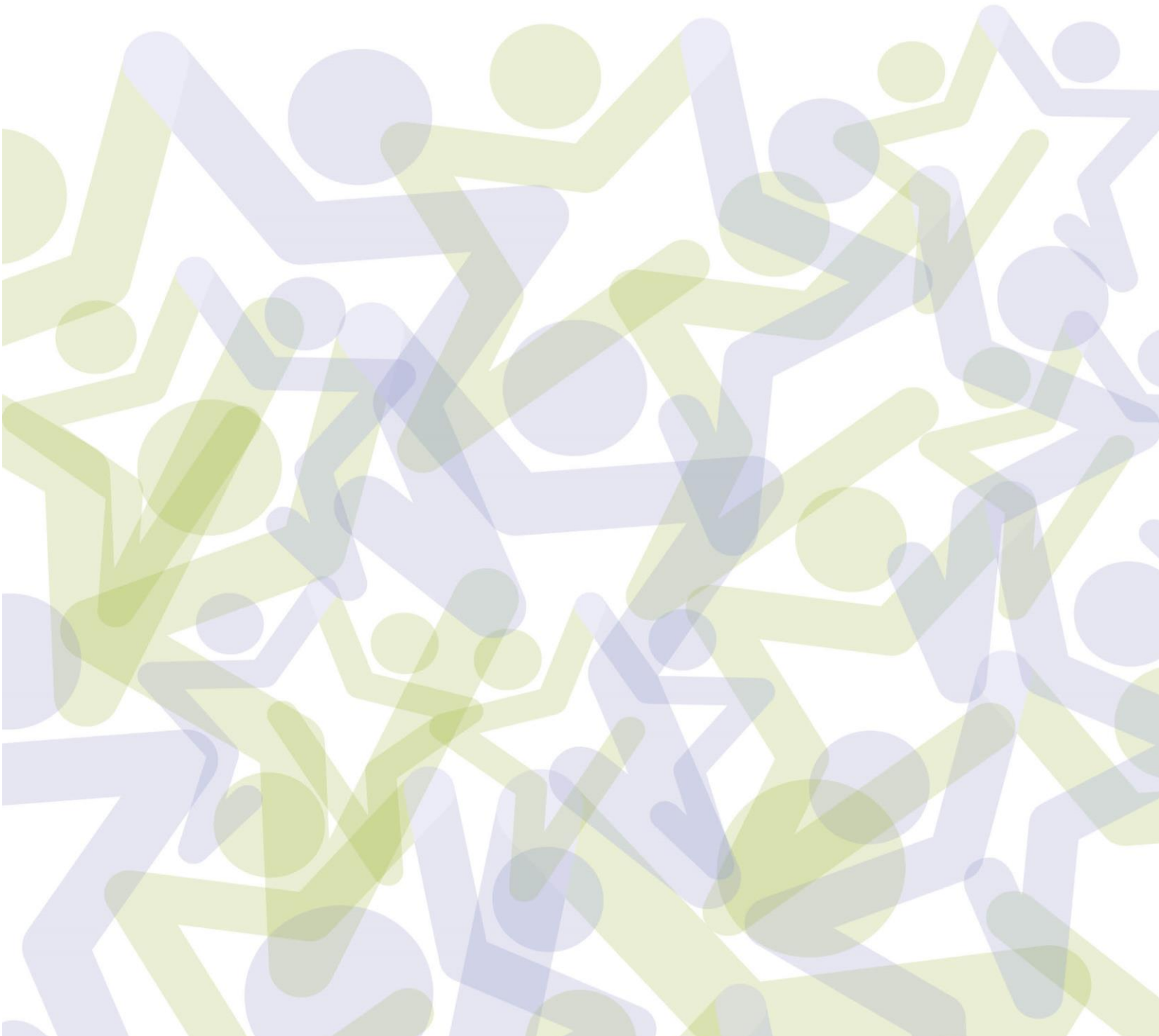
Surrey Safeguarding Children Partnership

Annual Report 2021-2022



Introduction

The Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 provides that the safeguarding partners (outlined below) must publish arrangements on how safeguarding services will be coordinated in their local area; they should act as a strategic leadership group in supporting and engaging others in the work of safeguarding children and promoting their welfare. These arrangements should also include implementation of national and local learning, including learning from serious child safeguarding incidents.

The purpose of these local arrangements is to safeguard and promote the welfare of children, and to enable the safeguarding partners and relevant agencies to work together to identify and respond to the needs of children in the area.

The legislation shares the responsibility for these arrangements between the Local Authority, the Police and the Clinical Commissioning Group (CCG) across an agreed geographical area. The Surrey Safeguarding Children Partnership (SSCP) consists of the three safeguarding partners, Surrey County Council (SCC), Surrey Police and the Surrey Heartlands Clinical Commissioning Group. In addition, the Surrey Safeguarding Children Partnership includes Education and Schools on the Executive on equal footing with statutory Safeguarding Partners. From April 2022, the Surrey Safeguarding Partnership will include Frimley CCG. As per the SSCP's published arrangements, the three named statutory 'Safeguarding Partners' have formed an Executive Group for the Partnership, joined by representatives from the county's schools and colleges, district and borough councils, and the Police and Crime Commissioner's office. The published arrangements also provide that representatives of the Third Sector will attend the Executive Group on an issue by issue basis.

The membership of the Surrey Safeguarding Children Partnership includes 'relevant agencies' and this group has been extended to more fully represent the breadth of interests/stakeholders in children's safeguarding in Surrey.

The SSCP, as a multi-agency partnership, works to keep all children and young people safe in their homes and communities, and to fulfil their potential. The SSCP's vision is that our partnership arrangements will make a difference to the lives of children and young people in Surrey. They will ensure that agencies work better together, that collectively we learn from local and national practice and continuously improve services to enable children and young people to be safe and feel safe in their families and communities. This annual report covers the period from 1st January 2021 until 31st March 2022.

2021-2022 has been a time of considerable change and transition. In 2021 we saw the departure of Detective Chief Superintendent Carwyn Hughes, Head of Public Protection, who was the Surrey Police representative; we also said farewell to Dr Amanda Boodhoo the Surrey-wide Associate Director of Safeguarding, Surrey Heartlands CCG. The contributions of Mr Hughes and Dr Boodhoo to the work of the SSCP has been immense and we want to acknowledge this in this report. We were also pleased to welcome temporary Detective Chief Superintendent, Sailesh Limbachia, from Surrey Police who succeeded Mr Hughes and Sara Barrington as the new Associate Director for Safeguarding, Surrey Heartlands CCG.

The Annual Report

Working Together 2018, provides that -

The safeguarding partners must publish a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.

In addition, the report should also include:

- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from Early Help to looked-after children and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- a record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.[1]

The Annual Report of the SSCP is part of the Surrey safeguarding partners' accountability to members of the full partnership, the national Child Safeguarding Practice Review Panel, relevant agencies and, most importantly, Surrey's children and families who are the principal beneficiaries of the activity of the Partnership.

This report provides an overview of the impact of the SSCP's work to ensure the safety and wellbeing of Surrey's children and families as well as an update against the partnership's key priority areas outlined in the partnership's strategic safeguarding plan. In addition, this report will provide an update on the Partnership's statutory functions in relation to the evaluation of multi-agency safeguarding training and learning from serious incidents.

This report looks at the ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision. Finally, this report will draw conclusions about the effectiveness of our current arrangements and indicate our priorities for continued improvement.

The Annual Report will be divided into 5 sections as follows:

Section 1: Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families

Section 2: Progress on the SSCP's priorities including analysis of areas where there have been little or no evidence of improvement

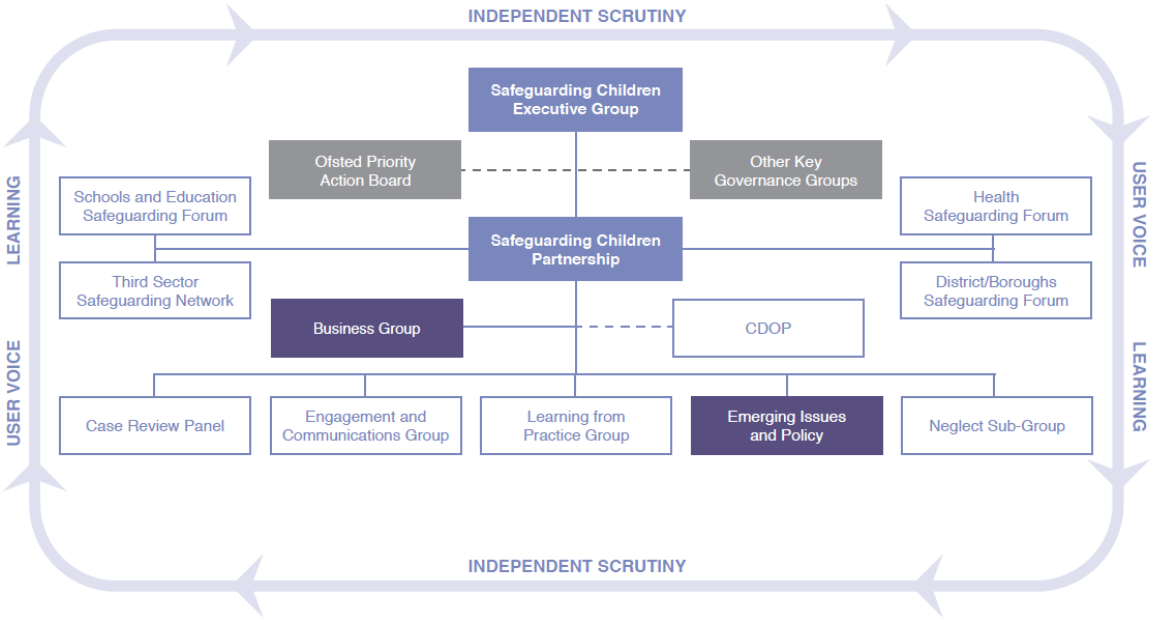
Section 3: A report on the key decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements.

