.
6. When a child dies from potentially modifiable factors, Surrey CDOP researches public health data and evidence of best practice around reducing these child deaths. This evidence is then used to inform practice across the County.
7. Surrey CDOP writes to heads of services and asks for assurance of changes in working practices where serious incidents have been raised.

Child Death Notifications in 2016 – 2017:

Between 1st April 2016 and 31st March 2017, Surrey CDOP was notified of 62 deaths of which 44 were children who were resident in Surrey which is a decrease in actual numbers of deaths since the previous year when 66 children were notified, of which 54 were from Surrey.

Of the 44 Surrey child deaths notified to CDOP between 1st April 2016 and 20th March 2017:

- 30 were male and 14 were female
- There were 22 Neonatal deaths (infants who die before reaching 28 days of age)
- A further 9 were aged between one month and one year of age.

There were 23 deaths classified as expected and 21 classified as unexpected (deaths that were not anticipated as a significant possibility 24 hours before death or where there was an unexpected collapse leading to or precipitating the events that led to the death). This shows no change in the number of unexpected deaths since the previous year in which 21 had also been classified unexpected deaths.

7 of the deaths notified to CDOP during this time period were referred to the SSCB Strategic Case Review Group (SCRG); 5 were referred by CDOP, 2 were referred by another organisation. 3 did not meet the criteria for a Serious Case review (SCR), 2 met the criteria for a full SCR and 2 are still awaiting a decision.

CDOP learning 2016-2017

CDOP has reviewed and closed a total of 57 child deaths between 1st April 2016 and 31st March 2017. The cases reviewed include deaths outside of this time period. Of the 57 deaths reviewed, 14 (25%) were identified as having public health modifiable factors to reduce the risk of future similar deaths.

Following each CDOP panel meeting, learning from child deaths is shared with all the multi agencies across Surrey for further dissemination to staff. Modifiable factors are highlighted and recommendations made to prevent future similar deaths. In cases where the learning is deemed necessary to share nationally this is taken to the NNCDOP for their consideration and distribution.

When modifiable factors are identified either at final review or the rapid response stage, Public Health research the national picture and produce a public health paper to increase awareness which is also shared with all the multi agencies.

To date, the CDOP Public Health Lead has created public health papers on SUPC (sudden unexpected postnatal collapse), Meningitis W and suicide; these papers have been shared through the SSCB Health Group and other multi agency representatives for dissemination within their own organisations.

What are we worried about?

The safer sleep re-audit completed in January 2017 highlighted that the Back to Sleep advice is well embedded, has resulted in a change in sleeping practice and mothers were able to recall the advice easily. The advice regarding co-sleeping and the associated risk factors appeared to be less so. Evidence has shown that many more babies' lives could be saved if all families had access to and followed safer sleep advice. Providing the mother, her partner or the main carer with the opportunity to regularly discuss infant sleeping practices can help to identify and support them and the wider family in establishing safer infant sleeping habits, and in reducing the baby's risk of sudden infant death syndrome. The re-audit highlighted that the completion of the safe sleep assessment is not yet embedded in practice on a county wide level. The re-audit report is presented to the SSCB Health and Child Safeguarding Group. Provider's actions in response to the audit will be reported back and monitored via the SSCB Health and Child Safeguarding Group.

What do we want to see in 2017 – 2018?

- Safer sleep awareness and education: Health professionals and other professionals who have contact with families are in a unique position to educate parents about safer sleep advice. It is very important that Professionals work together to ensure safer sleep messages consistently reach all families. It is only through consistent and regular discussions with parents about safer sleep that Professionals can empower parents to change behaviour and adopt safe sleep practices in order to protect children and prevent future deaths.
- Further in depth interrogation of the data collected to identify local themes/modifiable factors.
- The Rapid response audit is due to be undertaken in April 2017 to review and monitor the quality of the Rapid Response service in Surrey, to ensure the maintenance of a Rapid Response protocol with all agencies that is consistent with the Kennedy principles and in line with statutory requirements.
- Oversight of CDOP's to transfer from the Department of Education to the Department of Health. Surrey CDOP to update child death review processes in accordance with new guidance when available.
- Seek assurance that system changes in implementing the new Men ACWY vaccine mean that eligible young people attend their GP practice for the vaccine as part of the catch up programme.

Following the Wood review, oversight of CDOP's will be transferring from the Department of Education (DOE) to the Department of Health (DOH). Several stakeholder events have been undertaken in early 2017 to consult with professionals on how the child death review process will continue to evolve to allow for more regionalised sharing of learning as well as maintaining the local focus and learning. A new bill and legislation is due to go before Parliament in autumn 2017 and it is expected that supplementary guidance will be produced by the DOH. Surrey CDOP has contributed to these events and will review new legislation and guidelines once these are available.

In response to the Wood review, Surrey CDOP has approached neighbouring CDOP's (Kent, Sussex) and is arranging a CDOP learning event in November 2017 to discuss the regionalisation of CDOP learning going forward and develop a process that will enable this to take place.

