Surrey Safeguarding Children Board (SSCB)

Annual report

April 2014 - March 2015

Contents

Foreword

I am delighted to present the Surrey Safeguarding Children Board (SSCB) 2014-2015 annual report.

During 2014-2015 the SSCB has rigorously carried out its statutory functions under regulation five of the local safeguarding children board (LSCB) regulations to enable it to achieve its objectives under section 14 of the Children Act 2004, which are to coordinate and ensure the effectiveness of what is done by each person or body represented on the board, for the purpose of safeguarding and promoting the welfare of children within Surrey.

The period covered by this report has been one of considerable challenge for partner agencies and the SSCB in response to statutory inspection outcomes, restructuring of services within organisations to achieve more effective use of resources and the associated impacts of change throughout the partnership. The SSCB has met its statutory duties by responding proportionately and effectively to national and local issues, and acknowledges that there is still significant work to be undertaken to improve safeguarding outcomes for children and young people in Surrey.

The SSCB is appropriately resourced and during 2014-2015 has successfully maintained its financial viability through reviewing both staffing of the support team and the work methods employed to ensure value for money for the partners. A review of financial contributions has been agreed to be undertaken with a view to increasing contributions for the financial year 2016-2017.

Significant restructuring of services as a result of both local and national initiatives have had varying impacts upon services to children and families. The SSCB continues to monitor such changes and provides challenge to partners to ensure that there is no adverse impact upon children, young people and families in Surrey as a result of change within local services.

The SSCB has a strong and effective governance structure in place, which as it has become embedded into the board's work is having a positive and measureable impact upon the board's impact and ability to challenge and influence service developments. In particular, links are strengthening with the Health and Wellbeing Board, the Surrey Safeguarding Adults Board (SSAB) and the Children and Young People's Partnership and the Community Safety Partnership Board.

During 2014-2015 the SSCB published three serious case reviews and commissioned two new serious case reviews. Two partnership reviews were also undertaken and SSCB has proactively piloted a number of different methodologies in

approaching reviews and adopting the systems approach, as detailed in the Munro Report 2011. Additionally, in response to the need to understand the common recurring themes in serious case reviews and domestic homicide reviews and to reflect on the learning from practice audits, the SSCB conducts a mapping exercise of serious case reviews, domestic homicide reviews and audit recommendations to inform the planning of a series of practitioner workshops.

The SSCB proactively implements its published learning and improvement framework to identify where barriers to learning from serious case reviews, case reviews and audits being taken into frontline practice occur. Partners are challenged to review their single agency practices and share their findings to inform the wider partnership. The SSCB holds regular development events throughout the year to raise strategic awareness of key issues, challenges and emerging practice relating to changes in Government policy.

During the 2014-2015 reporting year the section 11 audit of statutory agencies was undertaken, and in parallel to this, a section 11 audit for schools was launched. The findings of both these audits are used to drive forward improvement and provide a health check of services throughout the county. The SSCB follows up the audit outcomes by offering bespoke support to partner organisations to support single agency service improvement and safeguarding arrangements.

Surrey local authority, partner agencies and the SSCB took part in a pilot integrated inspection in October-November 2014, which was undertaken by five inspectorates. This was a demanding process and challenge was undertaken in relation to the inspection outcomes, which resulted in the SSCB report not being published and the local authority report being published in June 2015. However, the SSCB undertook its own action plan and to ensure that the key areas of concern identified in the local authority inspection were scrutinised.

As a result of feedback from partners and OFSTED, the multi-agency thresholds document was amended in January 2015 to explicitly clarify Children's Services involvement in children in need work and the level of needs document is currently subject to further review and clarification.

In March 2015, key partners presented an update to the board on early help arrangements and the Surrey Family Support Programme and considered the recommendations arising from the SSCB early help audit. As a result of this a number of actions have been taken forward to the early help governance board.

Additionally in March 2015, there was an extraordinary meeting of the SSCB to agree the revised governance and operational arrangements for children missing and at risk of child sexual exploitation (CSE). This included the development of a

CSE strategy and action plan, enhanced training programme and clear pathways and risk assessment tools.

This annual report for 2014-2015 clearly demonstrates the significant amount of effective safeguarding activity undertaken by all partners within Surrey and the continuing challenges. It details the progress made against the four SSCB priorities and how partners are held to account to deliver improvements.

My thanks to all those who chair or are members of the various groups which make up the SSCB and to all practitioners within the children's workforce who demonstrate their commitment and passion to protecting children and to improving practice.

The challenge for the SSCB, as it moves forward, is to support and challenge partners in their improvement work and to increasingly demonstrate and evidence the impact of this activity on children's outcomes.

Alex Walters
Independent Chair, Surrey Safeguarding Children Board

The Surrey context

Surrey's children

There are approximately 278,248 children and young people, aged 0-19 living in Surrey of which 246,600 are under 18. The majority are safe, well educated and cared for. They also experience good health and have good leisure and employment opportunities and benefit from higher than average socio-economic circumstances.

Surrey has one of the lowest rates of child deprivation in the UK, with the most recent data indicating that there are approximately 10% of children and young people in Surrey, aged 0-19, living in low income households. There are indications that the current economic climate and welfare reforms are likely to increase family stress and hardship.

Children and young people from minority ethnic backgrounds account for 20% of children living in the area compared to a national average of 22%.

In Surrey more than 187 languages are spoken, however the proportion of children with English as an additional language remains below the national average.

The joint strategic needs assessment (JSNA) for Surrey acknowledges the significant impact that a positive parenting experience has upon a child's emotional wellbeing and development. Conversely the impact of a negative parenting experience can hinder the development of positive outcomes.

The JSNA focuses on the four priorities of the Children and Young People's Partnership:

- early help (including healthy behaviours)

- complex needs (including paediatric therapies)
- emotional wellbeing and mental health
- safeguarding (looked after children and domestic abuse).

The JSNA considers interrelated issues which can adversely impact the lives of children and young people from early years through to adulthood:

- parental mental health
- parental substance and alcohol abuse
- living in poverty/hardship
- domestic abuse
    - 53% of survivors of domestic abuse have a child under 16
    - young women aged 16-24 are at increased risk of domestic abuse
    - there is an increased risk of domestic abuse during pregnancy.

Within Surrey, some families have been identified as having multiple needs and require additional support:

Between 1 April 2014 and 31 March 2015:

- 1091 early help assessments were completed across the county of which 50% (539) related to children between 0 to 5 years old. 2% related to an unborn child.
- 2060 children were on the Surrey Children with Disabilities Register.
- 6610 children and young people countywide were receiving disability living allowance.

Key data at 31 March 2015

Children's Services:

- 995 children were subject to a child protection plan compared with 925 in 2014. Of the 995, 516 were male, 454 female and 25 relate to an unborn child.
- The category of abuse recorded is as follows: neglect (506), physical (52), sexual (48), emotional (359) and multi category (30).
- 779 children were looked after children compared with 793 in March 2014.
- 102 unaccompanied asylum seeking children.
- 9,979 children in need referrals were received in the year to 31 March 2015 compared with 11,777 in the year to 31 March 2014.

- 16,450 completed contacts were handled through the Multi Agency Safeguarding Hub of which approximately 97% were referrals from the police.
- The number of children subject to a repeat plan has decreased but still remains high. The percentage at the end of the 2014-2015 reporting year is 17%, compared to 20.2% in 2013-2014.
- The numbers of children whose plans ended after being the subject to a child protection plan for more than two years was 6.5% in comparison to 6.8% in March 2014.
- There were 779 looked after children as at 31st March 2015, and a total of 102 adoptions and special guardianship orders (SGOs) during the year, which is in line with the national trend for lower figures than in 2013-2014.

Education

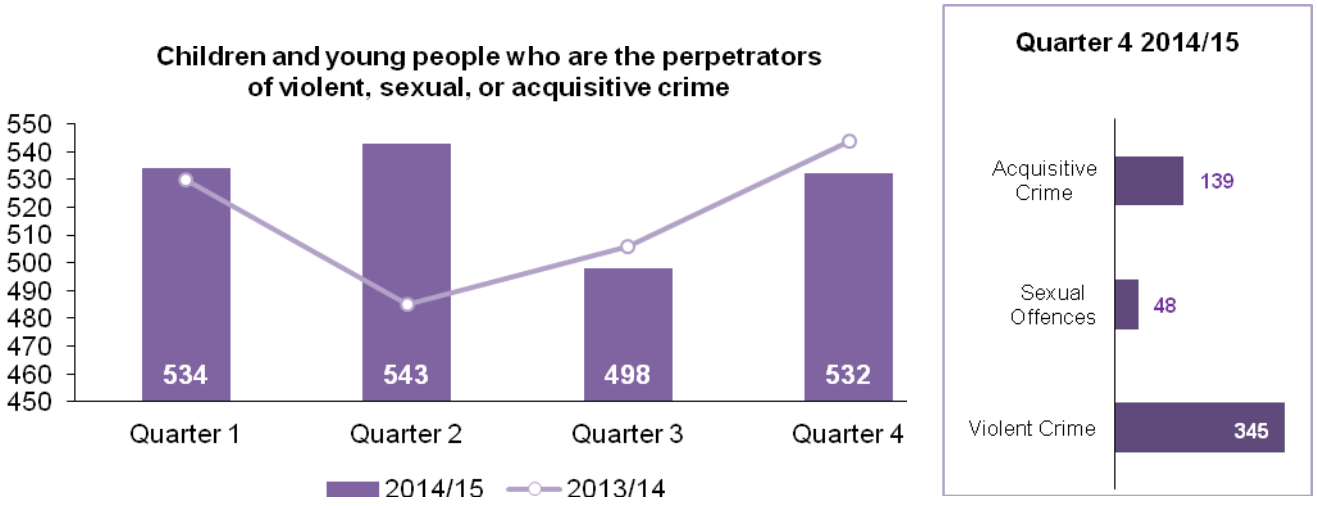
- Educational achievement shows that Surrey children continue to perform better across all key stages, in the majority of performance areas than their peers regionally and nationally.
- Over 87% of Surrey schools are now rated as good or outstanding by OFSTED compared with 81% in 2013-2014.
- 72% (over 50,600) of Surrey children under five years old are now registered at a Surrey children's centre compared with 62% last year. 53% (over 37,000) visited a centre in the last year compared with 45% last year.
- 80% (just under 4,500) of children under five years old living in disadvantaged areas are registered at a children's centre (9% more than 2013-2014) with 65% visiting a centre in the last year (7% more than 2013-2014).