Section 4: How has the SSCP sought and use feedback from children and families to inform their work and influence service provision

Section 5: Conclusions and Next Steps

[1] Working Together 2018, chapter 3, pp. 80-81, paragraphs 41 to 43,

The Surrey Safeguarding Children Partnership current arrangements and structure



The SSCP is structured as follows:

- ***The Executive Group*** - The members of this group form the strategic leadership group and 'virtual management team' for Surrey's safeguarding arrangements. The Executive meets on a monthly basis.
- ***The Surrey Safeguarding Children Partnership*** - the overall aim of the Partnership is to ensure Surrey's arrangements fulfil the vision and values of the partnership in their operation. The Partnership meets on a termly basis, that is three times per year.
- ***The Business Group*** - the key role of the Business Group is to ensure the business of the Safeguarding Partnership and decisions taken are progressed efficiently and effectively. The Business Group meets on a quarterly basis.

SSCP Sub-groups

- ***The Case Review Panel Sub-Group*** - the purpose of this group is to ensure that the SSCP fulfils its responsibilities in relation to reviewing child serious safeguarding practice incidents and translating learning into practice improvements.
- ***The Emerging Issues and Policy Sub-Group*** - is a new Sub-Group and was formed in September 2021. The purpose of the Emerging Issues Sub-Group is to ensure that the SSCP is sighted and able to respond strategically to risks and issues emerging across our safeguarding system and to review and update key policies, strategies and protocols on behalf of the SSCP.
- ***The Engagement and Communications Sub-Group*** - this group leads in an annual programme of engagement and communications with both users of safeguarding services and with practitioners across the safeguarding partnership workforce.
- ***Learning from Practice Sub-Group*** - The role of the Learning from Practice Sub- Group, is to work on behalf of the partnership, and to embed a learning culture and 'cycle' into our safeguarding arrangements that improves outcomes for children and families.

- ***The Neglect Sub-Group*** - The purpose of the Neglect Sub-Group is to take ownership and be accountable for the strategic oversight of the effectiveness of multi-agency practice in cases of neglect in Surrey.
- ***The Child Death Overview Panel*** – oversees the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. This process runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case to identify changes that could save the lives of children.

In addition to the SSCP's Sub-Groups, the published arrangements include the following sector-led safeguarding forums and networks:

- the District and Borough Councils' Safeguarding Forum
- the Health Safeguarding Forum
- the Schools and Education Safeguarding Forum
- the Third Sector Safeguarding Network.

Section 1: Impact on outcomes for children

In this section, the SSCP will report on areas where we feel the SSCP has had a positive impact and comment on where there is the need for continued improvement.

The SSCP's work from January 2021 to March 2022, shows that there is some evidence that the Partnership arrangements are working to keep children in Surrey safe and that agencies provide appropriate support to children and families. However, there is also clear evidence of the need for system-wide consistency and less variability in the quality of multi-agency practice. This includes the need for all agencies to be able to demonstrate evidence of improving frontline practice; and for all agencies to be able to consistently demonstrate how their practice results in improved outcomes for children. We are beginning to see that there are clear signs of improvement in safeguarding across Surrey, however, these improvements need to be consistently embedded.

Evidence from External Inspections

Surrey County Council

In January 2022, towards the end of the SSCP's reporting period, OFSTED conducted an inspection of Surrey County Council's children's services. The inspection was from 17th January to 28th January 2022. Inspectors found that,

> Services for children and families in Surrey have improved since the inspection in 2018, when they were judged to be inadequate overall. While improvements are evident and children are safer, some inconsistencies remain. Some children benefit from helpful services at an early stage, which make a real difference to their lives; others receive a less effective service. Most social workers listen carefully to children and make sure that children's views inform decision-making. When children come into care, they are placed within their wider family if this is possible and in their best interests. Most children in care live in long-term homes and make

good progress. Many care leavers are supported well to live independently, developing confidence and skills to assist them into adulthood.

Leaders are determined to continue the trajectory of improvement, building on strong partnerships and routinely taking children's views into account as part of service development. Leaders are implementing a clear and comprehensive improvement programme, based on a thorough understanding of current performance.[2]

Inspectors found that overall the local authority requires improvement to be good.

The SSCP congratulates the County Council for its achievement in moving out of intervention. They have improved in all areas and the SSCP notes the recommendations in Ofsted Inspection Report. The inspection outcome represents a solid foundation on which the County Council can continue to build.

Whilst this inspection was focused on the local authority, this finding is consistent with the SSCP's analysis of safeguarding practice across our multi-agency system. The SSCP, using performance information and intelligence from audit and quality assurance activity, have found that services across all parts of the county are improving, however, there is more work to be done to ensure that safeguarding services across all agencies are consistently good. We have found that our responses to children in need of help and protection are too variable; this means there are areas where the practice is good, child-centred and can evidence improvement for children and families. However, there are also examples where practice falls short of our expectations and ambitions for children and their families.

Surrey Schools

In the reporting period January 2021 until 31st March 2022 Ofsted inspected 58 Surrey Schools.

4 schools were judged as being outstanding

48 schools were judged as being good

5 schools were judged as requiring improvement

1 school was judged as being inadequate.

An inspection of youth offending services in Surrey by Her Majesty's Inspectorate of Probation

There was also an inspection of the Youth Offending service during this reporting period. HM Inspectors rated Surrey Youth Offending Service across three broad areas:

1. the arrangements for organisational delivery of the service,
2. the quality of work done with children sentenced by the courts, and
3. the quality of out-of-court disposal work.

Overall, Surrey YOS was rated as 'Good'. Inspectors also inspected the quality of resettlement policy and provision, which was separately rated as 'Good'.

[2] Inspection of Surrey local authority children's services Inspection dates: 17 to 28 January 2022

Inspectors noted that "Surrey YOS has made noteworthy progress since our last inspection in 2019 when we rated the service as 'Inadequate'. The partnership has taken a systematic approach to service improvement with notable results."[3]

Inspectors also found that "The quality of the casework inspected in both court and out-of-court work was impressive. Provision for resettlement was also good. The YOS management team and practitioners know the children well and have access to an impressive range of services to address their needs."[4] Inspectors also noted that they "saw innovative practice and the multi-agency daily risk briefings were an effective way of intervening with children at an early stage"[5]

Surrey Police

Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service, Police Effectiveness, Efficiency and Legitimacy (PEEL) inspection 2021-2022

The PEEL inspection framework makes graded judgements across 8 areas of policing:

1. preventing crime
2. investigating crime
3. treatment of the public
4. protecting vulnerable people
5. responding to the public
6. developing a positive workplace
7. good use of resources
8. managing offenders

Inspection makes graded judgements from Outstanding, Good, Adequate, Requires Improvement and Inadequate.

The PEEL Report 2021-2022 judgments for Surrey Police are detailed as follows:

Outstanding	Good	Adequate	Requires Improvement	Inadequate
Preventing crime	Investigating crime	Responding to the public	Managing Offenders	
	Treatment of the public	Developing a positive workplace		
	Protecting vulnerable people	Good use of resources		

As noted above, Surrey Police requires improvement at managing offenders and suspects.

Inspectors note that "The force must prioritise safeguarding when it suspects online offences of indecent images of children. It should carry out repeated intelligence checks to confirm whether

[3] HM Inspectorate of Probation, An inspection of youth offending services in Surrey HM Inspectorate of Probation, March 2022
[4] ibid
[5] ibid

suspects have access to children."[6] The report also found that "Staffing levels in high-harm teams isn't keeping up with demand." Specifically, inspectors "…found that high-harm teams had high caseloads and were under-resourced. This includes the sexual offences investigation team, the paedophile online investigation team, and the child abuse team."

Health Inspections

The Care Quality Commission (CQC) Inspected Ashford and St. Peter's Hospitals NHS Foundation Trust's St Peter's Hospital between 16th, 17th and 18th November 2020; the report was published on 27th January 2021. St Peter's Hospital was found inadequate. The Care Quality Commission Inspection stated that the reasons the "rating for the hospital went down because:

- Nursing staff numbers were consistently below planned levels.
- Staff were not up to date with mandatory safeguarding training.
- The environment on the wards and in theatres did not always meet national guidance.
- There was a significant number of senior surgical staff who felt disengaged and disenfranchised and the strategies to address this appeared to be lacking impact.[7]

There were no other CQC reports published during this reporting period. However, according to the CQC, out of the 40 Hospitals registered in the Surrey area:

- 2 are rated as outstanding
- 25 are rated as good
- 2 are rated as requires improvement
- 9 are unrated

The external inspectorates including Ofsted, HM Inspectorate of Probation, Care Quality Commission and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service support the analysis of the SSCP that whilst there are pockets of outstanding and good practice across our system, there remain areas which require improvement to be good.

[6] Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service, PEEL 2021/22 Police effectiveness, efficiency and legitimacy An inspection of Surrey Police

[7] Care Quality Commission (January 2021) Ashford and St. Peter's Hospitals NHS Foundation Trust, St Peter's Hospital Inspection report

There is evidence of improving engagement work with children and young people who are at the threshold for support at levels two and three, with a renewed focus on ensuring action is taken to address issues that matter to children, young people and their lived experiences.

The numbers of children and families accessing Early Help services is increasing. This is a positive outcome as it is an indication that children and families are accessing help and support before concerns escalate.

The evidence is that more work needs to be done to deepen the understanding of thresholds and levels of need. For example, contacts to the Child Single Point of Access (C-SPA) which result in information and advice are at about 60%. This means that only 40% of contacts result in an intervention with children and families. This is important because it indicates that there is a need for further clarity both in the nature of the concern being raised and the kind of support that is being requested and offered.