SSCB Quality Assurance – April 2016 to March 2017

Introduction

The following areas were reviewed during 2016 – 2017 as part of the SSCB audit programme:

- Section 11 audit and follow up meetings.
- Domestic Abuse (May 2016) : Domestic Abuse Management Board and Community Partnership and Safety Board has overall responsibility of developing and delivering an action plan based on the findings of the audit
- Quality of Return Home Interviews (September 2016) : Children's Services Quality Assurance Team and Surrey Police carry out routine audits to monitor the effectiveness and quality of the Return Home Interview Services provided by Missing People Charity
- Family Support Programme (February 2017): The Family Support Programme has overall responsibility of developing and delivering an action plan based on the findings of the audit
- Child Protection Plan under the category of Neglect (March 2017): The SSCB Neglect Group has overall responsibility of developing and delivering an action plan based on the findings of the audit
- The Surrey Safeguarding Children Board conducts challenge events for areas of priority identified by the board. Relevant/Key members from partner agencies are invited to meet with a multi-agency panel and discuss the issues, evidence and actions around specific areas.

In 2016 – 2017, the SSCB conducted the following challenge events:

- Child Sexual Exploitation – July 2016
- Domestic Abuse – September 2016
- Neglect – November 2016
- It is proposed that a challenge event for Early Help /MASH will take place in autumn 2017.

What's working well?

- Audit activity takes place regularly based on board's priorities and findings from other reviews and audits
- Rigorous S11 scrutiny process and partners acknowledged that this has been beneficial in understanding Section 11 standards more clearly, highlighting good practice and identifying areas for improvement for their relevant agency
- Roll out of Safer Surrey/ Signs of Safety enables practitioners to engage families better through a strength based approach
- Families needing help are usually signposted to relevant services where they can benefit from including outreach providers and counselling services
- Established link between data-sets, audit activities and training development. Where relevant, audit findings are informed by available data and audit highlights any gaps in training that requires addressing

What are we worried about?

- Information sharing – this includes information sharing between agencies specifically schools, local authority and police as well as the third sector. Information governance and data protection issues often create barriers in sharing useful information between agencies but especially from mediation, counselling and other confidential services.
- Communication – communication between agencies about different services provided by different agencies is often inconsistent and inadequate. For example, partner organisations are not always clear about the scope of Family Support Programme and the services they offer. Access to relevant information is not always easy for the professionals involved with the families due to different IT systems
- Voice of the child - audits highlight the need to keep children as the focus of intervention is embedded in culture but there is still a significant gap in using their views to inform service planning
- Transition - Inconsistent joint working between Children's Services, Health and Adult Services especially services around transition and disabled parent's parenting capability. This is mainly due to the fact that many services do not exist for adults and as a result some of the support stops when a child turns 18
- Guidance and Tools – Inconsistent use of available tools and guidance across all agencies. Professionals are sometimes not aware of relevant guidance and tools available to support them in their roles.

What do we want to see in 2017 – 2018?

- The need to keep children as the focus of intervention becomes embedded in culture
- Further work needs to be carried out to explore how to provide ongoing support to families with complex mental health and learning difficulty as parental mental health and learning difficulties came up as one of the most common contributory factors in a number of audits.
- Clear and consistent risk assessment tools need to be rolled out across the partner agencies and embedded in practice.
- All agencies need to support work in reducing drift and targeting support at an earlier stage as some of the audits suggest lack of coordination between agencies and escalation in some cases led to drift.
- SSCB to engage with wider community, not just statutory partners

SSCB Annual Training Report April 2016 – March 2017

SSCB is responsible for ensuring that partner agencies have access to good quality multi-agency safeguarding training.

The training team comprises of 1.2 full time equivalent training officers and a full time administrator; Training is delivered by SSCB Business Team members, a mix of partner agency representatives and commissioned trainers.

What's working well?

- The SSCB has delivered / coordinated 174 training courses in the period April 2016 to March 2017 (Foundation and specialist training). This is an increase of 91 courses from a total of 83 courses in 2015 – 2016. This has been possible because of the slight increase in training officer hours, extra administrative support and the introduction of the new SSCB website and automated boking system.
- 3,897 delegates from a range of agencies have been trained. (Health, Education, Children's Services, Borough & District, Early Years, Independent & Voluntary sector).
    - 28% of delegates were from Surrey County Council
    - 4.5% Boroughs and Districts
    - 8.5 % Voluntary Sector