Young People

- Number of children who are not in education, employment or training (NEET) in March 2015 was 548.
- The Youth Support Service homelessness prevention team placed 290 young people who presented as homeless in safe accommodation.
- Youth Support Services restorative intervention approach has contributed to a 90% reduction in the number of young people entering the youth justice system. Surrey had the lowest rate of first time entrants to the youth justice system of any youth offending team area in the country. At just 133 per 100,000 young people, compared to a national average of 409. Surrey achieved the lowest rate of young people who are NEET of any large local authority in England at 1.7%, compared to the south-east average of 4.2%.

- 326 young people at risk of becoming homeless were supported to prevent this happening, with only three young people spending one night each in bed and breakfast accommodation. Before the homelessness prevention service began there were usually more than 20 young people aged 16-17 in bed and breakfasts each night.
- Services for Young People engaged around 10,000 young people in high need communities in early help to build their resilience and reduce their risk of future negative outcomes.

Children and young people who are perpetrators of violent, sexual or acquisitive crime



Priority groups of vulnerable children

Gypsy, roma, traveller (GRT) and electively home educated children

The Children, Schools and Families Directorate is currently working with partners to implement 'brighter futures' which is Surrey's strategy for gypsy, roma and traveller children and young people (2014-2017). Surrey's traveller communities include fairground (known as showmen), circus, gypsy roma and Irish travellers. The latter two categories are recognised as minority ethnic groups and as such are afforded protection under the Equality Act 2010. Across a range of health, educational and social measures, outcomes for ethnic travellers are often poor compared to their Surrey peers and nationally. 'Brighter futures' seeks to tackle local inequalities and to work collaboratively with local GRT communities to improve outcomes and aspirations for Surrey's GRT children and young people.

Parents from the GRT community are keen for their children to achieve a basic standard of literacy and many children leave formal education after Key Stage 2 and join the adult community. High mobility and disengagement from formal education leads to implications for safeguarding. The race equality and minority achievement (REMA) team work with Surrey's traveller communities. Currently there are 945 traveller children accessing education in Surrey. There are also many more children from the traveller community whose parents choose not to ascribe their ethnicity for fear of prejudice and discrimination. There are presently 135 traveller children who are known to Surrey's elective home education department.
Under the law, education is compulsory but not school attendance. Parents or guardians can therefore elect to home educate at their discretion. Section 7 of the Education Act 1996 applies, which states that 'parents are required to provide efficient and full time education, suited to the child's age, ability, aptitude and take account of any special need the child may have'.

Local authorities have no statutory powers to monitor the quality of home education but have a duty to intervene if it appears that parents are not providing a full time, efficient and suitable education. The local authority is working hard to ensure that the legislation and guidance relating to elective home education is applied consistently and equally to GRT children and young people, as historically their cultural beliefs have been allowed to impact on ensuring the provision of 'full time, efficient and suitable' and a poor provision has been allowed to 'drift'.

The timeline for monitoring engagement has been tightened and the uploading of all elective home education students onto EMS will result in better recording, reporting and monitoring of home elective home education students. This will enable the local authority to pass young people who are not receiving a 'full time, efficient and suitable' education outside of school (as required in legislation) onto colleagues in the Education Welfare Service more quickly and efficiently.

At the end of June 2015 there were 811 children on the elective home education register, an increase of 130 across the academic year 2014-2015. 55 elective home education children have a statement of special educational need (SSEN) or education, health and care plan (EHCP). This is an increase of 13 across the academic year 2014-2015.

Female genital mutilation (FGM)

In March 2015, the Department of Health published guidance for professionals on managing the risk from FGM. FGM became a criminal offence under the Female Genital Mutilation Act of 2003. Under the Serious Crime Act 2015, the law governing FGM has been strengthened.

All NHS organisations are required to have local safeguarding protocols and procedures for helping children and young people at risk of FGM. Under the new guidance, NHS organisations have been asked to review their procedures in handling cases where FGM or the risk of FGM is alleged. These will need to conform to the overarching principles of working together 2015, but there needs to be specific procedures in place that consider the characteristics of FGM. This includes the information sharing protocols with partners throughout a girl's childhood.

The SSCB has, in response to this, established a task and finish group to develop a partnership wide response to this guidance. The group has four main strands of work:

- Scoping the extent of the problem of FGM in the county and mapping areas of risk.
- Researching good practice throughout the country to inform local practice.
- Reviewing and updating SSCB policies and procedures for FGM.
- Developing a training package for practitioners across all agencies.

This group is due to reconvene in September 2015 to review progress against each of these strands and an update provided to the SSCB.

Forced marriage/honour based abuse

The diversity crimes unit (DCU) is a small team of detectives with an office coordinator. The team are based in Guildford and cover the county and deal mainly with honour based abuse and forced marriage. Victims come to notice through various means. The DCU ensure that the victims of honour based abuse and forced marriage are safeguarded and a number of safeguarding measures are put in place.

Honour based crimes are particularly difficult to tackle without specialist knowledge or understanding. The abuse takes place at home, behind closed doors and victims are terrified of coming forward. They are fearful that the abuse will worsen, or worse case scenario that they might even be killed. Quite often it is fear of the unknown.

The DCU team ensure that a comprehensive honour based abuse risk assessment is completed. The history of the victim is very important. This includes how the victim has been brought up, their family routine, beliefs and culture which are essential in order to make the best risk assessment. When a potential victim of honour based abuse comes to the notice of the DCU, they are taken seriously and the risk is not underestimated. The victim is spoken to alone, away from family members, even if some creativity is needed to achieve this. The aim is to be victim led, taking into consideration their views and being mindful of not doing anything to heighten the risk

to them. Honour based abuse can escalate quickly from a not so serious incident to more serious incidents, especially when their family become aware of police or other agency involvement.

All agencies need to be aware that a person from a cultural background where honour is likely to be a risk factor, must give consideration to the implications of this even if this person comes to notice for an unrelated matter, such as a victim of sexual offence or even as a suspect for an offence. If this person is a child, the norm would be to inform the parents or use them as appropriate adults. However, in such circumstances this could make them a victim of honour based abuse or even a forced marriage.

In cases of risk of forced marriage, quite often evidence is questioned for a forced marriage protection order (FMPO) application by social services, legal teams and at court. The DCU works with legal services, the Forced Marriage Unit and social services to assist with the FMPO application.

The DCU aim to work together with other agencies and police departments to safeguard victims of honour based abuse or forced marriage. This includes raising awareness through training inputs.

Any challenges with the victim are usually overcome by gaining their trust and understanding their individual circumstances taking into consideration all factors. A single point of contact for the honour based abuse victim in the early stages is helpful as well as referring them to outside agencies for further support.

Between 1 April 2014 and 31 March 2015 there have been 57 recorded honour based abuse incidents:

- Eight people under the age of 18 have been victims.
- One incident has had two suspects under the age of 18 (assault).
- 42 people under the age of 18 years have been linked to incidents.

Private fostering

The family and friends team within Surrey's Fostering Service is accountable for discharging the local authority's responsibilities in respect of private fostering arrangements, as stipulated under the Children (private arrangements for fostering) Regulations 2005. The care services manager provides the strategic, developmental and operational lead, in compliance with the national minimum standards.

Surrey's statement of purpose for private fostering is updated annually. The document is available to staff, key stakeholders and the public.

An inspection by OFSTED in October 2014 noted that 'where private fostering arrangements are identified, initial visits are carried out within a week and private fostering assessments are carried out in a timely manner.' It was noted that the number of children known to be privately fostered was low. Awareness raising done in 2013-2014 was acknowledged, but pointed out that data is not collated about high risk groups to inform targeting of awareness raising work. A new communications strategy is being developed to ensure ongoing and targeted awareness raising to include these high risk groups.
No awareness raising had been done in 2014-2015 due to a high volume of special guardianship orders and connected persons fostering assessments being completed by the family and friends team. There have been 31 notifications of new private fostering arrangements received in 2014-2015, seven more than the previous year.

21 new arrangements started and 22 arrangements ended in 2014-2015. There were 11 children in private fostering arrangements on 31 March 2015.

Surrey Children's Services has exceeded the Government's performance indicators for private fostering in all four measured areas in 2014-2015

- The local authority responded to 96.8% of the notifications by means of an initial visit to the child, carer and premises. 93.3% of these visits were undertaken within the regulated seven working days timescale, a 6% improvement on performance last year.
- 100% of the fostering assessments due within the reporting year were completed within the regulated 42 working days timescale. There is no required performance set by the Department for Education in this regard, but Surrey has set an internal target of 70%.
- Compliance with statutory visits every six weeks to arrangements that started after 1 April 2014 was 95.2%. This reflects an 11.9% improvement on the performance in the previous year.
- Compliance with statutory visits to arrangements that started before 1 April 2014 (which could include both six weekly and 12 weekly visits) was 75%, reflecting a 16.7% improvement on the performance in the previous year.

From analysing information it would appear that children aged 10-15 years old living in private fostering arrangements which they have made themselves when choosing not to live at home, are more likely to be living in unsuitable arrangements. The risk of harm may not necessarily be imminent, but should not be ignored.
An information leaflet about private fostering is provided to parents and carers once notification of a private fostering arrangement had been received. There is a separate information leaflet for children to share the same information in an age

appropriate manner. This leaflet is currently being reviewed by the Children's Right's Service to ensure information is pitched appropriately.

Children in private fostering arrangements, private foster carers and parents are provided with advice and support throughout the duration of the private fostering arrangement. Satisfaction surveys are completed on a regular basis by children in private fostering arrangements to get feedback about the quality of service and support.

Children who are in a private fostering arrangement at the time of their 16th birthday qualify for an assessment of needs, information, guidance and advice from the Care Leavers Service. They are advised in writing how to access this support in future. The information is also included in Surrey's family and friend's policy.

Areas for improvement in 2015-2016

Strategic

- Develop a communication strategy to promote ongoing and targeted private fostering awareness raising and identify and notify high risk private fostering arrangements.

Operational

- Continue to maintain or exceed the Department for Education minimum requirements for private fostering performance indicators.
- Independent auditing of private fostering arrangements by the SSCB's quality assurance officer
- Further and regular auditing of private fostering arrangement by managers in the service
- Implementing any learning from auditing into practice

Development

- Awareness raising to staff within Surrey's four referral, assessment and intervention service teams

Children with special educational needs and disabilities (SEND)

Key achievements during 2014-2015

- Developed a vision, principles and analysis around SEND.
- Published a local offer of SEND for families and professionals.