An important piece of work in relation to early help and levels of need took place in 2020 to 2021. This work involved a number of cases identified by schools and education providers. Education and Children's Services colleagues within Quality Assurance reviewed the work with approximately 35-40 children and following those discussions an internal review of Children's Services records was undertaken to determine a RAG rating. From this exercise 10 children had a deep dive audit as well as multi-agency meeting to discuss the learning. The report highlighted several areas for learning and the key take-away messages are as follows:

- Neglect and the impact of cumulative harm is often lost as a main focus of harm due to putting more consideration and planning toward issues such as parental substance misuse and domestic abuse.
- Resolving difference of opinions with Education is a priority; when the views are different, Children Services needs to be more focused on taking stock of these concerns as Education's views were in the majority agreed with within this review.
- Best practice standards and measurable tools for neglect have to be adhered to in order to make consistent decisions for children when history and sustainable change has not historically been fully explored.
- The escalation policy must be rigorously applied and followed by all agencies.
- Multiple staff turnover over time needs to be considered as a risk factor given the potential area for practice gaps, which can negatively impact decision-making and full view of the child's experience. Staff turnover featured heavily for almost all children reviewed.

Performance data also shows that there is a sustained downward trend in the numbers of children who are being referred to Children's Services for a second or subsequent time. The reduction in repeat referrals is a good indication of safe de-escalation and prevention of children re-entering the social care system.

Children in Need

The numbers of children on Child in Need Plans is relatively stable, averaging approximately 2,200. The evidence from performance data is that children who are on Child in Need Plans receive timely support and, where appropriate are generally 'stepped down' appropriately

Child Protection

In March 2022, there were 1,009 children on Child Protection Plans. The evidence from our analysis of our performance data is that the experience of children who are on child protection plans is variable. This is confirmed by the findings of inspectors:

> In many cases, persistent, long-standing risks and needs are being addressed and reduced effectively, often through parents engaging with services for the first time. In some teams, this work results in insightful and effective multidisciplinary interventions for children and families. In others, the understanding of the child's experience is not well enough developed, resulting in some over-optimism. This means that the experiences and progress of children vary. The frequency and quality of supervision of staff are too variable and contribute to this inconsistency in social work practice.[8]

From a SSCP perspective, we remain concerned regarding the quality and effectiveness of multi-agency involvement in child protection processes. Information from Local Child Safeguarding Practice Reviews and Rapid Reviews is that all agencies do not always participate in these processes. For example, a published LCSPR found that "Strategy Meetings and Child in Need Meetings were not well attended by partner agencies".

Looked After Children

As of March 2022, there were 1040 children who were looked after by the Local Authority. 91% of children who are looked after by the local authority, have up to date reviews. Inspectors reported that

> Decisions for children to come into care are timely, well considered and based on comprehensive risk assessments. Senior managers have effective oversight of these and other key decisions, such as when children are to be subject to court proceedings or placed with connected carers.
>
> Children are seen regularly by social workers, who are predominantly child-focused and ensure that they understand the perspective of the child through direct work. They tailor their communication to meet the child's needs through direct observation, or feedback from others.

Care Leavers

In March 2022, there were 820 care leavers. This is a downward trend. The evidence is that care leavers are well supported by committed personal advisers. Contact with care leavers is generally proportionate to their needs. The views of care leavers are considered, and this is reflected in care leavers' plan. The health needs of care leavers are well understood, and personal advisers work well with care leavers and health professionals to ensure that specific health needs are addressed.

Summary of the Journey of the Child

The information provided above indicates that children in Surrey are generally safe. Our work in relation to Early Help needs to be improved. We want to see a lower number of contacts into the C-SPA which result in information, advice and guidance and a higher proportion of contacts which result in specific interventions for children and families. Part of the work to address this includes the Police Single Point of Access (P-SPA) which works alongside the C-SPA. Surrey Police have invested in an additional temporary Chief Inspector post to facilitate the roll out of Surrey Police's Early Help

[8] Inspection of Surrey local authority children's services Inspection dates: 17 to 28 January 2022

offer and to drive process change around the volume of level 1 SCARF submissions within the P-SPA. This is in addition to the Early Help co-ordinator role already appointed within the central Public Protection team. It is expected that approach will achieve the dual outcomes of reduced workload of the P-SPA, in not reviewing level 1 need and capacity building and resilience within the team affording more time for the Multi-Agency Partnership Enquiries (MAPE) and Domestic Violence Disclosure Scheme (DVDS) processes as examples. There has also been the development of a multi-agency oversight group to provide governance and multi-agency oversight of Early Help. This oversight group has recently revised their Terms of Reference.

The work to support children in need and children on child protection plans needs to be improved. We want to see greater consistency in the quality of multi-agency work to protect children. This includes embedding good practice in the quality of referrals, the quality of assessments, the quality and timeliness of planning, and a general improvement of outcomes for children and families.

The work to support children who are looked after and those leaving care is generally good, but there are some areas for improvements especially in relation to sufficiency of placements.

There is wide and active engagement in our multi-agency safeguarding arrangements at all levels including at the Executive and across all Sub-Groups, Networks and Forums. There is a challenge for the SSCP in ensuring that we are closer to frontline practice.

We believe that the SSCP's priorities are correct and are based on intelligence and evidence from our local safeguarding context. We are seeing evidence that agencies are growing in their understanding of their respective roles in relation to safeguarding and that the Effective Family Resilience Model and the Helping Families Early Strategy is enabling all agencies to work effectively with families and each other. There is also a developing culture of strong support and challenge within the Executive, however, we are working to embed this at all levels within our multi-agency system.

Areas for continued improvement and focus include embedding good systems for information sharing, which all professionals are confident and knowledgeable about. We also want to work together to create a culture of continuous improvement and learning and an environment in which effective, consistently good quality multi-agency practice can flourish.

SSCP Challenge Activity

As part of its challenge and assurance work, the SSCP has successfully facilitated effective challenge across the following areas:

Emotional Well-Being and Child and Adolescent Mental Health.

This has involved using the finding from Rapid Reviews and Local Child Safeguarding Practice Reviews, as well as the findings from the Thematic Review of Adolescent Suicides published in September 2020 to influence the strategic and operational aspects of this work. This has included working closely with the Surrey Health and Well-Being Board, the Surrey Safeguarding Adult Board, and Surrey Public Health. As a result of this work there has been the development of the Mental Health Delivery Board led by Tim Bates, the Children and Young People Suicide Prevention Partnership led by Public Health. To oversee the effectiveness of the MindWorks contract, which delivers child and adolescent mental health services across Surrey, there has been the establishment of The MindWorks Reference Group. The MindWorks Reference Group is created to provide an informal space to discuss and provide feedback on the MindWorks Surrey service model in an open

and constructive way. The group brings together colleagues from the Surrey system and the newly formed provider Alliance.

Work with Gypsy Roma and Traveller (GRT) Families.

A local child safeguarding practice review which was commissioned in 2020 found that the response to members of the GRT communities was inadequate. The SSCP sought assurance from Surrey County Council (SCC) regarding the work with GRT communities. Since that that time we have seen a step-change in the quality of responses to GRT communities. This work has included SCC providing bi-annual updates on progress regarding this work. There has been the establishment of a GRT Community Forum, which links in with members of the GRT community to address issues of concern. There has also been the commissioning of ethnographic research into effective engagement with GRT communities. As part of awareness raising, there has also been the development of a communication strategy aimed at increasing Surrey-wide awareness of GRT communities. Cultural awareness training has also been rolled out across Surrey; this training is provided by Friends, Families and Travellers, a national GRT charity that works to create awareness and end discrimination.

Work with Primary Care.

The Independent Chair raised a challenge, seeking assurance from the named GP regarding the commitment of GP practices across Surrey to safeguarding vulnerable children. A report was provided to the SSCP Executive in November 2021 which highlighted:

- GPs involvement in MAPEs
- the commissioning of a Surrey-wide audit into primary care and safeguarding.
- support for GPs through ad hoc safeguarding supervision.
- the development of a model safeguarding policy which can be adapted and used by GP practices across Surrey.
- the provision of level 3 training for GPs and GP Registrars.
- GPs involvement in Rapid Reviews and Local Child Safeguarding Practice Reviews.
- Work with Looked After Children.

The SSCP considered that the range and quality of this work was impressive.

Section 11 and Challenge

It is the duty of Safeguarding Children Partnerships to hold agencies to account in terms of their safeguarding arrangements and practices. In Surrey the Surrey Safeguarding Children Partnership (SSCP) tests the strength of safeguarding arrangements across agencies by requesting that they complete a S11 self-assessment every two years. In the interim year the SSCP requests a progress report from all statutory agencies to ensure that actions are being taken in a timely and appropriate way. It also provides an opportunity to identify good and developing practices across the partnership.

The 2021 approach

Of the 55 agencies (Statutory and non-statutory) that completed the Section 11 self-assessment in 2020, 41 agencies had action plans and in 2021 all 41 agencies were asked to submit a progress update report on these action plans.

Stage 1 (Assessment) of the process was for all update reports to be assessed by members of the SSCP Business Team in relation to: timeliness of progress and the quality of evidence especially in relation to impact.

Stage 2 (Moderation) of the judgements was led by the lead assessor in the SSCP Business Team and involved volunteers from the different agency groups who provided context and challenge.

In March 2022, on completion of the moderation process feedback was provided to the Safeguarding leads for each agency.

Findings

Excellent or Good progress has been made by most (71%) agencies since the last S11 self-assessment in 2020. For the 24% of agencies that have made slower progress over the last 12 months, the impact of Covid-19 has been cited as a key factor.

Engagement with the SSCP Forums and Networks is having a positive impact on supporting and driving understanding and progress now (especially in District and Borough Councils and Third Sector Forums) but there are still some agencies who do not have access to an appropriate forum such as Her Majesty's Prison Services.

Multi Agency Training and Its Impact On Practice

The SSCP is committed to supporting the development of a culture of continuous learning across all agencies, through the development and implementation of a learning framework, which enables our safeguarding system to respond to local and national policies and emerging themes.

Multi-agency safeguarding training is delivered through the Surrey Children's Workforce Academy (SCWA). A key challenge for the SSCP and the SCWA is the accurate and effective evaluation of the impact of training on practice. Part of this challenge is the fact that improving frontline practice includes a variety of factors including management oversight, reflective practice and multi-agency safeguarding training.