    - 13% Early Years
    - 20% Education
    - 14% Health
    - 2% Independent sector
    - 3% Police and Probation
    - 6.% Out of School and Sports Clubs
    - 1% Other
- The team is working to implement the Training Needs Analysis (2016 – 2018) and the March 2016 Training Review undertaken by an independent consultant. Many of the actions have been or are in the process of implementation.
- Quality Assurance: The SSCB have adopted the Kirkpatrick 4 stage model of evaluation to evaluate the impact of its training.
- Impact analysis outlines a range of positive outcomes. Delegates reported that following training they have made improvements in note taking, record keeping and information sharing. Delegates also reported that following training they have better understanding of safeguarding requirements, of other professionals' roles and of the child protection process.
- The team facilitated a successful SSCB Conference in November 2016 with approximately 500 practitioners in attendance. In March 2017 a further event for 500 delegates on the impact of CSE on boys took place. Feedback again has been very positive.
- Successful Train the Trainer sessions for a range of safeguarding areas and levels of training have been well attended and delivered new trainers for the SSCB.
- We have worked with partners from Surrey County Council and Surrey Community Safety Partnership amongst others to deliver workshops on serious case reviews, audits and domestic homicide reviews and Safer Surrey.
- The introduction of the new website in May 2016 has made a significant difference to the capacity, efficiency and effectiveness of the training team.

What are we worried about?

- Demand in terms of numbers of practitioners across Surrey requiring training and the team's capacity to meet this. There are currently 451 delegates on the waiting lists for training.

- The team receives inadequate data from agencies relating to the number of practitioners requiring foundation and other multiagency training such as Safer Surrey, (Signs of Safety), Learning from Serious Case Reviews, CSE level 2, Neglect etc, making it difficult to forward plan.
- It is increasingly difficult to retain internal trainers from the Partnership to support the roll out of comprehensive training programmes.
- Structural changes across the Partnership such as reduction in the Early Years training offer will impact on safeguarding training, knowledge and support.
- External training providers are commissioned by a range of agencies to train practitioners. This can result in a failure to provide a consistent Surrey message to partners.
- The forthcoming Wood Report may impact on the SSCB structure and have implications for the training function.

What do we want to see in 2017 – 2018?

- Improvement in the SSCB ability to measure the impact of all SSCB training courses. A focus group is planned for May 2017 to gather further insight into the impact of a range of training courses.
- Work will be progressed with the website contractor to enhance the functionality and effectiveness of the SSCB learning platform. A range of SSCB e-learning will be developed.
- The SSCB training team will be proactive in supporting and disseminating the Safer Surrey (Signs of Safety) cultural shift and learning.
- Ongoing planning and delivery of the 2017 SSCB conference.
- Ongoing commitment from partners to offer suitable venues, with access to IT equipment, for training.
- Ongoing commitment from partners to support staff who contribute to the training pool.

SSCB Communications Group

The Communications Group activities established as an independent group in Dec 2016. Prior to this the Communications function was delivered through the Learning and Development Group.

What's working well?

- The communications group effectively promotes the activities of the SSCB by disseminating information relating to safeguarding widely to organisations in the statutory, voluntary and independent sector.
- The group has updated publicity material and leaflets to promote the SSCB and its priorities such as Private Fostering and the work of the Child Death Overview Panel.
- The Group supported the CSE awareness month by disseminating information via the website and supporting the successful CSE (Boys) event in March at Dorking Halls.
- The group assists in developing the SSCB media response for published Serious Case Reviews.
- Key messages and updates are shared via the SSCB quarterly newsletter. The SSCB newsletter is circulated across Surrey on a quarterly basis. Feedback has been positive.
- The group uses the SSCB website as an effective platform to reach practitioners, parents and children in Surrey.
- The SSCB has increased its contacts of agencies working in Surrey including the voluntary and leisure sector.
- Surrey Youth Focus was given funding by Surrey County Council to set up a Safeguarding Young People Network for the third sector.

What are we worried about?

- Those organisations; primarily in the voluntary or independent sector who are not currently part of the SSCB network.
- The capacity of the group to disseminate messages and deliver campaigns.
- Our effectiveness in communicating with children and parents in Surrey; listening, consulting and ensuring meaningful participation.
- How the group can best promote and coordinate a wide range of safeguarding campaigns and initiatives taking place in Surrey during the next 12 months.

What do we want to see in 2017 – 2018?

- The group builds on its work to continue to disseminate the SSCB's key messages to all sectors, practitioners and volunteers working with children and families.

Chapter 4

Business Plan

Surrey Safeguarding Children Board Business Plan: 1st January 2016 to 31st March 2018

Overarching priority:

To ensure the SSCB is able to deliver its core business as identified in Working Together 2015.

(a) to **coordinate** what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to **ensure the effectiveness** of what is done by each such person or body for those purposes.

In order to do this it has five core business objectives:

- Optimise the effectiveness of arrangements to safeguard and protect children and young people
- Ensure clear governance arrangements are in place for safeguarding children and young people
- Oversee serious case reviews (SCRs) and child death overview panel (CDOP) processes and ensure learning and actions are implemented as a result
- Ensure that single-agency and multi-agency training is effective and contributes to a safe workforce.
- Raise awareness of the roles and responsibilities of the LSCB and promote agency and community roles and responsibilities in relation to safeguarding children and young people.