- Surrey's local offer website went live in September 2014 and was commended by Department for Education.
- Joint needs analysis for therapies completed.
- Joint therapy forum established with agreed terms of reference.
- Joint therapies commissioning strategy agreed.
    - Joint commissioning strategy for speech and language therapy was drafted and consulted on.
    - A review of the occupational therapy service was jointly commissioned and was underway. Phase 1 was disseminated to partners.
    - Co-design events for new speech and language therapy service were underway.
- Joint strategic review of short breaks undertaken - Cabinet and clinical commissioning group (CCG) boards agreed recommendations for future of Applewood and Beeches. Recommendations include:
    - Surrey County Council to continue to run Applewood as a short break service.
    - The responsibility for funding short break services for children and young people currently accessing Beeches will transfer from Surrey CCGs to Surrey County Council.
- Implemented the SEND pathfinder pilot.
- New 0-25 business processes and planning systems for education, health and care plans (EHCP) and pre-statutory plans launched on target, 1 September 2014.
- A new pre-statutory/step down process (pathway process) that aligns with the early help assessment was agreed with education settings.
- Information and training rolled out to frontline staff and education settings. Some additional capacity was secured so that training could be offered to some social care teams and health colleagues. E-learning on the new business process started with Surrey and non-Surrey staff through the portal and the Surrey Skills Academy.
- Surrey consulted on and published its transition plan setting out a timetable for the transfer of children and young people with special educational needs (SEN) statements and learning difficulties assessments. As of March 2015 transfers were underway in line with the timetable.
- Surrey's implementation of the new mediation requirements of the legislation was confirmed as compliant by the Department for Education.
- Additional capacity was secured to accelerate work around personal budgets.

The Department for Education announced continuation of SEN reform grant funding for financial year 2015-2016. The minister has invited OFSTED to formally inspect local areas on effectiveness in fulfilling new duties.

The impact of these achievements is:

- Understanding a family's view of support is crucial. Work is underway to agree with family representatives a way of monitoring whether the new system is a more efficient, joined up and family-friendly experience and delivers the right outcomes for children, young people and families.

Challenges for the future:

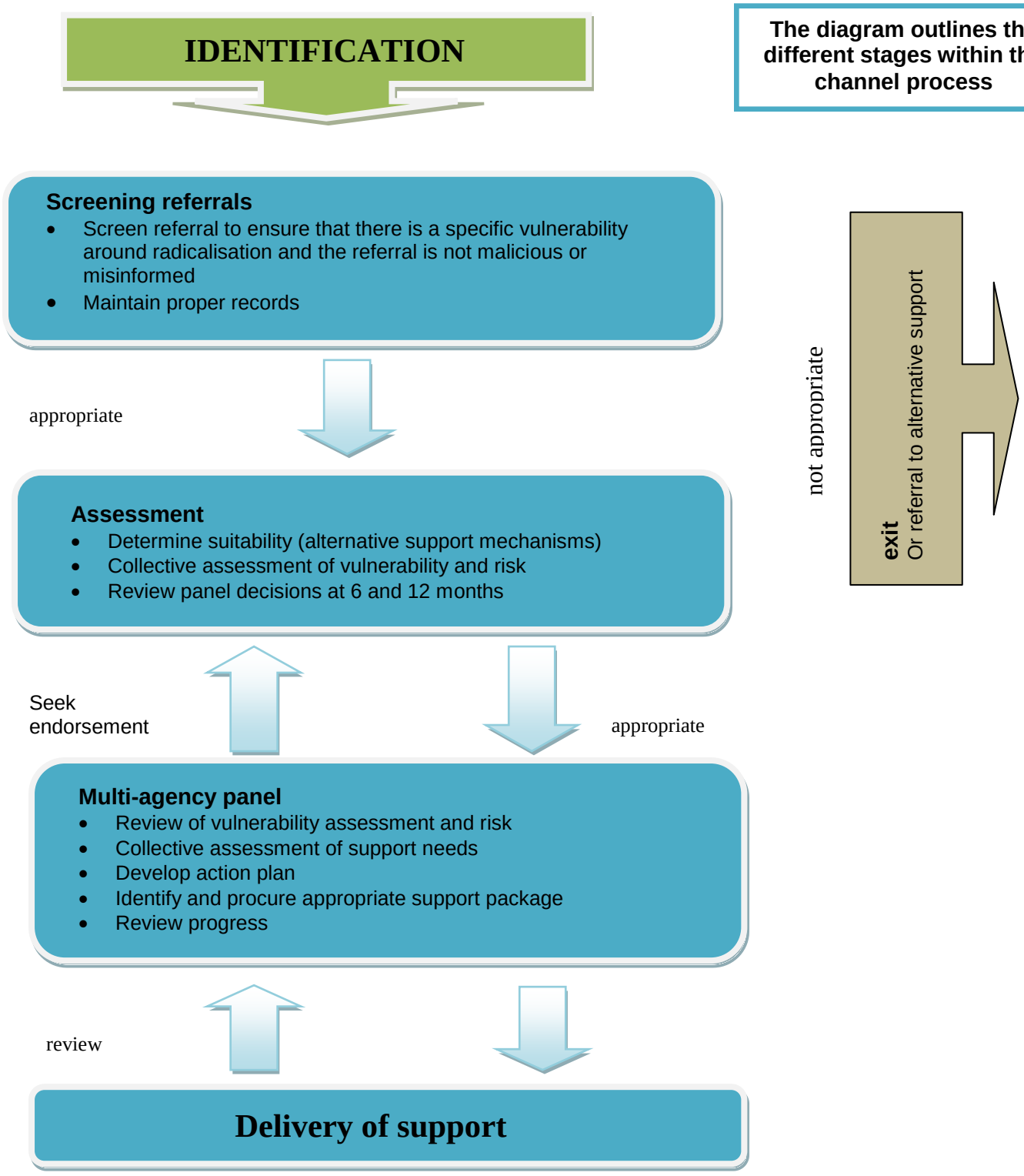
- The SEND system continues to face some significant challenges; working collaboratively to deliver a holistic customer journey, managing demand and cost pressures, and meeting legislative requirements.
- These will be addressed through a transformational SEND programme, to be signed off by the SEND Governance Board in September 2015. This aims to:
    - Transform the customer experience.
    - Rebuild the system around the customer.
    - Reshape the local offer.
    - Develop inclusive practice.

This is a three to five year programme that will change processes, provision, culture and ways of working.

Radicalisation

SSCB has received a presentation on the Prevent agenda and the flow chart below describes the pathway when cases are referred. An initial referral would be directed to the police and they would do the initial assessment to see if it fits the channel panel criteria. If it does, there would then be a multi-agency group meeting to discuss the case / issue and develop an action and / or support plan. If a referral does meet the criteria, there might still be a group discussion about how else the case / issue will be managed. All of this is predicated on the basis that the individual(s) concerned want to participate, they can choose not to and in that case the agencies concerned would want to discuss how they now deal with the referral.

The diagram outlines the different stages within the channel process



Effectiveness of local safeguarding arrangements and outcomes for children

The role of Surrey Safeguarding Children Board

Surrey Safeguarding Children Board (SSCB) was established in April 2006 and is chaired by an independent chair, Alex Walters, who is independent of any organisation working within Surrey. Alex Walters was appointed to the SSCB in September 2011.

The SSCB is the key statutory mechanism for agreeing how the relevant organisations in Surrey will cooperate to safeguard and promote the welfare of children and ensure the effectiveness of what they do and provide strategic oversight.

The two objectives of the SSCB as set down in 'Working Together to Safeguard Children 2015' are:

- To coordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in their area.
- Ensure the effectiveness of what is done by each such person or body for that purpose.

This entails a wide range of responsibilities across the Surrey area including:

- Establishing and monitoring thresholds for the provision of services by partner agencies.
- Developing policies and procedures for safeguarding and promoting the welfare of children in the area.

- Commissioning and evaluating single and multi-agency training.
- Establishing specific, local protocols to reflect local priorities.
- Communicating and raising awareness of how to safeguard and protect children in the area.
- Monitoring and evaluating the activities of partners through S11 and auditing activity.
- Undertake reviews of child deaths and conducting serious case reviews to identify lessons to be learned.
- Maintain and implement a Learning and Improvement Framework.

In the wider Surrey context the SSCB has a statutory scrutiny and monitoring role in relation to the Children and Young People's Partnership (CYPP) and the themed partnerships working within the CYPP and holds them to account in their work to improve outcomes for children and young people. This scrutiny function applies to the Health and Wellbeing Board and other statutory partnerships such as the Community Safety Board (CSB) where there are issues that impact upon the safety of children.

In addition to the statutory functions of the SSCB, the 2012-2015 SSCB Business plan identified **four targeted priority areas** of focus. Progress towards these priorities is reported on throughout this annual report and in Appendix A.

How safe are children and young people in Surrey?

In October/November 2014 OFSTED, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspector of Prisons (HMIP) and Her Majesty's Inspector of Probation (HMIP), undertook a joint integrated pilot inspection and review of the local safeguarding children board (LSCB) partnership, with agreement that only the local authority and the LSCB reports were to be published.

The SSCB was disappointed that the design and delivery of the joint review of the SSCB was flawed and resulted in judgements that did not reflect the evidence. The SSCB formally complained to OFSTED and the outcome was the decision not to publish the SSCB report.

The local authority report is being published during June 2015 and the findings of this report conclude that aspects of Children's Services work are inadequate and that in some contexts children are not being kept safe.

The SSCB has already sought assurance on key practice areas identified in the local authority report specifically in relation to early help, children in need, missing children and those at risk of child sexual exploitation and has identified through the range of audits undertaken by the SSCB specific areas for practice improvement.

The SSCB will continue to undertake an oversight and scrutiny role in relation to the improvements required from all partner agencies involved in this and subsequent inspections and the SSCB's own improvement plan.

Impact and role of SSCB in monitoring service effectiveness:

The SSCB measures and monitors the effectiveness of safeguarding arrangements in a number of ways including:

- Individual case analysis including child deaths, serious case reviews partnership reviews and multi-agency audits.
- Review of performance management information.
- Monitoring single and multi-agency training.
- Section 11 safeguarding self assessment by all statutory partners including schools.
- Multi-agency reporting from area sub groups.
- Feedback from staff, children and young people and their families.
- Regular reports to the board providing evidence of key safeguarding performance i.e. independent reviewing officers' annual report, annual complaints reports, local authority designated officer (LADO) reports, MAPPA and MARAC arrangements.
- Challenges and concerns that are brought to the attention of the board by partners or regulators.