The SCWA's core offer includes training on:

- the Early Help System and Thresholds,
- the Child Protection System,
- Child and Adolescent Resilience (contextual safeguarding)
- Neglect (including the use of the Graded Care Profile 2 Tool)
- Domestic Abuse (including coercive control) and Harmful Traditional Practices

In addition, the SCWA offers awareness raising and introductory level e-learning packages on the following topics:

- Domestic Abuse
- Child Sexual Exploitation
- Gangs and Youth Violence
- Bullying and Cybercrime
- Human Trafficking and Modern Slavery
- Neglect
- Hidden Harm (parental substance misuse, parental mental health and domestic abuse)
- Safeguarding Children with Disabilities
- Sexual Abuse and recognising Grooming
- Self-Harm
- Honour-Based Violence and Forced Marriage
- Abuse related to beliefs in Witchcraft
- Conscious bias and unconscious bias
- Suicide awareness (children and adults)

All e-learning packages are offered to practitioners free of charge and can be accessed via Olive.

Training Delivered

The SCWA year is based on the academic year and runs from September to July each year. In total, the SCWA delivered 244 instructor-led learning events (39 learning programmes) between September 2020 and July 2021. As noted above, the core offer is supplemented by 14 e-learning courses on all areas of the core offer. During the financial year 2020 – 2021, the SCWA saw 8,659 course completions via the SCWA's e-learning platform. Covid-19 meant that the vast majority of

training was delivered virtually. The pandemic also meant that overall registrations and attendances were down.

In March and April 2021 the SCWA hosted Professor Evan Stark, a leading academic in coercive control, who delivered a webinar and a masterclass on coercive control to a combined audience of approximately 345 partnership practitioners and managers.

Evaluation of Training

The SCWA regularly monitors and evaluates the effectiveness of multi-agency safeguarding training and seeks feedback from learners regarding the impact of training on their current practice. Evidence from facilitators who gather verbal feedback during learning events, tells us that practitioners value and welcome the learning offered by the Academy.

Furthermore, feedback gathered from practitioners in 2021 demonstrates the value of this training and indicates the impact on their practice in the following ways:

- practitioners feel empowered, knowledgeable, and more confident to practice, but also to challenge professionally where appropriate, after attending SCWA learning events,
- practitioners value the toolkits explored during SCWA learning events as these help them with evidence-based practice,
- practitioners welcome the space that SCWA learning events offer for reflection on their practice and their thinking as well as the opportunity to network and learn together with practitioners from other organisations,
- practitioners value the opportunity to revisit theoretical concepts that underpin their practice,
- practitioners especially value the fact that facilitators are experts in their area of safeguarding practice, and in most cases, are themselves experienced and passionate practitioners who use experiences from their own practice share and illustrate learning.

Section 2: Progress on our Priorities

In reporting on the performance of the Partnership, we will want to indicate a shift from an outline of the Partnership's activities, towards reporting on the effectiveness and impact of our collective activity to keep Surrey's children safe and promote their welfare.

What is clear from the analysis of the SSCP's activities during this reporting period is that the partnership has delivered significant levels of activity; generally speaking this is of a good quality. The challenge for the SSCP is to consistently demonstrate that these levels of activity are achieving the desired impact of improved outcomes for children and families. Demonstrating and evidencing impact remains a key area for development for the SSCP.

During the period January 2021 until 31st March 2022, the SSCP key priorities were identified as follows:

1. Early Help and Thresholds
2. Adolescent Resilience and Support: with a focus on each of the following areas
    a. Children's emotional well-being and mental health,
    b. online safety,
    c. contextual safeguarding and
    d. safeguarding children with SEN-D
3. Neglect

Priority 1: Early Help and Thresholds:

The SSCP Executive and Partnership agreed that in 2021-2022 its first priority would be early help and thresholds. As a safeguarding children partnership, we wanted to ensure that local thresholds and levels of need were clearly understood, and consistently applied, with effective multi-agency working and clear pathways for support.

To ensure effective oversight of early help the SSCP approved the launch of the Early Help Oversight Group. This group reports to the Executive on a termly basis. The aim of the Early Help Oversight Group is to ensure effective multi-agency coordination and integration of early help; to ensure that request for support are appropriate and result in timely interventions and support for children and families. At their meeting March 2022 the SSCP Executive endorsed the setting up of the Early Help Strategic Board.

The SSCP is assured that the work regarding Early Help includes all three safeguarding partners and that schools and education has a strong voice and presence in these arrangements.

As part of the Surrey Police's work regarding Early Help, there is a dedicated Early Help co-ordinator who provides support to each team. This role has moved to Surrey Police's problem-solving team to enable it to be embedded within neighbourhood teams. From a schools' and education perspective, there is a lack of access to schools' performance data, which prevents a confident analysis of the numbers of education professionals that have taken part in the training in EHA. The SSCP is aware that schools continue to deliver a great deal of support and that some of this work is not recognised or recorded as "Early Help". Work still needs to be done to help schools quantify and quality assure the significant support that schools and education providers are delivering at the Early Help and targeted levels of the Effective Family Resilience framework.

Another related challenge for schools and education providers is the need for clarity regarding good practice and a shared understanding of what success looks like for the Early Help offer overall. Analysis of the numbers and quality of referrals has highlighted some issues related to understanding the need for consent at levels 1-3; however, this analysis also indicated that when referrals from schools provided details – through the use of a school's electronic reporting system – of all the action that had been taken by a school, (a) this action was recognised as Early Help and (b) it was much easier to evidence whether or not a threshold of need had been met.

Health representatives continue to contribute to the work undertaken across the quadrant-based Family Resilience Networks (FRNs). In Surrey, as in other parts of the UK, 90% of patient contacts with the NHS take place in general practice; GPs and other primary care staff are therefore key in improving Early Help referrals from Health. Analysis of the 6-monthly CCG Safeguarding Dashboard indicated that only small numbers of EHAs and lead professional roles were undertaken by community practitioners in Health. Health visitors, school nurses and midwives are undertaking Early Help by using every contact and interaction with children and families to identify and signpost or support families to get the help they need, by utilising the family information directory. In addition, health visitors and school nurses undertake family health needs assessments assessing need and families are signposted to appropriate local services.

The most comprehensive and independent assessment of the Early Help arrangements in Surrey is provided by the January 2022 inspection of Surrey local authority children's services by Ofsted. Even though this was an inspection of the Surrey County Council Children's Services, Early Help is a

partnership responsibility and the findings of the inspection report are helpful in evaluating the effectiveness of service delivery and impact in Early Help. Inspectors found that:

- Children and their families benefit from effective early help services. Thresholds are well understood, although some families experience a short delay in allocation before they receive the right support, meaning that some children's needs may escalate.
- The children's single point of access service responds effectively to most contacts and referrals, ensuring that the vast majority of children are signposted for support and information, or have their needs assessed more fully. A small number of children are subject to repeated contacts and referrals before they receive the support that they need. …When there are concerns about children's exposure to domestic abuse, risk identification and safety planning are evident. However, the current police practice of submitting lower risk notifications in batches leads to a backlog within the service. This means that some children exposed to domestic abuse do not receive the support that they need soon enough.

The evidence is that the work on Early Help is developing and requires improvement to be good. The evidence available to the SSCP suggests that more work needs to be done to ensure that thresholds and levels of need are well understood across Surrey. An example of this is the high numbers of referrals into the C-SPA which result in advice and no further action.

The response to children and families in need of Early Help and support remains variable. We have found there are occasions where children and families do not get the level of support and intervention they need. The use of EHAs is not fully embedded across our safeguarding system. The clear benefits of EHAs include the fact that they help agencies provide an assessment of need, they also provide evidence regarding the level of support that has been provided to date and enables the SSCP and others to quality assure the work being done to support vulnerable families. The C-SPA continues to have volumes of referrals that result in information and advice and no further action. The judicious use of the C-SPA's consultation line would enable agencies to discuss their concerns before a referral is made and to possibly identify appropriate alternate courses of action other than a referral.

There are some key initiatives such as the Helping Families Early Strategy and the planned refresh of the Effective Family Resilience Model (Surrey's Early Help and Threshold Document). As these are implemented and embedded it is hoped that there will be a much clearer understanding of thresholds across our Early Help system, and that families will get the support they need in a timely way. However, there needs to be a clearer focus on agencies working together to implement the necessary improvements, so that there is evidence of how the Early Help process is consistently improving outcomes for children and families.

In 2022-24, the focus will be on evidencing impact on improved multi-agency frontline practice in relation to Early Help and prevention, and all agencies being able to demonstrate improved outcomes for children and families.

Legacy Cases

In January 2021, the SCC Quality Assurance Service was tasked by the Executive Director of Children, Families and Lifelong Learning, on behalf of the SSCP, to review several children that had historically been raised by Education professionals as children of concern due to long-term intervention without

significant or sustainable change, as well as current concerns that the level of intervention was not at the right level.

The thematic audit was presented to the Executive in September 2021. The overall finding from this thematic audit on children was that the concerns regarding decision making and practice, escalated by Education colleagues was confirmed and upheld. The review helped to identify key points and practice issues that led, in some instances, to children experiencing long-term involvement without the appropriate safeguarding response or escalation where the outcomes for children were not sustained.

The report highlighted the following key areas:

- Neglect and the impact of cumulative harm is often lost as a main focus of harm due to putting more consideration and planning toward issues such as parental substance misuse and domestic abuse.
- Resolving difference of opinions with Education is a priority- when the views are different, Children Services needs to be more focused on taking stock of these concerns as Education's views were in the majority agreed with within this review.
- Best practice standards and measurable tools for neglect have to be adhered to in order to make consistent decisions for children when history and sustainable change has not historically been fully explored.
- The escalation policy must be rigorously applied and followed by all agencies.
- Multiple staff turnover over time needs to be considered as a risk factor given the potential area for practice gaps which can negatively impact decision-making and full view of the child's experience. Staff turnover featured heavily for almost all children reviewed.