SSCB aims to provide the leadership and support required to enable children to feel safe and protected within their communities. In addition to the delivery of its core business SSCB has agreed four additional areas of improvement which require greater scrutiny based on audit, partner's reports to the board, evolving statutory guidance and inspection outcomes.

The Learning and Improvement Framework published by the SSCB contains more detailed information of how partners' improvement activities inform future priorities and is a statutory responsibility in WT 2015. SSCB Strategic Documents

Summary of the SSCB key areas of scrutiny 2016 – 2017				
The effectiveness of Early Help for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care.				
The effectiveness of the current **child protection processes** in protecting those children identified as in need of protection and who are looked after (LAC). To include consideration of **'neglect'**				
The effectiveness of the response and impact of partners work to protect children and young people at risk of **Child Sexual Exploitation (CSE).**				
The effectiveness and impact of Surrey Services in reducing the incidences of Domestic Abuse and protecting children and young people from harm.				
SSCB will focus on				
Strengthening accountability across partners Scrutinising how well partner agencies' safeguarding arrangements demonstrate improved processes and cultural change Ensuring that the SSCB's responsibility for strategic oversight of child protection arrangements is shared and understood by local agencies, across local partnerships and within Surrey's communities	**Training with impact and testing if learning is embedded** Reviewing safeguarding training to ensure that it is well co-ordinated across the partnership and has an impact on practitioners in the safeguarding system Testing how well learning is embedded in front line practice across Surrey Testing how well learning from case reviews is embedded in to practice across Surrey	**Auditing, scrutinising and challenging** **Maximising the use of performance data** Reviewing SSCB Quality Assurance processes to ensure that it is well co-ordinated across the partnership and has an impact on practitioners. Testing how well learning from audit is embedded in front line practice in Surrey	**Listening to children and families** Ensuring that children and young people's views are reflected within the partnership	**Engaging with local communities** Supporting the development of a co-ordinated and multi-agency response to • CSE • Early Help • Neglect • Domestic Abuse Ensure that local communities are better engaged in the work of the Board and within the partnership

Detailed Work plans 2016 – 17

Targeted priority 1 – To monitor and challenge the effectiveness of Early Help for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care. To ensure that the voice of children and young people is heard.

OUTCOME		Narrative
The Early Help workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate Early Help services for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care	**Early Help sub group** **Supported by** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **MASH & Early Help program board** • **Surrey Children & Young People partnership**	**Update on Early Help to SSCB in January 2017** • MASH is now established and is one of the busiest in the country. • The majority of staffing gaps in the Early Help Co-ordination Hubs have been filled. • There are 4 Early Help hubs in place. Initially approximately 1,000 cases were referred for Early Help each month. This dropped off during February and March and is being monitored by CSC. • Early Help partnership events were held in the Boroughs and Districts in February / March to explain the Early Help offer in each Borough or District. This will support the future development of the Early Help hubs. • An Early Help audit is planned for 2017 – 18. This will consider the impact of the MASH and Early Help arrangements. • An evaluation of the work of Family Support Programme was completed in November as part of this Early Help process. • Further significant work is required on Early Help Co-ordination processes and the EHM module.
The Early Help workforce is effective in **sharing relevant information** at a strategic and delivery level		
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across the Early Help sector.		
Agreed multi agency **plans, policies and procedures** relating to Early Help are delivered effectively, and the impact on C&YP is positive.		
The Early Help workforce is effective in **delivering excellent services** for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care		
Children and Young people receiving Early Help Services actively contribute to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.		

Targeted Priority 2 – To ensure professionals and the current child protection processes effectively protect those children identified as in need of protection and who are looked after (LAC). To ensure that the voice of children and young people is heard.

OUTCOME		Narrative

The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and who are looked after.	**Neglect sub group**
	
	Supported by
	• **SSCB QA**
	• **SSCB L&D**
	• **SSCB P&P**
	• **SSCB SCR**
	• **Surrey Children & Young People partnership**
		• Neglect was the scrutiny focus of the 23 November SSCB Board meeting and a number of partner contributions were taken forward by the Neglect Subgroup
		• A Neglect Challenge event took place on 24 November2016.
		• Actions for the SSCB arising from the event were:
		  ○ SSCB Neglect subgroup to update the SSCB Neglect Strategy and to ensure that we have clear outcomes for children – as at 31 March 2017 the work is ongoing and the strategy will be launched during summer 2017.
		  ○ SSCB to re-launch the Escalation Policy.
		  ○ SSCB Neglect subgroup to review multi-agency neglect assessment tool and guidance, ensuring that it is in line with the Safer Surrey approach and is communicated with staff across all agencies – this work will be completed in July 2017
		• As at 31 March 2017 the Neglect action plan was being finalised.