The SSCB maintains a challenge log, with separate more detailed logs being maintained relating to key issues requiring greater levels of scrutiny and monitoring. This ensures that focus is maintained on ongoing concerns and that a proportionate and appropriate response is achieved.

SSCB: abridged challenge log
June 2014 – March 2015

Date	Subject	Challenge	Action / update
2014-2015	**Private hospital provider**	Assurances relating to safe practice, tier 4 availability of beds, commissioning, sustaining improvement	Regular reports to SSCB from NHS England and CCG on progress against improvements.
10 Mar 2015	**Children and Family Court Advisory Support Service (CAFCASS)**	Impact of budget cuts.	Chair wrote to CAFCASS to seek some assurance about the impact of this decision to cut budgets and keep open 2 vacancies on the timeliness of the work of CAFCASS officers and whether this may mean delays in the system of both public and private proceedings for children.
09 June 2014	**Signs of safety**	Multi agency challenge to the impact of the proposed approach to adopting Signs of Safety in a short timescale / Funding (July 14).	Revisiting by Children's Service of proposals, further exploration of options and update to May 2015 board of the revised proposal to adopt a Strengthening Families approach. Further detailed presentation to July 2015 board of what this would look like for the partnership.
09 June 2014 Development Event	**Barriers to embedding learning from QA activity**	Event focussing on strategic issues relating to embedding learning into practice.	Presentations, discussion and challenge to partners to address identified barriers – which are through audit and practitioner feedback in workshops.
29 July 2014	**Child protection chairs report**	Lack of adequate narrative accuracy of data; actions of partners to address number of children on plan for over 24 months; why are cases getting stuck – are joint supervision opportunities / escalation procedures being followed. Attendance at conference.	Members to take back challenges and respond to these. Further detailed narrative to be provided to September 2014 board.
10 Mar 2015	**Named GP** presented response to challenge re attendance at CP conferences.	Challenges for GPs: conflicting priorities; short notice of child protection conferences versus clinical responsibilities. Getting information to the table- GPs need to be engaged in decision making 97% non attendance reiterated to not be acceptable.	Task and finish group to be established to agree a way forward and present update to July 2015 board.

Date	Subject	Challenge	Action / update
29 July 2014	**CAMHS Provision**	SSCB had received two letters, from London LSCBs, in relation to CAMHS provision at an independent school for disabled children in Surrey.	Letters from chair to seek clarity and assurance from CAMHS commissioners.
30 Sept 2014	**Child death overview panel (CDOP) annual report**	Capacity issues in CDOP raised	CCG Commissioning a further report to review capacity and arrangements and report to SSCB when completed (July 2015).
30 Sept 2014	**CSE (Rotherham report)**	Assurance of the capacity in Surrey to respond to this report and other published reports. Assurance sought by council leader about sufficiency of Surrey provision.	See section on CSE development.
10 Mar 2015	**CSE update**	Insufficient time on agenda to discuss this priority area of work and the development work post Rotherham reporting.	Extraordinary meeting focusing solely on CSE agenda to be scheduled for late March 2015.
30 Sept 2014	**Training**	Negative impact on budget of non-attendees - need to increase fees; non returnable booking fee to be introduced.	£12 non-returnable booking fee for all delegates including partners to be introduced for courses for 01 April 2015. Partners to offer more free training venues for MA delivery.
10 Mar 2015		Operational systems not in place to reimburse staff the £12 fee.	£12 fee has had a significant impact now implemented – positive impact on budget in moving towards a break even position. Decision to charge £12 ratified by SSCB – agencies need to develop / agree systems.
25 Nov 2014	**School nurse / health visitor capacity report**	Capacity issues raised by Public Health. Report needed contribution from other health partners.	Report to May 2015 board.
25 Nov 2014	**Data set**	Incomplete data – CAMHS. No missing children data. Concerns re high number of home educated children. Narrative is incomplete – CSE Data needs greater analysis. Why are child protection referrals higher than statistical neighbours?	SSCB officer / quality assurance group to take forward actions and improve data set for Q3.
12 May 2015	**Data set Q3**	Gaps still evident - housing data problematic, education and police data missing.	Further actions for Q4 data reflected in minutes. Missing children return interviews

Date	Subject	Challenge	Action / update
		Return interviews remain non compliant with statutory guidance.	update to arrangements to report to SSCB in July 2015.
25 Nov 2014	**LADO report**	Lack of referrals from health capacity due to 50% increase in national fostering agency (NFA) referrals which require investigation.	Health colleagues to take forward and report back how concern will be addressed. Additional capacity recruited.
25 Nov 2014	**Private fostering report**	Data shows 29% reduction in children being privately fostered.	Professional challenge particularly awareness raising within health to encourage health visitors to challenge who children are when they visit homes and ask about arrangements. Named doctor to reinforce the need to identify private fostering and raise GP awareness of recent campaign.
25 Nov 2014	**Missing children**	CSE need to review and improve current arrangements - return interviews not in place assurance given that these will be in place by January 2015.	CSE sub group to take forward and update SSCB.
25 Nov 2014	**Safeguarding adolescents**	To all partners to develop adolescent centred services and raise awareness of specific challenges in keeping adolescents safe.	Development event theme for SSCB May 2015 to explore issues further.
27 Jan 2015	**NHS attendance at SSCB**	Proposed arrangements for CCG to cover and for NHS England to attend health sub-group not acceptable to board.	Chair to discuss with NHS England and resolve and take to National AILC.
27 Jan 2015	**Section 11 report**	Woking BC to complete section 11.	Head of safeguarding to discuss with Woking BC.
27 Jan 2015	**Prevent**	To clarify arrangements in Surrey through CSPB.	Presentation to May 2015 development day and opportunity to seeks assurance re processes in place/in development.
10 Mar 2015	**Early help**	Significant challenges highlighted by partners across different fora.	See separate **early help challenge log.**
10 Mar 2015	**Family Support Programme (FSP) and roll out to phase 2.**	Representation required on the SSCB.	Report to provide assurance to board presented May 2015. Strategic lead covers both FSP and early help from June 2015 and now sits on the SSCB.

SSCB – monitoring of business plan targeted priorities:

Targeted priority 1: To work with partner agencies to reduce incidences of domestic violence and the impact this has on children, young people and families.

The Community Safety Board (CSB) leads on the multi-agency priority of domestic abuse for Surrey, linking closely with the Health and Wellbeing Board (HWB), who details domestic abuse within its safeguarding priority.

In January 2014, the domestic abuse strategy was presented and endorsed by the SSCB and throughout 2014-2015 there has been regular reporting of progress. The strategy is to be delivered by the domestic abuse development group through a variety of work streams and is overseen by the Community Safety Board.

The domestic abuse strategy has a shared partnership aim:

> 'To ensure all those affected by domestic abuse have the right information, services and support, at the earliest opportunity, to live lives free from domestic violence or abuse and gain the personal confidence to build healthy relationships for themselves and their dependants.'

An action plan is in place which focuses on the three themes of prevention, early intervention and response.

SSCB undertook two audits in relation to domestic abuse in 2013-2014 and the learning from these informed the domestic abuse strategy 2013-18.

SSCB audit findings:

- SSCB audit demonstrated good multi agency working in high proportion of cases which was supported by feedback from professionals.
- Early help assessment is embedding into practice and was demonstrated to be being used to measure the impact of domestic abuse on the child.

Challenges/concerns

- Domestic abuse risk assessment tools not adopted by all partners – some are not using any risk assessment tool.
- Perpetrator programmes not available to perpetrators not convicted of an offence to support behaviour change.

- Reach of support for victims raised as a concern.
- Counselling and support services for children experiencing / witnessing domestic abuse were found to be limited, not easily identified by professionals and not easily accessed.
- Male partners / fathers not seen in a timely way or included in the risk assessment.
- Lack of easily accessible information about where agencies can get information about resources, especially which domestic abuse outreach service covers which particular area. ESDAS and Your Sanctuary were well known, but are not the exclusive providers of services for the whole of Surrey.
- Information sharing was not taking place in a timely manner.

SSCB remains concerned that there is limited specialist support work currently being undertaken, which directly supports children affected by domestic abuse across the county and welcomes the approach to addressing this gap in service provision.

Children's Services has commissioned and awarded a two year grant to Surrey domestic abuse outreach providers to deliver support for children and young people affected by domestic abuse. This will cover prevention (healthy relationships), early help (step-down community support) and intervention (support for children and young people on a child in need plan or child protection plan). This grant will start on 1 June 2015.

The Office of the Police and Crime Commissioner (OPCC) has provided £16,000 to each of the four domestic abuse outreach providers to deliver 1:1 support for children affected by domestic abuse.

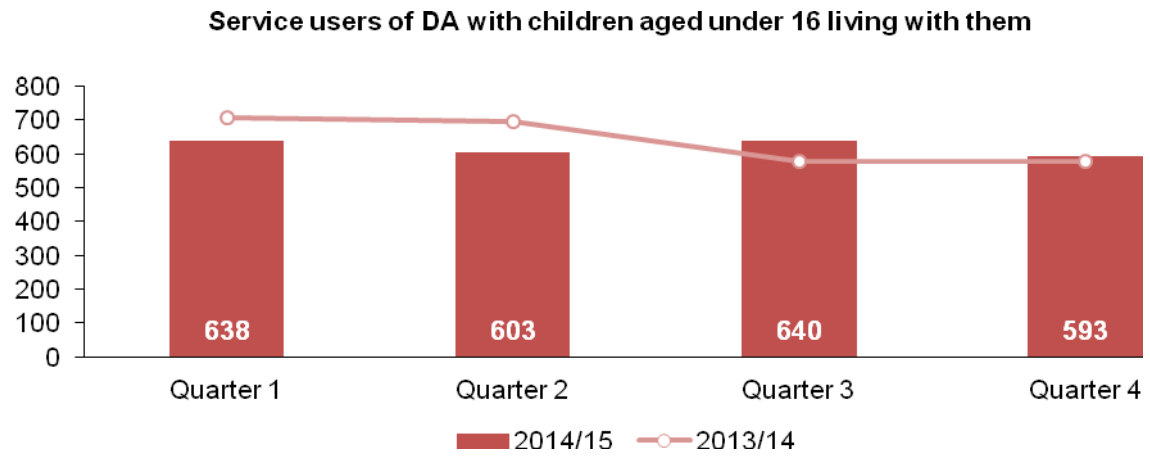
The LINX programme in Surrey is being rolled out to in recognition of the real need to support young people who have witnessed domestic abuse. 37 workers trained to deliver LINX, as at April 2015, have reported increased confidence in talking to young people about domestic abuse in their day to day work. The topic has been embedded in wider relationship and sex education programmes with groups of young people and within 1:1 work for those who are known to have witnessed domestic abuse or experienced poor treatment in intimate relationships.