In March 2022, a single-agency report was provided to the Independent Chair of the SSCP. The purpose of the report was to outline the progress and impact of the work. This report provided a largely, positive picture outlining that almost all children had seen their work safely closed or their situation had improved. It is noted that the ongoing presence of neglectful characteristics remains a challenge but an assessment of whether parenting was "good enough" remains a feature of the oversight of these children. The update reported that there was only one child whose circumstances had not improved; therefore her situation has been reviewed, escalated as needed, and she has been placed in care while further work with parents is undertaken.

A multi-agency action plan to address the issues raised by the review, with regular updates being provided to the SSCP Executive.

Responding to Inter-agency Escalations – The Finding a Solution Together Process (FaST)

During 2021, the SSCP undertook analysis of the existing escalation arrangements. This analysis found that practitioners were reluctant to initiate the escalation process as this was seen as a complaint-based process. The SSCP also found that:

- Practitioner confidence to initiate what has been perceived to be a combative process, was low

- There needed to be further clarification that professional disagreements should be resolved in the best interests of children at the earliest possible level; that is, by those working directly with children and their families
- Effective multi-agency resolution requires a culture that is collaborative, respectful and above all centred in the safety and well-being of children.

As a result of this analysis and based on feedback from frontline practitioners and their managers, the SSCP updated the escalation policy, which is now reframed as the Finding Solutions Together (FaST Resolutions process), addresses some challenges identified in the implementation and use of the current escalation process.

To enable the SSCP to effectively monitor and evaluate the effectiveness of the FaST Resolution Process, all key agencies (the Local Authority, the Integrated Care System, Surrey Police and MindWorks) has identified a single point of contact within their agency for all escalations moving on to stage 2 of the FaST process. To ensure the effectiveness of the FaST Resolutions Process, all escalations will be monitored by the SSCP Team and reported to the Business Group on a quarterly basis. The updated FaST Resolution Process can be found here: 7.2 The Surrey FaST Resolution Process | Surrey Safeguarding Children Partnership (procedures.org.uk)

The priority actions for Early Help are outlined as follows:

Working with Consent: We will ensure that an agreed multi-agency approach is in place with regards to requests for support being received without families' no consent to share information via a referral and where there is no statutory basis for overriding consent.

Consistency in the use and application of the Effective Family Resilience Model: We will work with partners to improve the understanding, use and application of the Effective Family Resilience Levels of Need document across the partnership.

The consistent use of Early Help Assessments by all key agencies.

Working with Partners to improve reduce the number of referrals that result in information and advice. There will be joint work with the Police and CSPA colleagues to keep a review of recently implemented pathways and how these are affecting the desired changes i.e. families and children supported on the scene via Family Information Service. The intended outcome of this to ensure that referrals are appropriate, that children and families received the help they need in a timely and proportionate way and that there is a reduction inappropriate requests for support to C-SPA.

Priority 2 Child and Adolescent Resilience and Support

The SSCP second priority in the period, 2021-2022 was child and adolescent resilience including Child and Adolescent Mental Health and Well-being, safeguarding children with SEN-D, contextual safeguarding and adolescent resilience in online spaces. As children and young people grow in independence and go into spaces and places away from the family home, they can become vulnerable to risks outside of the home. Emotional and mental health, SEN-D, contextual safeguarding and safeguarding children and adolescents in online spaces are all inter-related and interconnected issues. In response to these issues, the SSCP sought to build a joined-up approach that supports child and adolescent resilience.

Child and Adolescent Mental Health and Support

Child and adolescent emotional well-being and mental health was a very significant area of focus for the SSCP. This priority has been brought into sharper focus through the tragic deaths by suicide of 4 young people aged 14-17 and the attempted suicide of 2 young people in this age range.

In April 2021, Surrey went live with the Mental Health Alliance delivering the Child and Adolescent Mental Health Service across Surrey. Since they were commissioned, the Alliance has been active in getting a range of new support offers out to the community and have refined existing services. The Child and Adolescent Mental Health Service in Surrey is known as MindWorks.

The effect of this newly commissioned service is that more children and young people (CYP) are now accessing the early interventions offered by the Surrey Wellbeing Partnership. From April 2021, additional resources have been allocated to developing Early Interventions, and all partners providing services are now delivering to full capacity.

A better offer for schools has started to be delivered. This offer includes the fact that all Surrey maintained secondary and primary schools now have a named Primary Mental Health Worker. There is an Early Intervention Co-ordinator across each of the 11 districts and boroughs, and Surrey's special schools are being supported by MindWorks two new psychologists. CYP and families can now also access Community Wellbeing Practitioners (23 in total) for early support via referrals from schools or through the Access and Advice Team (AAT). There is also increasing access for children and young people to Cognitive Behaviour Therapy (CBT), groupwork and self-care packages, again accessed via schools directly or AAT. There is also support for schools to strengthen their whole school approach via the Mental Health Support Teams (MHST) and Surrey Healthy Schools.

There is now in place a 24-hour 7-day per week crisis line available for young people, families and professionals. Between May 2021 and February 2022, 2,207 children and young people and carers accessed support (together with 708 professionals). There is also an advice line focused on neurodevelopment. As of February 2022, 76 families accessed advice and support from the out-of-hours phone line. This was fewer than planned (the service's target was 5 families per week).

The Alliance has also launched a new website, which brings together information about resources and explains how to get help. The new website was designed with children and young people. Between September 2021 and January 2022, there have been 18,000 unique users who have viewed the site.

16,257 CYP have requested support from MindWorks Surrey between April 2021 to February 2022. This represents a 21% increase in referrals in comparison to 2020 to 2021. Within this figure, there has been a 38% increase in referrals for children under 10-years old, during this period, and the pressures within the services illustrates that CYP are coming to the service more unwell, with higher levels of acuity.

The changes in AAT have been welcomed and these create a better experience for children and young people. However, it is not operating efficiently and in March 2022, there were 1000 children waiting for help. A mitigation plan is being finalised to address the extra demand and will be in place by mid-April 2022, with immediate steps being taken to increase staffing to reduce the backlog. A transformation plan has been established and commences in April 2022 to ensure that a long-term solution to this repeated problem is designed and implemented.

Waiting times for assessment and treatment across all pathways needs to be reduced. This is a reflection of the national picture. Discussions with Surrey and Borders Partnership about how to tackle this are taking place and more staff are being recruited to manage this demand.

From feedback from schools, there is evidence that the work with schools and education providers is showing green shoots of success. Regular feedback is provided by schools via a range of forums. Further work is planned on improving early support to CYP and their parents / carers within primary school age is required.

Waiting times from referral to assessment is reducing from 1753 CYP on the waiting list in April 2021 to 706 CYP in February 2022. However, there are 400 CYP waiting between 366 and 545 days, and 273 CYP waiting over 546 days. Waiting times from assessment to treatment are reducing from 860 CYP in April 2021 to 495 CYP in February 2022, with 229 CYP waiting over 546 days. As noted above, these waiting times need to be reduced.

As noted above, the sustained challenge of the SSCP has been impactful in ensuring that this area of work continues to progress. The SSCP is assured that for the longer term, the governance arrangements are potentially more effective to ensure effective oversight. The SSCP is also assured by the developing relationship with the Mental Health Delivery Board, (the very latest information suggests that they have responded positively to the concerns raised by the SSCP for the need to streamline the governance arrangements for mental health and there is now a proposal to merge the Mental Health Partnership and Delivery Boards.

Contextual Safeguarding and Adolescent Safeguarding

In response to the SSCP priority related to Contextual Safeguarding (now identified as Adolescent Safeguarding), a new approach to safeguarding adolescents has been developed. This approach has been developed through engagement with approximately 500 representatives of partner agencies over the summer term 2021. This level of engagement was designed to ensure that there is an integrated model shaped to meet the needs of all adolescents.

Part of the structure and approach means that Surrey is committed to being 'child first' when we approach the range of issues that can present during adolescence. The Safeguarding Adolescents vision is driven forward by the 'Joining the Dots' group, which was established to bring together those working on missing, exploitation, hidden crime, youth justice, edge of care, resources, targeted youth support and safeguarding. The everyday work with adolescents is guided by 3 key principles:

1. Would this be good enough for my child?

2. What kind of adult do we want the young person to become?
3. Are we managing risk for the child and the organisation?

The approach has agreed the following success indicators:

- ***Meeting the needs of Children***: that is, identifying and understanding the factors that impact on the children and young people in surrey and ensuring we meet their needs
- ***Assessments represent a young person's journey and experience***: assessments that are timely and take into account the child's strengths, needs and risks - recognise the historical context and experiences of each child to inform our planning
- ***A direct offer of help to address any identified needs***: Practitioners who are able to invest time to build a strong trusting relationship with the child. Assessments that result in a direct offer to enable the mitigation of risks and best identify need.
- ***Assessments are dynamic, collaborative and adapt light of emerging needs and risk***: There is good evidence that children have been listened to and enabled to inform their own destiny.
- ***Interventions are tailored to meet the child's needs***: Tailored interventions in light of extra-familial harm with practitioners who are tenacious and who do not give up on the child and believing in them

In terms of next steps, the areas that require our priority focus include the need to review and re-establish risk assessment processes for adolescents in Surrey and clarify accountabilities. There is also a need to introduce a joined-up case formulation approach across adolescent services. As a safeguarding system we want to ensure consistency of safety planning to ensure family, child and practitioners are clear on agreeing actions to keep the child safe in the community.

To ensure that there is an effective response to safeguarding adolescents across all agencies in Surrey, we need to adopt innovative and smarter ways of creating a new model of practice that incorporates an early case formulation approach and access to resource panel at the point of referral/allocation. This will also include a review of the terms of reference, membership, frequency and scope of the High-Risk Vulnerability Panel and Risk Management Meetings. Related to this is the need to explore relationships and how, we as a system collaborate with other local panels. e.g. Joint Action Group, Community Harm and Risk Management Meetings.

Online Safeguarding

Evidence from our *Thematic Review of Adolescent Suicides in Surrey 2014-2020* and presentations to the Executive have highlighted the need to support children and young people to stay safe online. As part of our strategic safeguarding plan for 2021-2022, the SSCP committed to working with children, families, schools and key agencies to develop responses to staying safe and promoting well-being in online spaces.