The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level		
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's services.		
Agreed multi agency **plans, policies and procedures** relating to children in need of protection and who are looked after are delivered effectively, and the impact on C&YP is positive.		
The Children's workforce is effective in **delivering excellent services** for children, young people and families who are identified as in need of protection and who are looked after.		
Children and Young people identified as in need of protection and who are looked after **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.		• CP Chairs QA report to SSCB November 2016. Data for the 6 month period April 2016 – September 2016 provided to Board showed that of the 325 children invited to their CP Conference 118 attended (36%). 5 children received independent support. • A Children's Case File Audit focusing on Neglect was completed in November 2016

Targeted Priority 3 – To challenge and scrutinise the effectiveness of the response and impact of partners work to protect children and young people at risk of Child Sexual Exploitation (CSE). To ensure that the voice of children and young people is heard.

OUTCOME		Narrative
The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and who are looked after.	**CSE sub group** **Supported by** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **SSCB SCR** • **Surrey Children & Young People partnership**	• The SSCB has overseen the development of a new CSE strategy and action plan with a clearer focus on a small number of priority actions to address CSE in Surrey. This follows the completion of a CSE peer review in May 2016. The new strategy and action plan is informed by and responds directly to findings of the peer review. • CSE work was the scrutiny focus at the 20 July 2016 and the 13 March 2017 SSCB Board meetings • There was a CSE Challenge event on 28 July 2016. 2 young people were part of the panel scrutinising agencies work in respect of CSE. • Police officers have undertaken 'Total Respect Training'. • Children's Services have ensured that the piece of work carried out by the Children's Right Team (as commissioned by Surrey Children's Services) on the issue of CSE is now taken forward and used. • The SSCB Event 'Under the Radar' on the 16 November provided a platform to launch the strategy and action plan. This was supported by co-ordinated communications activities and awareness-raising across the partnership using existing communication channels. • Drawing on the 'See me, hear me' framework, existing engagement with children was scoped and effective mechanisms to listen to and respond to children's views is being developed. Children placed outside of Surrey • Children continue to be invited to contribute as appropriate to their Looked After Children Reviews / CP Conferences / Return Home Interviews (on their return from a missing episode).
The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level		
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's' services.		
Agreed multi agency **plans, policies and procedures** required to protect children and young people at risk of Child Sexual Exploitation are delivered effectively, and the impact on C&YP is positive.		
The Children's workforce is effective in **delivering excellent services** required to protect children and young people at risk of Child Sexual Exploitation.		
Children and Young people **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.		

Targeted priority 4 – To monitor and challenge the effectiveness and impact of Surrey Services in reducing the incidences of Domestic Abuse and protecting children and young people from harm. To ensure that the voice of children and young people is heard.