Work is also underway to develop a pilot perpetrator intervention programme and is expected to be commissioned for 2016-2017.

SSCB will continue to maintain this as a targeted priority for 2015-2016.

The SSCB report card was updated to provide data relating to support for children and young people living in households with domestic abuse.

	2014-2015	2013-2014	2012-2013
New contacts / referrals to Surrey domestic abuse outreach services.	3,573	3,313	3,210
Number of new services users with children under 16.	1,872	1,996	1,705
Number of new services users with children living with them.	2,474	2,559	2,327
Total number of children affected by domestic abuse supported by outreach services.	3,111	3,305	2,897
Number of 16-17 year olds accessing Surrey domestic abuse outreach services.	58	48	20
Total number of incidents of domestic abuse reported to police (includes crime and non-crime incidents).	13,873	13,439	11,806



The Domestic Violence Protection Notice (DPVN) and Domestic Violence Protection Order (DVPO) were introduced in June 2014 in Surrey and are aimed at perpetrators who present an ongoing risk of violence to the victim and family with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of perpetrators.

The DVPN/DVPO process builds on existing procedures and bridges the current protective gap, providing immediate emergency protection for the victim and allowing

them protected space to explore the options available to them and make informed decisions regarding their safety.

Domestic Violence Protection Orders where there were children in the family

	2014-2015			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
DVPO where there are children in the family.	-	17	9	13
Number of children in the families.	-	27	17	18

Targeted priority 2: To ensure sufficient, timely and effective early help for children and families who do not meet the thresholds for children's social care.

Surrey's early help strategy 2013-2017 and the multi agency level of needs document (March 2014) were signed off through the children and young people's partnership structure in 2013 and are currently under review to include:

- The early help pathway including the relationship with other care and support pathways.
- The contribution of multi-agency safeguarding hub (MASH) developments to early help provision.
- The role of schools and early help.
- Information sharing across agencies.
- Development and roll out of electronically available early help application.
- Developing the workforce and local networks to support early help.
- Increase the use of early help tools and guidance to inform practice.
- Developing social capacity to support children and families.

In October/November 2014, OFSTED inspected the local authority and concerns were raised in respect to children in need services and cases being stepped down and difficulties in interpretation of thresholds for intervention by professionals.

Partners independently had reported a lack of clarity between levels 2 and 3 in the threshold document and particular concerns about the management of section 17 children in need cases. There is a lack of clarity of the referral pathway and a degree of confusion amongst professionals as to which of the front doors to Children's Services referrers should use. The SSCB has engaged in the partnership's

development and has been monitoring the effectiveness of its work programme throughout 2014-2015.

Reports updating on activity to address these concerns and to provide clarity on processes were presented at the March 2015 SSCB meeting.

The SSCB at this meeting also presented the findings of the multi-agency audit on early help with the agreed recommendations being taken forward by the early help governance board.

The SSCB multi-agency audit highlighted a complex early help system with many different strands.

The change in Children's Services structures to the referral assessment and intervention teams from more traditional structures, revised step up and step down processes and the introduction of special educational needs and disability (SEND) against a backdrop of challenging budgetary climates all happening concurrently led to anxieties and uncertainty being evident. Partners were particularly anxious about step down processes and found that they had inconsistent support from Children's Services as they embedded new structures and revised practices.

A lack of monitoring and performance data, including case tracking of step down cases has hindered the SSCB's opportunity to explore further what the concerns were and whether these were symptomatic of change being introduced or a problem with the process itself.

Achievements 2014-2015:

- The majority of early help assessments were completed in a timely manner within timescales.
- Tier one – early help assessment stage works well for children 0-5 years old and children with a disability.
- Training was reported as being good but rolled out too slowly.

Areas for improvement:

- Confusion amongst agencies of how the various strands of the system fit together.
- Lack of knowledge about resources available.
- Concerns about administration processes.
- Tracking and monitoring of the impact of step down processes.
- Early help e-assessment to be expedited.

- Understanding of how step down is working with schools.
- Training content to be reviewed to ensure that there is understanding of the lead professional role particularly.

The e-help system is an electronic multi-agency web-based tool to record and share early help activity. The e-help system is now being used by the early help Partnership Service to record all paper early help assessments completed by practitioners in the community. This includes reporting of early help activity. The wider roll out of the e-help system is being reviewed, to ensure it is co-ordinated and enhances the Multi-Agency Safeguarding Hub (MASH) and early offer of help developments.

Multi-Agency Safeguarding Hub (MASH)

The current MASH based at Guildford Police Station contains the police, adult services, health, the mental health trust and children' services. Currently it processes only police notifications for adults and children's safeguarding concerns.

The safeguarding partnership in Surrey is working with a consultancy skilled in setting up MASH arrangements across the country. A new multi-agency model for delivering services to children and families and adults in Surrey will be introduced in 2016. This model will develop the existing MASH.

The MASH will be a single point of entry for all referrals, notifications and police reports in Surrey which includes where there is a need for early help support or where there is a specific concern about the welfare of a child, young person or vulnerable adult. The MASH will bring together a variety of agencies into an integrated co-located multi-agency team; where information is shared appropriately and securely on children, families and adults around the child or young person in order to make timely and appropriate decisions.

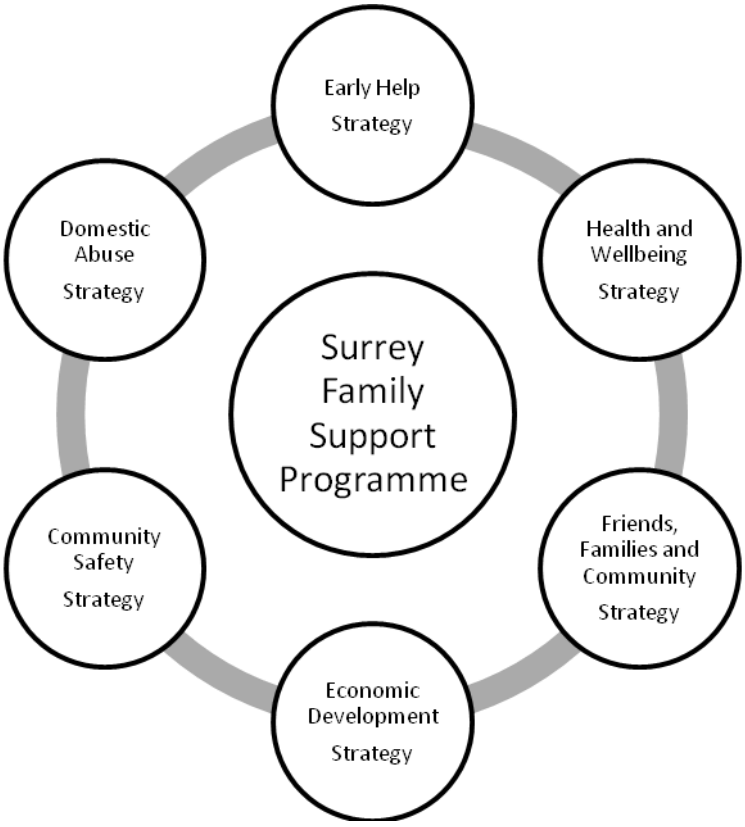
By working closely together across professional boundaries MASH will help to ensure early identification of concerns and provisions of help, which is vital in promoting the wellbeing of children, young people and adults.

In the year to 31 March 2015, 9,979 children in need referrals were received compared with 11,777 in the year to 31 March 2014. 16,450 completed contacts were handled via the Multi-Agency Safeguarding Hub of which approximately 97% were police referrals.

Family Support Programme

The Family Support Programme (FSP) has been successfully developed and implemented since the pilot project in 2012 and services commenced in April 2013. FSP enables a multi-agency approach to support families with multiple and complex needs. The programme is directed at families who are struggling, where numerous professionals and agencies are working with the family and where there is a risk that without a coordinated approach the family may drift into acute services.

The FSP programme works with the key countywide strategies working with vulnerable communities and families and makes a significant contribution towards the Children's Services early help strategy.



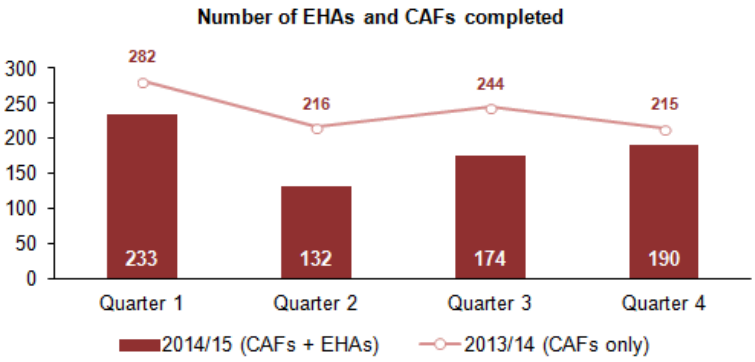
All families who receive intensive support through the programme undergo an early help assessment which assesses the needs of all members of the family. Where there is already an early help assessment in place or where another assessment has been completed, eg children's social care assessment, this is expanded to include all members of the family.

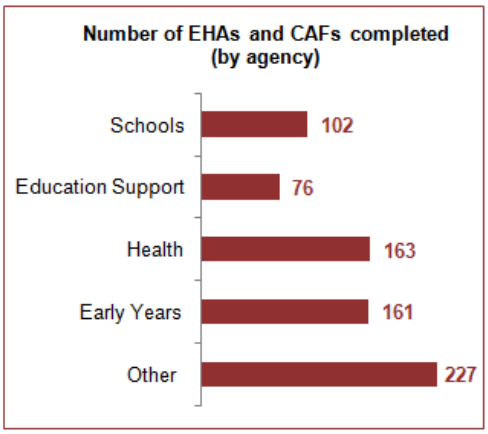
All assessments address safeguarding concerns and include the voice of individual children. 29% of all the early help assessments completed in 2014-2015 have been completed by Family Support Programme staff.