To ensure that the SSCP had assurance regarding emerging risks as a result of technology assisted harm. The SSCP commissioned an Online-risks Tactical Group. The Group included representation from the Police, Health, the Local Authority and Education. The SSCP recognises all agencies that support children and families are increasingly called upon to respond to a range of emerging issues and online risks. These issues emerge quickly and need an urgent but coordinated multi-agency response. The purpose and function of the Online-risks Tactical Group is to lead a response on how all agencies will work together to respond to emergent-community-wide online and emerging risks which threaten children and young people's physical and emotional health and well-being.

During 2021-2022 the group responded to the following challenges:

- The Blue Whale Challenge – The "Blue Whale challenge" was reported to be an online "suicide game" aimed at teenagers which set 50 tasks over 50 days.
- National Rape Day – this was a viral thread which was posted on Facebook and TikTok in April 2021. A controversial video apparently called for widespread sexual violence on the 24th of April.
- Facebook self-harm challenge
- There was also an example where an urgent multi-agency response to the **cannabis edibles** issue arose and several different responses were required to mitigate the risks to children and young people.

Each of these risks were assessed and appropriate action plans and communication plans were agreed to safeguard children. The area of technology assisted harm remains a concern for the SSCP, especially with regarding to the SSCP's work in relation to adolescent vulnerability, adolescent suicide and the need for increased awareness of self-harm. In particular, there is concern about the role of social media in criminal exploitation, county lines, sexual exploitation, self-harm and suicidal ideation. This will remain an area of priority focus in 2022 to 2024.

Supporting Children and Young People with additional needs and disabilities who may be at risk

The focus of the SSCP's work in 2021-2022 in relation to safeguarding CYP with additional needs has focused on children and young people with Autistic Spectrum Conditions (ASC). ASC was identified in the SSCP's *Thematic Review of Adolescent Suicides in Surrey 2014-2020* and the National Child Mortality Database report on child and adolescent suicides published in October 2021 also included ASC as a risk factor for self-harm and suicide.

As part of the on-going response, Surrey launched its All-Age Autism Strategy. This strategy was developed by autistic children, young people, adults and family carers together with professionals from across Surrey's service system, to make our joint ambitions clear.

The SSCP is continuing to seek assurance that children with Education Health and Care Plans (EHCPs), who are also on a Child In Need plan, a Child Protection plan, and those Children who are Looked After by the Local Authority are effectively safeguarded and that their needs are being met. To support this continuing understanding, the SSCP's Learning from Practice Sub-Group has commissioned a multi-agency audit into children with Special Educational Needs and Disabilities. The results of this audit will be presented to the SSCP Executive during the Summer term of 2022.

Areas for improvement in 2022 includes ongoing activity to continue to focus on the early identification of need and support and reduce the need for a statutory plan to meet needs. We will continue to develop the early help offer for children with SEN-D further, so that it is available at the time children and their families require it and as a result, we see a reduction in requests for EHCP assessments and the demand for specialist services. We want to improve multi agency EHCP timeliness and to increase Annual Review completion rates with an enhanced focus on priority annual reviews. Surrey County Council will consult on and introduce a new Team around the School approach to maintain placements for children. We also want to strengthen engagement and coproduction with CYP, Family Voice and parents throughout the SEND Transformation Programme.

The SSCP welcomes the Government's recognition of the need to resource the SEND transformation programme and their commitment of an additional £100 million in funding.

Priority 3 improving the quality of our practice in relation to neglect

In setting this priority, the SSCP aimed to ensure that practitioners in all agencies are supported with the skills, awareness and tools to effectively intervene in cases where neglect is a factor. Specifically Partners aimed to achieve full implementation of an evidence- based tool through the utilisation of the GCP2 toolkit. The Partnership also wanted to be in a position to evaluate, monitor and challenge the impact of the GCP2 partnership response (including GCP2A an antenatal pilot) through the use of a multi-agency platform 'ECINS' and data capture for Neglect. Impact was also to be monitored through an SSCP audit and independent scrutiny. The Surrey Children's Workforce Academy also ensures that the learning with regard to neglect is taken forward across the wider partnership.

As noted above, a part of this priority included ensuring that Surrey multi-agency professionals are trained and confident in the utilisation of the GCP2 tool (and the screening tool which sits alongside it for professionals who have brief interventions with children and families). A related aim included improving awareness and understanding of Neglect within communities (public, voluntary services, community services for example) and sharing preventative messaging so that early identification can be achieved. The SSCP also undertook the oversight of the development of a Neglect communication strategy to be led by the SSCP Partnership team in order to achieve an increased understanding and a shared narrative of Neglect across the Partnership through the adoption of an evidence-based model and typology for Neglect.

During the reporting period, the roll out of the GCP2 tool has included training 768 GCP2 Practitioners across the partnership and the delivery of 6 courses for Managers in Children's Services and for Managers across Health. There has also been a range of bespoke workshops for CP Chairs. Other training opportunities has included:

- Practice sessions on DA, Adolescent neglect, report writing and strengths-based practice.
- Weekly ECINS workshops to 400 practitioners
- Produces a GCP2 Film – to be used for inductions and provides an overview of the of the GCPR2 Tool in Surrey
- Delivered action Learning sets for SCS Assessment teams
- Delivered Bitesize learning for DSLs
- Lunch 'n' learn sessions with expert speakers
- Delivered a refresher webinar, entitled part of your practice "Part of your Practice"

We have also launched a GCP2 pilot in a midwifery service. In 2021-2022, there has been 227 GCP2 assessments completed (139 on E-CINS and 27 in progress). A wide support network is in place to support the practice of GCP2 trained practitioners e.g. GCP2 Teams site, Champions & Practice Leads, Case Studies & other guidance documents, Practice sessions, monthly e-bulletins. Other developments include the Neglect Matters campaign which was launched with the aim of improving professionals' knowledge and raising awareness in the public community around how to spot the signs of neglect and what to do about it.

What we know when the Graded Care Profile 2 Tool is used, child and families experience a more effective response to neglect. However, the consistent use and application of the tool needs to be embedded across our system.

The Ofsted inspection in January 2022 found that

> The effectiveness and impact of interventions for children living in neglectful situations are not consistent. Senior managers have introduced a new assessment tool and trained all staff, as well as professionals from other agencies, but practice is not well embedded or applied across all teams or organisations. While some practice is highly effective when practitioners use this tool with families, other practitioners and partners have not adopted this better practice, meaning that some children continue to live in neglectful situations for too long.[9]

The role out of the GCP2 tool has been met with a variable response from schools and education settings. The GCP2 tool can be particularly useful in identifying what support might be needed at a Level 2 of the Effective Family Resilience framework, because of its capacity to specifically identify needs. In some primary schools, it is being used consistently both in school and at home – but this remains a very mixed picture. There is a fair amount of resistance to its use in the secondary phase. There are ongoing concerns/challenges by some school colleagues in all phases of the sector about the role of school professionals in carrying out such an assessment in the home. These challenges need to be resolved.

Throughout 2022-2024, the SSCP, through the Neglect Sub-Group will continue to seek evidence and assurance regarding the following outcomes across the Partnership for practitioners and for children and young people:

Outcomes For Practitioners

- Practitioners in all agencies are skilled at identifying and assessing neglect.
  - The GCP2 tool is used to identify and assess neglect (this means there is a common understanding of the types of neglect and the risks associated with neglect)
  - Neglect is identified and responded to early
  - Support is provided to safeguard children and strengthen parenting capacity

Outcomes For Children and Young People

- Children receive a timely and effective response to neglect
- The voice and lived experience of the child is heard and guides the intervention
- Children are supported to stay with their families in their communities when and where it is safe to do so
- Success is measured by improvements in the child's experience of care

The Neglect Strategy 2021-23 has 7 main aims which will be the focus of the work of the Neglect Sub-Group, and progress on these aims will be reported to the Business Group on a quarterly basis.

The SSCP will also seek assurance that the GCP2 tool has been embedded in all agencies across the Partnership. This evidence needs to demonstrate that we are making a positive difference for children by effectively identifying and intervening in cases of neglect. It is anticipated that a further 12 –18 months of focussed activity is required, with reviews at 6 monthly intervals to ensure pace of delivery. As neglect is a priority of the partnership and to date it has struggled to make sufficient progress the Neglect sub-group will update the Business group on a quarterly basis.

[9] Inspection of Surrey local authority children's services Inspection dates: 17 to 28 January 2022

Section 3: Learning from Case Reviews

In 2021-2022, the SSCP effectively cleared the backlog of Serious Case Reviews inherited from the erstwhile LSCB. The 4 remaining reviews were published in 2021.

Although published in 2021, these reviews related to serious safeguarding incidents which occurred from 2016 to 2019 and the learning from these and other reviews was published in the SSCP-Thematic-Review-Surrey-SCRs-and-Case-Reviews-2020-Final.pdf (surreyscp.org.uk) published in September 2020 and included in the SSCP Annual Report for 2019 to 2020.

In 2021-2022 the SSCP published one Serious Case Review and two local child safeguarding practice reviews.

The Serious Case Review related to the death of an infant who was subject to a child protection plan under the category of neglect.

Since the publication of this Serious Case Review, work has been done to strengthen contingency planning by the Child Protection Chairs. Practice guidance has been issued to all Chairs, and panels have been introduced across all quadrants to consider contingency planning before legal gateway meetings.

The learning from the Child Safeguarding Practice Review Panel's report, *Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm* (July 2020), has been shared widely across all agencies. This learning is included in training related to child protection and SUDIs. In addition, the SSCP has produced a 7-minute briefing (7MB) that can be used by managers and practitioners to share the learning from this review within teams. This 7MB has been published and is used to support practitioners' awareness and understanding in relation to SUDI. SSCP-Safer-Sleep-7-Minute-Briefing-1-1.pdf (surreyscp.org.uk). In addition, managers are promoting the use of a safer sleep assessment form that practitioners can use in their work with families.