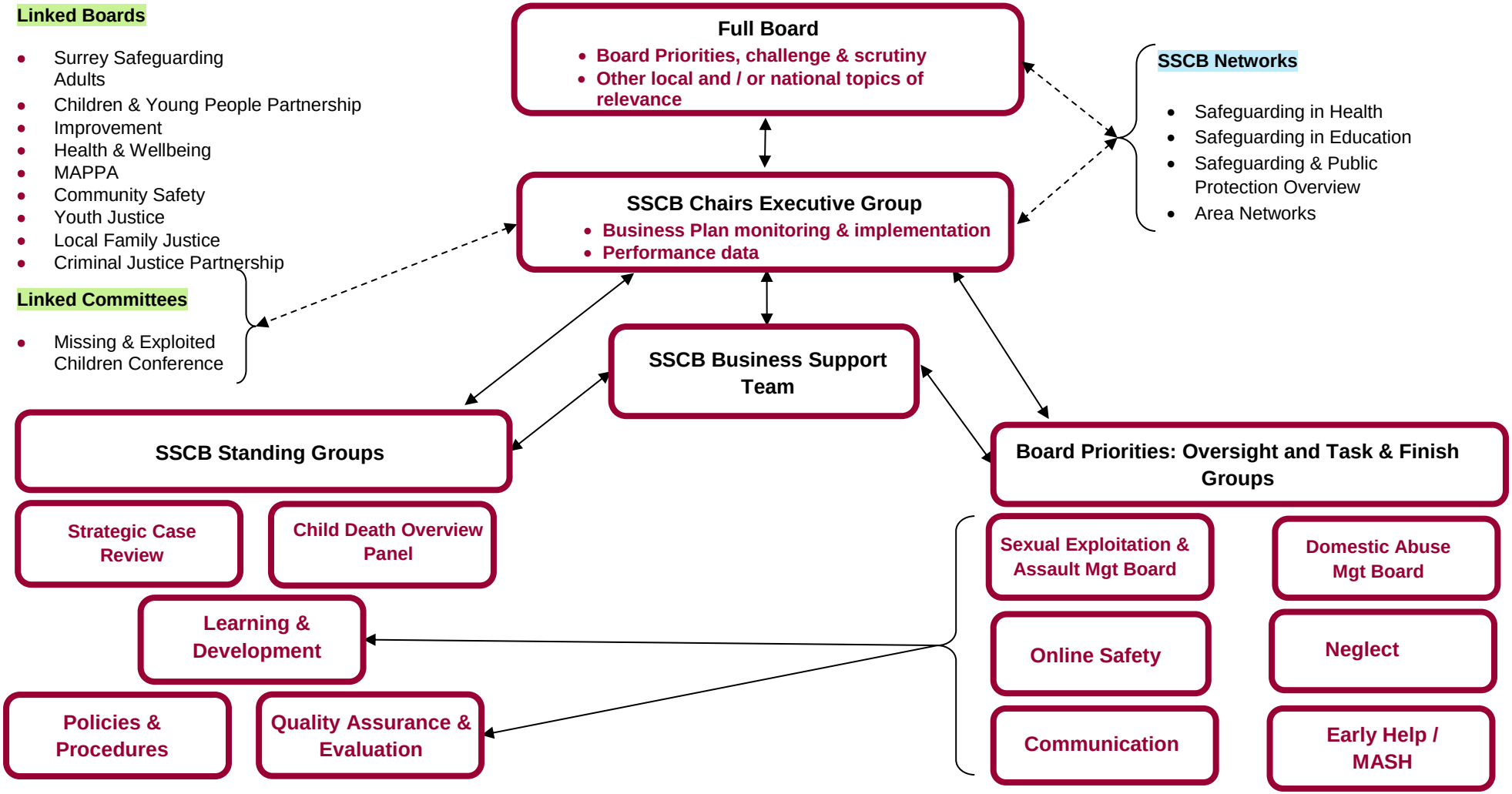
OUTCOME		Narrative
The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and vulnerable due to incidences of Domestic Abuse	**Domestic Abuse sub group** **Supported by** • **SAB** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **SSCB SCR** • **Surrey Children & Young People partnership**	• Domestic Abuse was the scrutiny focus for the 19 September 2016 SSCB Board meeting. • A Domestic Abuse challenge event was organised by SSCB on 22 September 2016. • Unfortunately the young people invited to take part were not able to attend but sent their questions for the panel. • The Domestic Abuse Management Board provides a multi-agency strategic lead for work in relation to Domestic Abuse. This Board is chaired by the Police. • The Surrey DA Strategy (2012 – 2018) focuses on developing services that maximise prevention, early intervention and provide holistic responses to those affected by DA. • SSCB Policy and Procedures are being updated • Work to promote healthy relationships is undertaken as part of all schools PSHE curriculum supported through the Healthy Schools Programme. • School staff have access to a range of training and development opportunities promoted through the Safeguarding Children's Board and Community Safety Board as well as Surrey Domestic Abuse Services (SDAS) Healthy Relationship training. • The Office of the Police and Crime Commissioner has supported access to drama productions for schools which have focused upon domestic abuse and unhealthy relationships.
The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level		
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's' services.		
Agreed multi agency **plans, policies and procedures** required to protect children and young people at risk from Domestic Abuse are delivered effectively, and the impact on C&YP is positive.		
The Children's workforce is effective in **delivering excellent services** required to protect children and young people at risk from Domestic Abuse.		
Children and Young people **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.		

Chapter 5

Further information about the Surrey Safeguarding Children Board

Surrey Safeguarding Children Board Structure 2016

Role of the Surrey Safeguarding Children Board (SSCB): to coordinate and ensure the effectiveness of what is done by each person or body represented on the Board, for the purpose of safeguarding and promoting the welfare of children within Surrey.



Main Board

This Board is made up of representatives of member agencies. They are sufficiently senior to be able to sign agreements on behalf of their agency and ensure that their agency co-operates with the SSCB policies and procedures.

Chairs' Executive Group

The Chairs' Executive Group manages the operation of the SSCB, drives forward the strategic priorities and ensures the smooth running of the Business Plan. The members of the Chairs Executive Group are made up of the chairs from each of the SSCB sub group.

Sub Groups

Members of the sub groups are staff from partner agencies represented at the SSCB. The members of the sub group are selected to ensure each group has the relevant expertise and knowledge to deliver the SSCB business plan.

Independent Chair

The SSCB is led by an Independent Chair Mrs Elaine Coleridge-Smith.
The Chief Executive of Surrey County Council appoints the Chair.

Surrey County Council

Surrey County Council is responsible for establishing and maintaining the SSCB. Mrs Julie Fisher the Director of Children Services sits on the Main Board and meets regularly with the Independent Chair.

Lead Member for Children Services

This role is held by Clare Curran elected Councillor with responsibility to ensure that the local authority fulfil its legal responsibilities to safeguard children in Surrey. The Lead Member attends the main board meetings as a participating observer and is not part of the decision-making process.

Partner Agencies

All partner Agencies are committed to ensuring the smooth and effective operation of the SSCB. Designated professionals provide advice on safeguarding matters to partner agencies. There is a Designated Doctor and Nurse who take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across Surrey.

Lay Members

SSCB appointed two local residents as Lay Members to support stronger public engagement and contribute to the SSCB work in the community

Third Sector

The SSCB has representatives from Surrey Youth Focus and Home Start.