FSP Phase 1 impact data

Based on assessment data from a sample of 113 families at the point of joining the programme:

- 67% of families had children who were significantly missing school and or being excluded from school.
- 57% of families were involved in crime and or anti-social behaviour.
- 66% of families had at least one adult member who was in receipt of an out of work benefit.
- 33% of families had children with current or a recent history of involvement with children's safeguarding services.
- 33% of families had a recent history of domestic abuse and or violence.
- 51% of families had mental ill health.
- 30% of families had a young person not in educational, employment or training (NEET) young person(s).
- 27% of families were at risk of being homeless.
- 17% of families had inter-generational unemployment/NEET.
- 9% of families included an ex-prisoner.





*Other includes Family Support Programme, Youth Support Services, Youth Justice, Housing Social Care, Police Voluntary Organisations, Welcare, Home Start and unknown.

Targeted priority 3: To ensure professionals and the current child protection processes effectively protect those children identified in need of protection and who are looked after.

Reports are routinely provided to the SSCB on a four monthly basis which demonstrate the effectiveness of child protection (CP) conferences and performance data is collated and monitored to ensure that wherever possible statutory time-scales are adhered to.

Work has been undertaken throughout 2014-2015 to improve partner agency engagement in CP conferences and a detailed audit was undertaken by SSCB to provide analysis to inform challenge.

A data analysis undertaken of attendance at initial CP conferences is summarised below.

Key agencies attendance at initial child protection conferences

The SSCB continues to challenge the engagement of GPs in the CP conference process. As a result, the named GP presented a report to the Board to identify the issues arising and also to work with partners to find solutions.

A task and finish group is taking forward some ideas for engagement and will present findings to the July 2015 SSCB. The role of GPs in providing information and contributing to the work of the SSCB has been highlighted in a significant number of serious case reviews.

An ongoing SSCB focus has been the functioning and impact of core groups.

Good practice:

- Timescales included in a child protection plan.
- Views of children included in the record of a meeting.
- Evidence of good multi agency working.
- Continued improvement in the number of fathers involved in core groups.

Areas of concern:

- The anticipated improvement in practice as a result of previous audits was not demonstrated.
- The audit highlighted the lack of SMART (specific, measurable, attainable, relevant, timely) child protection plans.

- Child protection plans continue to be too long and complicated, without the focus on specific issues that need addressing.
- There was evidence that the plan was being reviewed in the core group, however there was also mixed evidence about the effectiveness of the core group reducing risk.
- There was inconsistency in the regularity of core group meetings.
- There was an improvement in the recording of contingency plans however auditors felt that more work was required to ensure that these continued to focus on the safety and well being of children.
- The audit identified that in the majority of core groups the wishes and feelings of the children were not recorded.
- Ethnicity and culture were not being addressed sufficiently, however this could also be a reflection of the small random audit sample.
- CP plans were not regularly identifying core group membership and in more that 50% of the core groups it appeared that not all the members attended.
- Attendance by some partner agencies continues to be problematic.
- There continued to be a lack of significant progress in the management and reduction of risk.
- The use of the core group template has been available for some time and its recent incorporation into the integrated children's system (ICS) has meant that recording is better; however it does not appear to have facilitated key issues being addressed.
- It was the view of the auditors that having the same person chairing and recording core groups did not facilitate good recording and where notes were taken by another person the quality of the record was improved.

The findings of this audit have been widely disseminated to ensure that when a further audit is undertaken that these areas of concern have been addressed and practice improved. The follow up audit has been scheduled for July 2015.

SSCB sub group CP dissents, offers a unique and effective service to professionals and families. The sub group forms part of the review and audit process of decision making by CP chairs where there has been a dissent against the decision of the conference chair. This forum allows the review of the reports to conference together with the notes of the meeting at which the dissent was recorded and is viewed as an example of good practice.

Targeted priority 4: to develop, agree and communicate a multi-agency child sexual exploitation strategy; identifying key priorities and monitoring procedures to measure the impact on children, young people and families.

Child sexual exploitation (CSE) has received a high level of national media attention over 2014-2015 and continues to be an area of safeguarding receiving significant attention locally.

A number of concerns were also raised in the November 2014 inspection relating to unallocated cases and the robustness of the monitoring of young people who go missing and those specifically at risk of child sexual exploitation.

The SSCB has led with key partners a complete review of the CSE governance, monitoring and reporting mechanisms and has introduced considerable improvements.

Activities include:

- Revised governance and membership of the CSE strategic leadership sub group supported by a robust operational review and restructure of front line services.
- Revised membership of all key groups to ensure that membership of each group enables the key objectives of the group to be driven forward.
- Revised and significantly strengthened action plan based upon the four key themes of the national work plan and nationally published learning from serious case reviews and thematic reports.
- Development of a communication plan across the county setting out awareness raising approaches to target all sectors of the community.
- Commissioning of work to understand the scope and scale of CSE in the county.
- Review and revision of screening tools and risk assessment tools used by professional in identifying young people at risk.
- Review and updating of the training pathway for professionals.

Within Surrey, there is now an established multi-agency response to missing and exploited children which is embedding into practice. Multi-agency missing and exploited children's conferences (MAECC) are held in each of the area quadrants, to consider and assess local levels of risk. These groups report into a MAECC oversight group chaired by the head of safeguarding and head of public protection. Clear terms of reference set out accountabilities and responsibilities of each group.

As at 31 March 2015 of the cases considered to have a current, possible or known CSE risk there were 20 cases in the high risk category and 60 at medium risk.

As part of raising awareness and prevention work, approaching 100 CSE champions have been trained across Surrey. Chelsea's Choice, a play highlighting the issue of CSE, has been delivered to secondary schools in Surrey, during 2014 with parents receiving supporting awareness sessions delivered by the Lucy Faithfull Foundation. Further sessions are planned in 2015-2016.

A CSE operating protocol for Surrey is being developed and will be launched across the county which will include signposting of services to children, families and professionals to appropriate support services.

Learning and improvement

Serious case reviews and partnership reviews 2014-15

- During the year 2014-2015, two serious case reviews were commissioned which will conclude in 2015-2016.
- Two cases were taken forward as multi agency partnership reviews and the learning fed back into the serious case review group (SCRG) and the wider SSCB.

The following reviews were published by the SSCB in accordance with Working Together to Safeguard Children 2013.

Initials	Date of publication
Child S	May 2014
Child X	January 2015
Child Y	September 2014

Commissioning of serious case reviews/partnership reviews is an important part of the SSCB work and supports the learning and improvement framework published by the SSCB.

A number of follow up learning activities have been undertaken during the reporting year and the SSCB has very effective and well established procedures in place for disseminating learning from both local and national reviews to the broadest possible range of practitioners:

- Updates on progress on SCRs, partnership reviews and learning are disseminated at all SSCB sub-groups.

- SSCB newsletter is widely circulated.
- SSCB learning leaflets are available to download at SSCB website.
- SSCB learning and improvement framework.
- Four serious case review workshops for supervisors and managers were held which covered learning and barriers to learning being taken into practice.
- All train the trainer, trainer update training and module one training included local and national learning from serious case reviews.

There is growing evidence that learning is influencing practice and partners are pro-actively sharing information to inform practice development.
During 2014, Guildford and Waverley CCG undertook a deep dive which focused on learning from serious case reviews. This thematic review was an example of good practice in itself and was used to test and evidence themes around learning having been taken into practice across nine health providers. 18 cases were reviewed across a range of ethnicities.

CCG safeguarding audit 2014

- 18 cases across nine providers chosen at random from cases where there had been concerns; Section 47 enquiries, safeguarding medical examinations.
- Age range unborn to age 17 across a range of ethnicities.
- 1 unborn, 7 female, 10 male.
- Of the 18 cases 10 were subject to a child protection plan, 8 were not.
- Of those subject to a child protection plan, 4 were categorised as neglect, one as possible neglect, 2 sexual abuse, 3 physical/emotional abuse. 1 child was a looked after child.

Outcomes:

A number of cases demonstrated that learning from SCRs had been taken into practice and a range of themes identified which providers need to address to improve outcomes for children, including:

- Maintaining a child focus.
- Using professional curiosity to ask questions around the male partner/father.
- Reducing missed opportunities.
- Developing through enquiry a more complete picture of the extended family.
- Ensuring that document keeping is good.
- Avoidance of being too optimistic relating to outcomes.

Findings were shared at a SSCB development event in June 2014, at which the board presented evidence from mapping of serious case reviews/domestic homicide reviews and learning from professional on the barriers to taking learning from SCRs into practice. Strategic leads and operational managers representing partners were challenged to take forward the key messages into their agencies and influence service development.

Serious case reviews commenced 01.04.2014 – 31.03.2015

Initials	Month commenced	Month reported/to be reported to board
Child AA	July 2014	July 2015
Child BB	August 2014	July 2015

In the past 12 months the following themes have been identified:

- Lack of information/assessment of fathers/male carers.
- Misuse of drugs and alcohol not being given adequate weight in assessment.
- Lack of recognition of the significance of bruising/injuries in non-mobile babies.
- Failure to access historical information/ records.
- Difficulty in working with resistant families.
- Poor record keeping.
- Failure to revise judgements in light of new information/human bias in reasoning.
- Lack of reflective and professional challenge / escalation of concerns.

These findings have been shared with all partner organisations and have directly informed the planned 2015-2016 audit activities of the SSCB quality assurance and evaluation group and the four SSCB area groups to monitor practitioners' understanding and embedding of learning into practice.

Key learning from child S

- The importance of recognising the significance of interacting risk factors including: failure to engage with services, lack of antenatal care, substance misuse, domestic violence, ambiguous feelings towards two pregnancies and a troubled parental history as a child.
- The importance of recognising the implications of parental misuse of alcohol and take action to reduce risk to the children.
- The importance of recognising the significance of bruising/injuries in non-mobile babies.
- The importance of ensuring that when a child on a child protection plan sustains an injury this is examined by a suitably qualified and experienced doctor.
- Working with resistant families requires practitioners to have highly developed interpersonal skills supported by effective supervision which addresses the emotional impact of such work.