To support the learning from this review, the SSCP published a thematic review of SUDI in 2021, highlighting the need for a whole system approach and the fact that all practitioners working with children and families are in a unique position to educate parents about safer sleep advice, and that these practitioners need to ensure that they understand and can explain information on safer sleep advice. The report can be accessed here: Child-Death-Review-Partnership-SUDI-thematic-review-002.pdf (surreyscp.org.uk)

We have shared the learning from this thematic review and the *Out of Routine* Report across our services and will continue to include the learning from this and similar cases in our training programmes and briefing sessions.

One of the LCSPRs related to injuries to a 7-week-old infant. The review found that there were missed opportunities to undertake assessments, especially in the absence of known risk factors and that there was a lack of professional curiosity and challenge around the information supplied by parents about father's first child. There was also a lack of focus on the role of fathers and significant males in families. There were also practice issues related to information sharing between agencies. This review also highlighted the importance of escalating concerns and the need to know how to raise concerns.

In response to this review, the SSCP has worked with the Surrey Children's Workforce Academy to ensure that practitioners are aware of the need to fully assess fathers' parenting capacity including when fathers are involved in ante-natal care and in the care of a new-born child. As a result of learning from Rapid Reviews and recently commissioned LSCPRs, this remains an area of continued focus.

Work has been done to ensure that when any agency is aware that a child has been removed from the care of a parent/s, including a child from a previous relationship, there is a need to inform the GP Practice. This would allow an entry to be flagged on both the Mother and Father's medical records and would ensure that the Practice is aware from the outset of any safeguarding concerns.

As noted above in this report, the SSCP has updated and rebranded its process for Escalation and Professional Disagreements. The SSCP has provided a range of briefings. This includes a YouTube video that is available to all agencies. Please see here FaST Resolution Process Spring 2022 - YouTube. To ensure that the SSCP is assured that professionals in individual partner agencies are aware of the procedure and that it is being used when concerns require escalation, key agencies have a single point of contact for escalations. Escalations are monitored and reported on a quarterly basis.

The local authority's approach to the pre-proceedings phase of the Public Law Outline (PLO) has been strengthened, this includes strengthening of practice and procedure in regard to Special Guardianship Orders

The second LCSPR was commissioned in 2020, and related to an incident in which a child experienced serious harm, in the form of a near fatal stabbing by a sibling.

In response to this review Surrey Police circulated a reminder to all officers in April 2021, reminding them of the need to consider the wider aspects of safeguarding when attending incidents; for example the need to think family, think child. Surrey Police has also significantly upgraded their Child Abuse Policy and Procedure and Officer training programme. This training specifically includes awareness and recognition of cultural issues in child neglect training sessions that have so far been delivered to over 1000 officers to date. Surrey Police also delivers training on Contextualised Safeguarding for both Surrey Police and Children's Services via the Surrey Children's Workforce Academy; and to date, Borough Commanders and members of the Child Exploitation Management Unit have been trained. Surrey Police has access to an Independent Advisory Group (IAG) that is made up of members from outside of policing and from different cultures, backgrounds and religions. The IAG are a valuable resource to Surrey Police and provide independent advice and support in raising awareness of cultural and specific community needs so that Surrey Police services are the best they can be.

This review highlighted the need for cultural awareness and for culturally relevant approaches to working with Gypsy, Roma and Traveller (GRT) Communities. To address the strategic and practice issues raised by the recommendations from this LSCPR, a range of initiatives have been put in place. Surrey County Council has commissioned anti-discrimination and cultural awareness training across Surrey to address the ongoing and established systemic issues that impact the way in which the Surrey system is able to identify and respond to the needs of the GRT communities effectively and a commitment to improving outcomes for GRT communities. Equality, Diversity and Inclusion is a significant priority for Surrey County Council. A corporate lead for Equality, Diversity and Inclusion (EDI) within Surrey County Council has been appointed and there is now a new EDI action plan which

has been endorsed by Cabinet. Also, an EDI hub has been set up to ensure that all staff have access to training, information and guidance to ensure culturally aware and inclusive practice.

Also in response to the recommendations of this review, the Child Protection (CP) Conference, Core Groups and Child In Need Meetings process has been reviewed. The effectiveness of CP Conferences, Core Groups and Child In Need meetings were audited in August 2020. As a result of this audit, the Core Groups and Child in Need procedures were updated in July 2021. These updated procedures highlight the need to have the correct membership of core groups and that key agencies are invited and supported to participate in CP processes. The updated procedures also outline clearly the expectations and responsibilities of core group members. This guidance is available via the procedures using the following link: 4.10 Implementation of Child Protection Plans | Surrey Safeguarding Children Partnership (procedures.org.uk)

The SSCP along with Children's Services has reviewed how key County Council, Borough Council and District Council Departments understand and fulfil their wider corporate and statutory roles and responsibilities. The District and Borough Councils has a representative on the SSCP Executive who provides challenge, oversight and accountability to ensure that Surrey's District and Borough Councils are fully sighted on their safeguarding responsibilities. The SSCP has a District and Borough Safeguarding Network which meets regularly. Each District and Borough has a named safeguarding lead. In addition, there are regular meetings with District and Borough council colleagues to ensure the full awareness of these councils of their responsibilities under Section 11 of the Children Act 2004 and Working Together 2018, and strong engagement in the county's safeguarding agenda. The District and Borough's Safeguarding Forum is focused on information exchange and on addressing issues where District and Borough councils can play important roles in shaping and implementing safeguarding policies and practice at a local level.

The SSCP is continuing to work with Surrey County Council's Children's Services and Early Help Providers to review and strengthen arrangements to ensure that practitioners from the Faith or Voluntary sector, who work directly with families on Child in Need or Child Protection Plans, or families who have an Early Help assessment, are included in Core Groups and Team Around the Family Meetings, as appropriate. On a strategic level the SSCP has included faith and third sector representation in our safeguarding arrangements. Surrey has a vibrant network of Third Sector and Voluntary Organisations. To ensure that the voice, experience and professionalism of the Third Sector is fully recognised and represented in our local safeguarding arrangements the SSCP has in place a Third Sector Safeguarding Network. Faith, Community and Voluntary sector representatives currently sit on the Partnership and work as part of the SSCP's Sub-Groups. We will continue to build on the current communications network to strengthen full involvement and leadership of the voluntary, community and faith sector in the work of safeguarding children and promoting their welfare.

Through the District and Borough's Safeguarding Forum, the SSCP will continue to work with District and Borough Councils to update and review their respective Priority Housing Protocols as needed to ensure that these protocols continue to meet the needs of children in need of safeguarding under Child Protection Plans or Court Orders under the Children Act, where accommodation is a key element of protecting children. Each District and Borough Council has in place a housing allocations policy and procedure, which outlines how they will discharge their responsibilities to children in need of help and protection under the Children Act 1989. This recommendation will be embedded as part of the District and Boroughs Safeguarding Forum's work plan throughout 2021-2022.

Learning from National and Local Child Safeguarding Practice Reviews

Learning from National and Local Child Safeguarding Practice Reviews is communicated through a range of channels including briefing papers, 7 Minute Briefings , termly SSCP briefings and Sharing the Learning workshops and regular Lunch and Learn sessions. All workshops and briefings are recorded so that they can be posted on the SSCP's YouTube channel, making them readily available to our partners and practitioners.

The Surrey Children's Workforce Academy attend both the Learning from Practice Sub-Group meetings and the Case Review Panel Sub- Group meetings and work closely with the SSCP to share the learning from Rapid Reviews and Local Child Safeguarding Practice Reviews.

Recommendations from each LSCPR and other reviews are tracked and monitored by the Case Review Subgroup and regular progress updates were requested from individual agencies. An action is only closed with the agreement of the Sub-Group members. Follow up audits can also be commissioned by the Case Review Group where evidence of change is required. The Learning from Practice group will lead on the commissioned audits and report back findings to the Case Review Group on completion.

The SSCP has published two Local Thematic Reviews (a SUDI Thematic Review 2021, and Surrey Child Death Review Partnership Neuro-disability and Infant and Child Deaths in Surrey: a Review of Deaths That Occurred Between 2016- 2020) and a further review of Adolescent Suicides is currently being undertaken. Clear guidance for the management of Serious Incidents and Rapid Reviews has been updated and published.

From January 2021 until 1 March 2022, the SSCP has had 13 Rapid Reviews following Serious Incident Notifications; 4 of these rapid reviews have resulted in LCSPRs; 3 have resulted in a partnership thematic review and 6 have resulted in no further action. The learning from each Rapid Review is shared across our system as needed and emerging themes are highlighted and presented in the SSCP's termly briefings.

Conclusions

The SSCP continues to make improvements in its work in responding to serious child safeguarding cases, undertaking Rapid Reviews in response to the notification of Serious Incidents and in the commissioning of LSCPRs. The SSCP also continues to strengthen its relationship with the Child Safeguarding Practice Review (the National Panel) and we are pleased that the National Panel have agreed with the SSCP's decision in the overwhelming majority of cases. The Case Review Sub-Group and the Learning from Practice Sub-Group work closely to ensure that the learning from these reviews are integrated into practice. This remains an area of development and focus for the SSCP. We are specifically concerned regarding the levels of assurance that the learning from LCSPRs and Rapid Reviews results in improved practice. There is a range of briefing activity across the SSCP including 7 Minute Briefings, termly briefings on emerging themes, practice issues and system-wide developments in multi-agency safeguarding, lunch and learn sessions, and preparation of a range of briefing summaries. The challenge is that we are not clear about how these are being used by practitioners and managers to share the learning and improve practice. This remains a question that Learning From Practice and the Case Review Sub-Groups are exploring. We know that there needs to be a closer link between the learning from Rapid Reviews and Local Child Safeguarding Practice Reviews.

Section 4: How We Have Listened to Children and Families

The SSCP's approach to listening to and responding to the voice of children and families is to primarily seek assurance from key agencies and to hold those agencies to account regarding the extent to which the voice of children and families is influential in shaping the services they provide.

The SSCP uses a number of mechanisms to reflect the voice and views of children and families, in developing our safeguarding arrangements. this includes:

- Rapid Reviews.
- Local Child Safeguarding Practice Reviews
- Multi-agency audits
- Direct feedback from children and families
- Working with the User Voice and Participation Team
- The Child Death Review Team also works closely with parents and families where there has been the sudden and unexpected death of a child. This work includes supporting families' engagement in Local Child Safeguarding Practice Reviews.