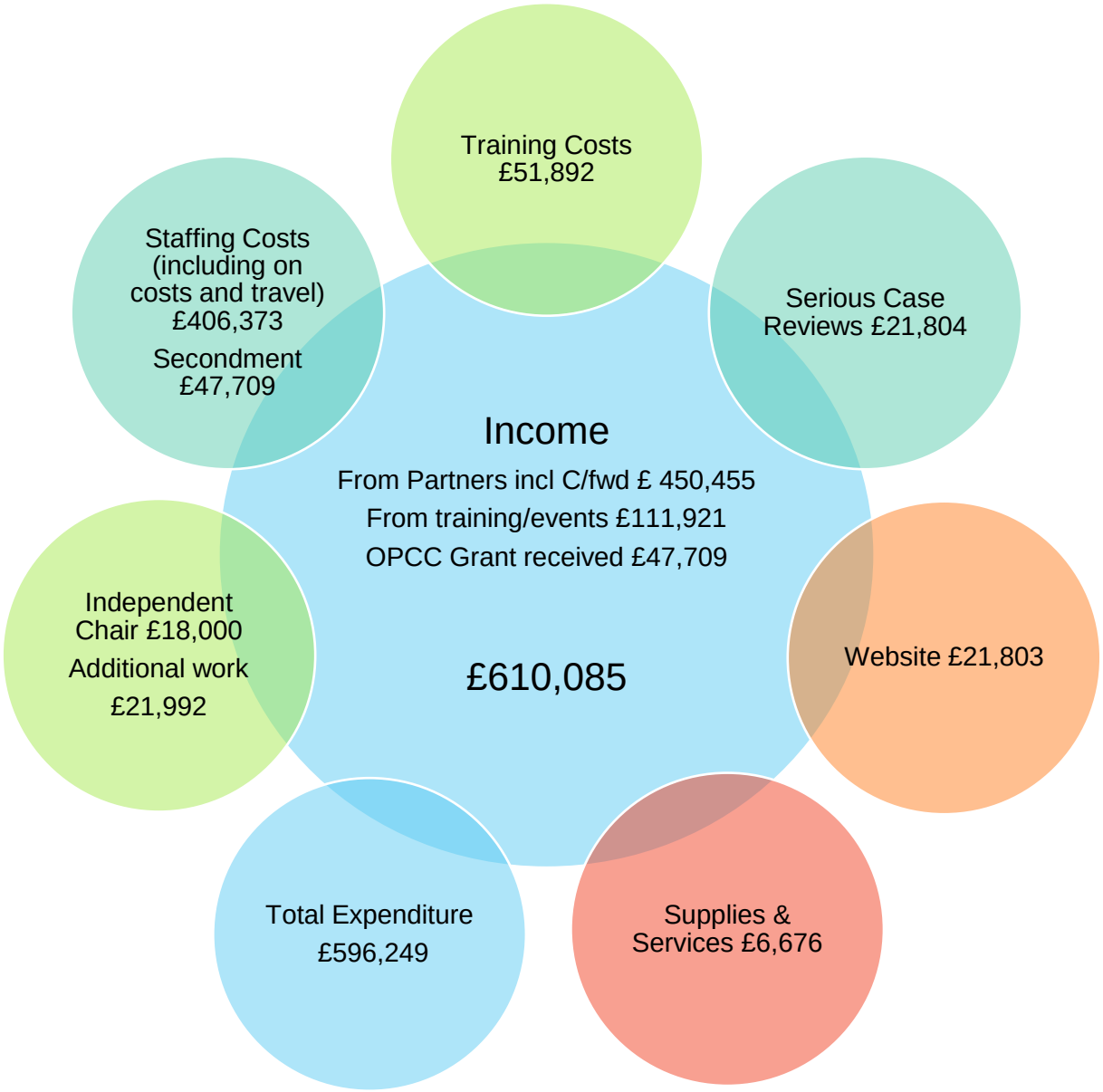
Financial Summary 2016 – 2017

SSCB was adequately funded by partner agencies during 2016 – 2017. Financial contributions from partners totalled £450,455 including the carry forward from 2015 – 2016 and a £20,000 contribution to the training function of the Board to enable partners to access training at no further cost. Surrey County Council contributes 45.52%, the CCGs contribute 36.86%, NHS Trusts 4.88%, Surrey Police 7.76%, Boroughs & Districts 3.07%, with combined probation services totalling 1.76% and CAFCASS 0.15%. In addition to contributing financially, SSCB partners contribute 'in kind' providing staff time, venues for training, trainers and hosting arrangements for the support team.

Income from training during 2016 – 2017 was £106,202. Training costs were £51,892. Venue costs accounted for £21,876, Training Consultants £27,328, and refreshment costs £2,688. This resulted in a net contribution from the training team of £54,310. The net surplus from conferences held during the year was £5,719.