Key learning from child X

- The importance of recognising the significance of bruising/injuries in non-mobile babies and following the correct procedure.
- The importance of ensuring that information about policies and procedures in widely disseminated to ensure that all staff are aware.
- The importance of ensuring that policies and procedures are clear and consistent.
- The need for good communication and timely transfer of records/information between partners.
- The need for appropriate professional challenge.

Key learning from child Y

There is a need to ensure that:

- There is consistent notification of attendances at A&E between midwives and health visitors.
- Health care providers of community services have management oversight of health visitor case transfers and in access to speech and language therapy for needy children.
- The review of maternity booking forms and policies is completed in a timely manner.
- There is an escalation policy to address cases where there are concerns across agencies.
- All agencies enhance their engagement with and assessment of peripheral fathers.
- An updated multi-agency risk assessment is undertaken before children are stepped down into the early help system.

Audits undertaken in 2014-2015

Between April 2014 and March 2015 the following audits and re-audits were undertaken, reporting to the SSCB quality assurance group, the SSCB area groups and four monthly to the SSCB:

- strategy meetings
- bruising protocol
- core groups
- early help
- supervision
- fathers and male carers
- neglect
- sexually harmful behaviour
- historical information
- staff survey
- survey on single agency audits

Themes and issues which have emerged from the audits include:

- Understanding of thresholds for referrals differs between partner agencies and professionals.
- Fathers and male carers, their views and their impact upon the family are routinely omitted from reports and assessments.
- Fathers and male carers are not given equal access to appropriate services.
- Not all partners submit reports for child protection conferences when required to do so.
- Barriers exist to embedding guidance and revised procedures into practice.
- The management of bruising in babies and non-mobile children, especially in relation to bruising in non mobile school age children is inconsistent.
- Guidance about the use of historical information is required.
- There is a lack of shared tools for assessments.
- Transferring knowledge into practice is difficult to evidence.
- Barriers to embedding learning from serious case reviews need to be addressed.
- The wishes and feelings of children are not consistently reported upon.
- Additional training for professionals is required and the links between domestic abuse, substance misuse and adult mental health need to be better understood.

- Analysis and assessments need to be improved across partner agencies.
- Health professionals participation in strategy meetings.
- Lack of consistency of agreed definitions as well as inconsistency of key terms e.g. agreed definition of neglect and how risk is defined and assessed.

The themes identified in audit reflect the recommendations of serious case reviews and partnership reviews suggesting that a multi-agency response is required to overcome some of the barriers which are known to exist and to encourage professional challenge and escalation of concerns when professionals are unable to reach an agreement in decision making.

Learning from all the audit activity is shared with partners and actions plans are developed following audits and case reviews which address the issues identified and these are reviewed by the quality assurance group and serious case review groups.

Specific areas for improvement identified as a training need for professionals include:

- working with fathers and male carers
- improving risk assessment and analysis particularly dynamic risk assessment
- ensuring that the wishes and feelings of children are gathered understood and reported
- tools for risk assessment and screening
- the need to review the bruising protocol.

Section 11 report and analysis

All relevant partner agencies responded to the 2014 safeguarding audit apart from one borough and a late return was agreed with the newly formed Kent, Surrey and Sussex Community Rehabilitation Company.

Overall the findings indicate that each partner who reported is keeping children safe. In order to provide a challenge to the responses the relevant area head of Children's Services and the SSCB quality assurance officer met with the safeguarding leads. Four main themes reoccurred, but not necessarily in each agency:

- The need to increase awareness of early help.
- Support to some partners regarding e-safety.
- Training including who needed safeguarding training and availability of training.
- Supporting agencies to ensure that children are given a clear message about their right to be safe.

In response introductions were made to the early help service and to the SSCB training officer and issues raised by e-safety will be sent to the e-safety group. A workshop was held specifically for borough and district councils to look at the themes which had emerged specifically from their audits. The participation group will consider and advise where necessary about appropriate literature.

Other learning from the audit included:

- The need to develop a formalised and agreed challenge process prior to the 2016 audit.
- The need to ensure the audit tool is relevant and appropriate to all partners.

To address this, a task and finish group will be set up in autumn 2015.

Allegation management/safer recruitment

Managing allegations within the children's workforce

Nationally, all agencies and settings that provide services or staff working with children are required (under statutory guidance – Working Together to Safeguard Children, 2015), to have clear procedures for responding to allegations against staff, whether they are paid or voluntary. Within education services, additional guidance (previously Safeguarding Children and Safer Recruitment in Education, 2007, updated in 2015 to Keeping Children Safe in Education), outlines specific requirements considered when managing allegations against staff working in education settings.

Within the guidance, the local authority designated officer (LADO) has the responsibility to oversee the allegation management process and to ensure it remains effective and transparent and meets the dual demands of both protecting children and also ensuring staff subject to allegations are treated fairly. The LADO provides consultation and advice to the process to ensure that the investigative response is consistent, reasonable and proportionate and that action taken is recorded in line with statutory requirements.

Referrals to the LADO have increased year on year since the introduction of the role. In 2012-2013, referrals totalled 658 in 2013-2014 they totalled 910 and in 2014-2015 they totalled 1093, of which 439 came from the education sector.

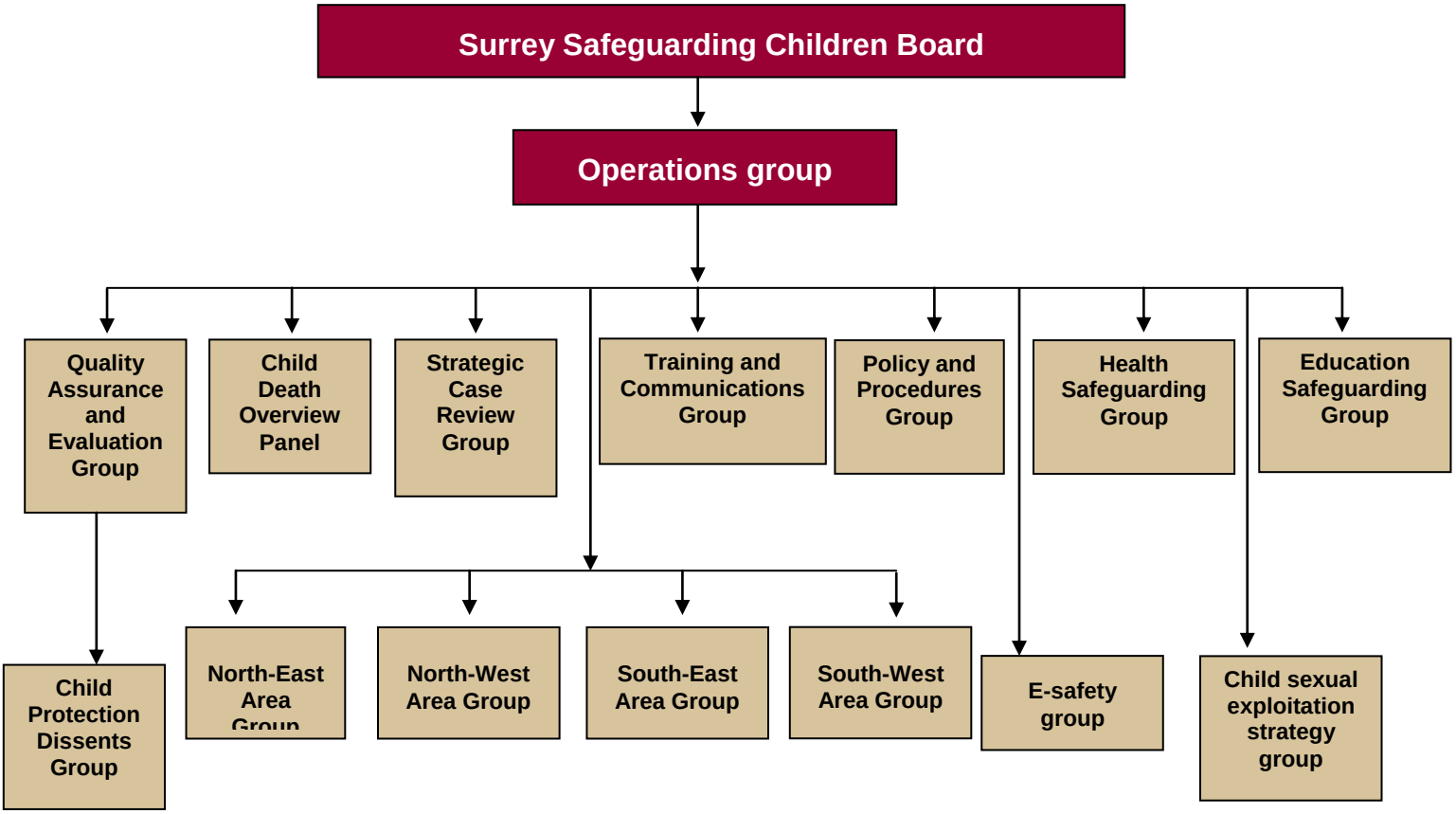
In line with part three of Keeping Children Safe in Education 2015, governing bodies and proprietors should prevent people who pose a risk of harm from working with children by adhering to statutory responsibilities to check staff who work with children, taking proportionate decisions on whether to ask for any checks beyond

what is required; and ensuring volunteers are appropriately supervised. The school or college should have written recruitment and selection policies and procedures in place. The school staffing regulations require governing bodies of maintained schools to ensure that at least one person on any appointment panel has undertaken safer recruitment training. Schools and colleges in every briefing and training event are encouraged to adopt a culture of safer recruitment and Surrey have created an online "safer recruitment" training programme accessible through the Surrey Skills Academy website to support schools.

The impact and future work plans of the SSCB's sub-groups in addressing the business plan priorities

Surrey Safeguarding Children Board sub-group structure

The Surrey Safeguarding Children Board structure reflects a diverse membership of partner organisations, which are represented in sub-groups and in the membership of the full board. This reflects the infrastructure of the Surrey area and the complexities of services provided to young people and families throughout the county.



SSCB operations group

Key achievements in 2014/2015
• The operations group is a meeting of the 14 SSCB sub-group chairs and is chaired by the independent chair. • It provides the conduit for the sub group chairs to be updated and informed of the work taking place within sub groups and the SSCB board and to ensure the dissemination of key messages and provides the ability to raise issues with the board.
How these achievements have impacted upon children in Surrey
• Through this SSCB structure there is increasing synergy and clarity about the key safeguarding messages/learning communicated to practitioners to support their work in safeguarding children.
Challenges for the future/next steps
• To ensure continued capacity for partner agencies to support the SSCB sub-groups. • To ensure good communication between the 14 sub-groups to avoid duplication and ensure synergy. • To ensure that key messages and learning are disseminated through the sub groups to front line practitioners in all agencies.