The SSCP oversees this activity through the work of the Engagement and Communications Sub-Group. During 2021-2022, the focus of this Sub-Group has been to seek assurance from all agencies across the Partnership regarding the ways in which they listen to children and young people and how they respond to their views and voice in commissioning and delivering services. Agencies attending the Sub-Group, present the ways in which their organisation or service has responded to children and young people.

BIG Survey 2021

The BIG survey is sent to all looked after children and care leavers annually. In the 2021 Big Survey, 50% of looked after children said they see or speak to their social worker once every 6 weeks, while 34% see their worker once a month or more. Young people told us this was a good amount. Contact tends to be face-to-face, but children report communicating with their worker over the phone (27%) and video call (23%), and secondary aged children via text (34%) and WhatsApp (11%).

Feedback from looked after children

The Big Survey 2021 asked secondary aged children if they knew who to speak to or where to go about their interests in careers and jobs. 85% of young people reported they did, while 15% did not know. The survey also asked if they felt they had enough information on education and career opportunities: 87% of young people either completely or partly agreed, while 13% did not feel they had enough information.

Feedback from Care Leavers

64% of care leavers felt completely able to manage their money and 32% felt partly able, giving a combined total of 96%. It is encouraging that only 4% do not feel confident in managing their finances. In 2020 the total number was 70% so this shows good improvement.

16% of care leavers did not know what bills they need to pay and a further 11% knew about only some bills. Although this is lower than 2020 there is still some work to do.

Care leavers were asked what made them happy, lots of examples were given which is positive and the most common themes were: “living, being happy, friends, family, working”. We also asked what caused them stress or anxiety and the most common responses were: “living, work, job, COVID, housing”. This shows us that more work needs to be done in supporting care leavers with their emotional wellbeing and mental health, housing and employment.

Three themes from young people

In seeking the voice of CYP, young people have identified the following issues:

1. Mental health support is important to all groups. They tell us they would like more support in improving their resilience rather than waiting to go into crisis to get support.
2. Young people tell us that they would like their workers to get to know them and acknowledge everyone is different. ‘Take the time to get to know us and spend quality time with us’
3. Young people want workers to be aware of what support is available for them. Be informed.

CYP have also identified the following, **Three must dos for professionals**

1. **Relationships:** *“If we want to, help us to keep in contact and maintain good relationships with our family and friends.”*
2. **Documentation:** “*Ensure our files and important documents such as ID and EHCP’s are kept up to date and are accessible.”*
3. **Quality Time:** *“Spend quality time with us!”*

In responding to children and young peoples’ expressed concerns, the SSCP has prioritised child and adolescent mental health, holding services to account for how they collectively respond in terms of the commissioning and delivery of services to children with poor mental health and in emotional distress. The SSCP has also prioritised and emphasised the importance of relationship-based practice, in adopting the Time For Kids Principles as part of our published arrangements. Throughout 2022-2024, we will review and improve our mechanisms for hearing and responding to the voice of children and families and where appropriate inviting them to be partners in the co-production of policies and approaches to multi-agency safeguarding.

Conclusions and Next Steps

This report demonstrates that the SSCP is functioning as a local child safeguarding partnership. the governance arrangements are working.

Like many local Safeguarding Children Partnerships, a significant challenge for key agencies includes recruitment and retention. This issue is particularly acute in Children's Social Care, Community Health Visiting and School Nursing and in the recruitment and retention of Child and Adolescent Mental Health practitioners. This is now a subject of discussion at Executive Meetings, and the safeguarding partners are working closely with each other to address this area as a matter of priority.

Throughout 2021-2022 the SSCP has worked carefully to strengthen our relationship with the Surrey Safeguarding Adult Board. The Independent Chairs and Partnership Managers of the SSCP and the SSAB meet on a quarterly basis to discuss issues of cross-cutting concern including retention and recruitment, transitional safeguarding, the needs of young carers, Domestic Homicide Reviews and Safeguarding Adult Reviews. Mental Health and Suicide Prevention has been a focus for both the SSCP and the SSAB and the Independent Chairs have made joint representation to the Health and Well-Being Board to highlight the need for an urgent response to the growing crisis in mental health.

What this report shows is that the governance arrangements are in place and are working in the sense that they enable the Safeguarding Partners to ensure that children are safeguarded, and their welfare is promoted. The local arrangements also enable the SSCP and partner agencies to collaborate and co-own the vision of how to achieve improved outcomes for children. The SSCP is al able to identify and analyse new safeguarding issues and emerging threats.

However, this report also clearly demonstrate that there is more work needed to ensure that the SSCP is able to ensure that learning is promoted and embedded in such away that local services for children and families are able to implement the required changes to ensure improved practice, which results in improved outcomes for children. The effective sharing of information across agencies to facilitate timely and more accurate decision making in the interests of children and families is not consistent and needs to be improved.

A significant gap in the work of the work of the partnership relates to the function of scrutiny, this includes the development and delivery of a plan for independent scrutiny of the SSCP's published arrangements. This aspect of the SSCP's functioning is under-developed and will need urgent attention in the next period

This report also highlights the need for the SSCP to be able to evidence clearly its role providing strategic leadership and in driving improvement in the quality of frontline practice. At present the quality of practice remains variable. Many of the areas for improvement are clearly understood and identified, however, there is a need to translate this knowledge and awareness into improved practice and improved outcomes for children.

The SSCP recognises the critical role of Schools and Education providers in safeguarding children and promoting their welfare. We know that when there is an effective working relationship between Education and Children's Social Care outcomes for children and families are improved; information is shared effectively, the use of Early Help Assessments informs requests for support and evidences the nature and level of concerns regarding safeguarding; escalation processes are used to build child-centred solution and resolve inter-agency disputes; there is good quality of engagement, interaction

and responsiveness between Schools and frontline practitioners and Managers; vulnerable children are identified, their needs are understood and assessed and key agencies who are involved in the child's life work well together to ensure that the child is safeguarded and that their well-being is promoted. The report on Legacy Cases demonstrates that the need for effective working with Education and is urgent.

Concluding comments from the Statutory Partners

The Statutory Partners for Surrey are satisfied that whilst recognising there are still improvements to be made, the Partnership continues to be effective overall in its work to support agencies to safeguard children and young people. The Partnership will however over the coming year monitor progress in the following areas:

- The development of system-wide consistency and less variability in the quality of multi-agency practice
- A focus on the quality and effectiveness of multi-agency involvement in child protection processes. Information from Local Child Safeguarding Practice Reviews and Rapid Reviews is that all agencies do not always participate in these processes From a SSCP perspective.

This activity will ensure that the Partnership will further strengthen its ability to support agencies in keeping children and young people safe in the future.

SSCP Priorities for 2022-2023

Child and Adolescent Mental Health and Emotional Well-being

Children's emotional well-being and mental health are the number one priority of the SSCP. In 2021-2022, there were 6 suicides of children under 18 years old. The incidents of self-harm and eating disorders are also increasing at an alarming rate. We want the Partnership work to secure support for children and young people's mental health and well-being.

The SSCP remains concerned regarding the re-commissioning and delivery of the new CAMHs contract and the emotional health and well-being of children and young people in Surrey more generally. The SSCP will have a keen interest in ensuring that this contract works for Surrey's children. The SSCP will:

1. Work with commissioners and providers to ensure that processes are in place to monitor the effectiveness of the delivery of the contract
2. We will ask commissioners and providers to offer evidence from parents, children and partners, that the CAMHs offer is working and that children receive the help they need when they need it.
3. We will seek to develop and embed a Child and Adolescent Mental Health Strategy that demonstrates that child and adolescent mental health and well-being is everybody's business.
4. We will develop and approve a self-harm protocol and will seek evidence that this protocol is working to improve practice and support to children and families where self-harm is a factor.

Neglect: improving the quality and timeliness of our practice in relation to neglect

Neglect remains one of the most prevalent forms of harm experienced by children in Surrey. Neglect is an urgent safeguarding issue which requires an urgent, skilled safeguarding response. We want to ensure that practitioners in all agencies are supported with the skills, awareness and tools to effectively intervene in cases where neglect is a factor. The outcome we want to achieve is that children identified as living in neglectful situations are identified and supported in a timely way so that their experience of care is improved, and impact of neglect is addressed:

- We want to see consistency in the effectiveness and impact of interventions for children living in neglectful situations.
- We want to see the use of the Graded Care Profile Two tool embedded across our safeguarding system across all teams and all relevant organisations.

Early Help and Thresholds: We want to ensure that thresholds are clearly understood, and consistently applied, with effective multi-agency working and clear pathways for support.

A great deal of work has been done in relation to early help in Surrey, including improving our understanding and application of thresholds and there is some evidence of improvement. However, there is still more work to be done. We want to ensure that

1. There is a shared understanding of thresholds with clear evidence of effective partnership working across all agencies
2. Levels of need and pathways of support are clearly understood and consistently applied across the system. There is evidence from practice (including audit) children and families and partners that this is working to keep children safe and promote their well-being
3. Threshold decision making is truly multi-agency with the voice of all partners being heard
4. Threshold decision making is transparent and consistent
5. The escalation process is effective in keeping children safe and resolving professional disagreements, within appropriate timescales and there is strong evidence to support this
6. Schools are recognised and valued as a key partner in multi-agency safeguarding.

The SSCP Budget 2022-2023

SSSCP Budget 2022-23	
Staffing	404,500
Non-Staffing:	
Independent Chair/Scrutineer	40,000
Training (Staff Development)	5,000
Venues	1,500
Miscellaneous	2,500
Subscriptions	1,500
ICT Development and Phones	5,000
Phew Internet	16,000
Independent Case Reviews	42,000
Innovation Budget	4,329
Staff Travel	4,400
Total 2021-22 Budget	**526,729**
Funded by:	
Partners' contributions	526,729
Total Contributions	**-526,729**