Other costs relating to the statutory functions of the Board included: Serious Case Reviews independent reviewer costs £20,529, Independent Chair's costs for the chairing of the SSCB were £18,000. During 2016 – 2017 the independent Chair also supported the Improvement Board work within the partnership, the chairing of the Quality Assurance sub group and attendance at sub groups totalling £21,992

The SSCB budget showed a small surplus of £13,836 after accruals (£132,062 before accruals) which will be carried forward into the next financial year. Partner contributions will remain unchanged in 2017 – 2018.


Training Costs £51,892
Staffing Costs (including on costs and travel) £406,373
Secondment £47,709
Serious Case Reviews £21,804
Income
From Partners incl C/fwd £ 450,455
From training/events £111,921
OPCC Grant received £47,709
£610,085
Independent Chair £18,000
Additional work £21,992
Website £21,803
Total Expenditure £596,249
Supplies & Services £6,676

Chapter 6

Messages for You

Children in Surrey

- We want to hear what you have to say: If you have a worker don't be afraid to let them know how they can help you to keep safe.
- If you are worried about yourself or another child do speak to someone such as a teacher or another adult you can trust.
- Don't be afraid to speak up.

Parents and Carers

- Please remember that the agencies are there to help you and your family. Ask for support early don't wait for the situation to get worse.
- Talk to professionals working with you about what needs to be done differently to keep your family safe.
- Find out about the issues that might affect your child, it is important that they are safe in the digital world. Ask how you can help to keep them safe on line.

The staff who work with children and young people.

- Be clear about who is your representative on the SSCB and use them to ensure the voices of children and frontline practitioners are heard.
- Be familiar with and use the SSCB threshold document and safeguarding procedures to ensure appropriate response to safeguarding children.
- Ensure you take advantage of all safeguarding training required for your role.
- Do not be afraid to challenge and raise concerns about any safeguarding decisions you feel that are inappropriate.
- Foster a culture of curiosity and learning
- Your knowledge and experience of children is important – be familiar with the SSCB escalation policy.

Partner Agencies

- Support the SSCB's priority given to Child Sexual Exploitation and ensure this is reflected within your strategic planning.
- Ensure that you continue to address Domestic Abuse and support the work of the Domestic Abuse Management Board.

- Ensure that efforts are made to secure effective Early Help support for families and that those children in need of protection are quickly identified and appropriate support offered.
- Partners to ensure that the SSCB work being undertaken to tackle neglect is evaluated and the evidence use to inform both strategic planning and service delivery.
- Recognise the role of voluntary organisations and Faith groups and ensure support is made available so that they can play their part in safeguarding children in Surrey.
- Ensure that information is shared at the earliest opportunity to protect children

Chief Executives and Directors

- Ensure that the workforce is aware of their safeguarding responsibilities and can access SSCB safeguarding training and learning events.
- Continue building on strengthening supervision and management oversight
- Recognise that the delivery of services in partnership is a challenge. A priority for 2017 must be our ability to work together and share information appropriately.
- Work together to re-balance capacity to best match demands
- Recognise that the SSCB needs to be informed about changes to organisational structure in order to understand the impact on the capacity to safeguard children in Surrey.
- Recognise that we must all ensure a culture of listening to children and their families about their experiences of the support they receive.

Conclusion

Throughout the period of this report Surrey Children's Services have continued to be under scrutiny following the June 2015 Ofsted inspection report that gave an overall judgement for of inadequate. Surrey has agreed a challenging improvement plan that sets out how services will move to an embedded culture of practice where CSF, and all partner agencies, are consistently and confidently doing the right things for children and young people, in the right way at the right time. There is now clarity about what needs to improve and what needs to be done to deliver the change required.

During this period the leadership across the partnership is significantly changed, giving rise to stronger governance and a clearer sense of direction. Significantly there is a greater sense of cohesion and integration across the partnership, and clear evidence of a shared drive to improve practice across all services.

Key to future improvements in both practice and partnerships is the successful embedding of Safer Surrey. The establishment of a Signs of Safety implementation group is an important decision and should support the drive to implement and use this model.

Frequently inspections and audits have highlighted that staff demonstrate a real the passion and knowledge of children in their care. This culture of care and genuine concern is one that we want to nurture in Surrey.

It is to be expected that work remains to be done. Whilst this report points out that the quality of practice still remains variable and in particular some partners have more work to do on supervision, management oversight and case recording, I hope readers get a sense of the achievements made and the real drive to improve. Partners should be congratulated for the way in which they have addressed problems and maintained focus and pace.

The coming year will require the same high level of drive and commitment. Demand for services is unlikely to lessen and financial constraint will continue across the partnership. In addition the 2017 Children & Social Work Bill and the Wood Review of the role and functions of Local Safeguarding Children Boards will demand considerable attention.

I would like to thank everyone involved in safeguarding the children and young people in Surrey. Your professionalism, commitment and skill is highly valued and greatly appreciated by all those who have contact with you.

Elaine Coleridge Smith, Surrey Safeguarding Children Board

surrey safeguarding CHILDREN BOARD