SSCB child death overview panel

The main work of the CDOP panel is reviewing the deaths of all children who are resident in Surrey, on behalf of the local safeguarding children boards (LSCBs).

The purpose of the review is to determine whether the death was deemed preventable, that is a death in which modifiable factors may have contributed to the death. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future.

Key achievements in 2014/2015
• The CDOP has held 10 meetings in the past year (including four neonatal panels). • Between April 2014 and March 2015 the CDOP was notified of 79 deaths of which 62 were children who were resident in Surrey which is a decrease in actual numbers of deaths since last year when 83 children were notified of which 66 were from Surrey. • The CDOP has reviewed and closed a total of 70 deaths during 2014/15. • Of the 237 deaths reviewed between 2010 and 2015, 41(17%) have been identified as having factors which may have contributed to the death and could be modified to reduce the risk of future deaths. • Modifiable factors identified through reviews included factors associated with sudden unexplained death in infancy such as parental abuse of alcohol, smoking and the baby not sleeping in appropriate environments as well as older children dying from head injuries.
How these achievements have impacted upon children in Surrey
• The only cause of deaths with modifiable factors where there have been sufficient numbers and common causes to identify significant learning patterns, which are backed up by national data, was those deaths defined as sudden unexplained death in infancy (SUDI). For SUDI the reviews of these deaths have identified significant risk factors which include a combination of parental abuse of alcohol or smoking in combination with the baby not sleeping in an appropriate environment. In response to this the CDOP was instrumental in developing a Baby Sleep Safe Campaign which was launched by Surrey Police and promoted through all health and social care agencies. This was aimed at raising awareness amongst professionals, parents and carers about the need to provide babies with safe and

appropriate sleeping arrangements in order to reduce the number of sudden unexpected deaths in infancy. The work included:

- Updating inserts on safe sleeping advice for the Child Health Record (Red Book) - November 2014, funded by Guildford and Waverley CCG.
- Practice guidance for staff to support best practice.
- Development of sleep safe assessment for babies for parents and carers.
- Development of an awareness programme for staff.
- Agreement on a consistent approach to the use of parental literature in order to promote consistent messages to parents and carers about safe sleeping arrangements for babies.

There were also a number of deaths from head injuries; nationally death from a head injury is the most common cause of death in people aged under 40. To address this, a resource was designed in collaboration with the South East Coast Clinical Network, public health and local CCGs. This involved the production of a resource for parents which includes a care pathway for children with head injuries which has been disseminated widely across health, social care and education setting.

Challenges for the future

Key areas for development to ensure that the Surrey CDOP processes continued to function effectively were:

- Developing a working protocol with the coronial service – an agreement was agreed in June 2014. The agreement was shared with all five acute hospitals. It is included in the updated CDOP information booklet produced for hospitals.
- Providing training for all staff involved in the CDOP process – this is ongoing and has also been offered to all acute hospitals.
- Keeping the database up to date, so that it is able to collect all the data required for the DfE data return and can provide more effective information for the annual report.
- Ongoing audits of rapid response arrangements to gauge their effectiveness. The first audit was completed in September 2014 to provide a baseline of the effectiveness and quality of the rapid response in Surrey. The results of the audit were shared with SSCB. A re-audit is planned for September 2015.

Parents are enabled to contribute to the CDOP process by providing feedback on services received. This is facilitated by the specialist nurse for CDOP and has continued throughout 2014/15 when all parents of children who were over a month old have been invited to contribute to the review process. The arrangements for neonate deaths are slightly different as they have separate support mechanisms

already in place however these parents will be advised that they can contact the specialist nurse for CDOP and contribute via her to the review process if they wish. The CDOP works closely with the Coronial Service providing coroners with information and receiving information from them. An agreement was finalised in June 2014 and information is requested by the specialist nurse before case discussions.

As the numbers of deaths with modifiable factors are relatively small (38 over a five-year period) and are from a number of causes it is hard to identify specific public health messages. It is important to build up the data-base to show whether specific deaths are indicative of trends and therefore need a more general response.

Next steps

The CDOP process is well-embedded within Surrey and there is good engagement by all agencies. Areas for further development in 2015/ 2016 include:

- Continuing to improve the rapid response process across Surrey.
- Encouraging the contribution by families to the CDOP process.
- Improving the neonatal CDOP panel processes ensuring regular attendance by obstetrician and midwifery staff.

SSCB strategic case review group

Key achievements in 2014/2015
• The strategic case review group (SCRG) has considered eight referrals during 2014-2015 relating to serious incidents/deaths of children in Surrey. • SCRG recommended that two be commissioned as serious case reviews which will conclude in 2015-2016 and will be overseen by SCRG. • The learning from one case was passed to the e-safety group to implement. • Two cases were undertaken as single agency case/ practice reviews and the learning fed back into SCRG. • One case had no further action for Surrey Safeguarding Children Board but a SCR was undertaken by another LSCB. • Two cases were taken forward as multi agency partnership reviews and the learning fed back into SCRG. • SCRG oversaw the process of the three serious case reviews published in 2014-2015. Child S, Child Y and Child X. The effectiveness and impact of the group has been significantly improved over the past twelve months with: • Robust systems being established to manage referrals. • Pro-active membership who are highly motivated to identify single and multi-agency learning to improve outcomes for children. • Good working relationships have been established with the serious case review national panel. • The group taking on responsibility for developing, monitoring and holding to account agencies through the implementation of the learning improvement framework, when learning from cases is identified. • Pro-active updating of multi-agency training resources/delivery of multi-agency SCR workshops. • Inclusion of updates on SCRs on all LSCB agendas and in newsletters.
How these achievements have impacted upon children in Surrey
• A wide range of opportunities to review practice and improve decision making by professionals. • Identification of recurring local and national themes which inform service offer. • Policies and procedures have been introduced to enable professionals to handle concerns effectively.

- Audits have shown that practice has improved as a result of learning including the use of the bruising protocol; effective use of escalation procedures and the recording of strategy meetings.
- Partners have been involved in improving practices, introduced as a response to learning; the bruising protocol for example has significantly impacted on practice and feedback from partners has highlighted challenges and barriers to overcome, in embedding procedures into practice.

Challenges for the future

- Ensuring that messages are widely communicated beyond the immediate sub groups and information sharing networks of the board.
- Supporting partners effectively to ensure that learning from case reviews is taken forward into frontline practice.
- Partnership funding of the commissioning of SCRs and partnership reviews.
- Developing thematic reviews of local learning to ensure that services respond to emerging trends and issues at an early point.

Next steps

- Commissioning a thematic review of learning relating to safeguarding issues for young people who go on to become young parents who have been known to services.
- Evidencing that outcomes for children improve as safeguarding practice improves in agencies as a result of lessons learned from local and national reviews.

SSCB quality assurance and evaluation group

Key achievements in 2014-2015
• The development of an SSCB neglect strategy and work plan. • Highlighting the challenges for partners in the early help structure. • Development of a participation strategy to gather feedback from children to inform service development – this was used to gather responses from children on the CP plan. • Carried out a comprehensive audit on CSE following the OFSTED inspection in November 2014 and the national thematic report. • The continued improvement in the development of a multi-agency report card, with all partners contributing to the narrative on the impact on the lives of children. • The review of the Section 11 process and in particular the significantly improved engagement from boroughs and districts in the process through workshops and action plans. • The extension of the Section 11 audit across all schools, including the many independent sector schools in Surrey. • The strengthening families approach has been adopted through the QA group and brought to the full board, where this new way of working was adopted. The QA group has established a multi-agency implementation board to drive through this change. • Regular attendance at events held by partners to promote the work of the SSCB.
How have these achievements have impacted upon children in Surrey
The work on the Section 11 audit has been critical in raising awareness of safeguarding children particularly with the boroughs and districts. Where this has had the most measurable impact is in the area of child sexual exploitation (CSE). Schools, boroughs and districts have been made more aware of the prevalence of this in community and as a result there have been increased referrals to police and Children's Services of children and young people, in addition local information sharing groups in the boroughs and districts have helped to identify hotspot areas that can be targeted and children made safer. The CSE audit had a major impact upon the multi-agency arrangements for monitoring cases where CSE is a factor. The findings of that audit influenced the new structures and these have had a major impact upon the lives of individual children deemed to be at risk of CSE. Since the new arrangements started, 14

children have been brought into care, 11 made subject to CP plans and regularly 80 children have their protection plans quality assured to make sure that all partners are doing everything that they can to keep them safe.

As a result of the work carried out to develop a neglect strategy for the county, there has been a greater awareness of the signs of neglect and significant shift in the way partners work together to combat this. Previously Surrey was out of kilter with other local authorities in the proportion of children subject to CP plans under the category of emotional abuse and neglect; the former being much higher and the latter lower. There were also a high number of children subject to plans for 24 months plus. Since the launching of the neglect strategy, Surrey is much more in line with its statistical neighbours in the use of category, indicating that the workforce is better at recognising neglect in families and the numbers of children subject to plans for more than 24 months has decreased significantly: from over 60 at the start of the year to 35 six months later, suggesting that the multi-professional network is responding more robustly in addressing the issues of neglect, when it is identified.

Challenges for the future

- There is an ongoing challenge in getting high quality and up to date data for the performance report card from all agencies and a clear narrative.
- The implementation of the strengthening families approach across such a large local authority will be costly and time-consuming.
- The Section 11 audit has highlighted some concerns in respect of Adult Services engagement with safeguarding agenda for children that needs addressing.
- As the cutbacks in services continue the ability of the board to identify sufficient auditors to carry out the work of the QA&E group.

Next steps

- Initiate a review of the multi-agency CSE arrangements, to ensure that they are as effective as possible.
- Scope the training requirements in order to effectively implement the strengthening families approach to safeguarding children, then commission the necessary core offer to the children's workforce.
- Develop a multi-agency data set for CSE that enables a comprehensive problem profile to be developed for the SSCB.
- To learn from the first participation exercise with children subject to CP plans to see how this can be developed and improve the engagement process.

North-east area group

Key Achievements in 2014/2015
• Reviewing and securing full membership, including a faith representative • Full membership now offers a positive opportunity to engage in multi-agency discussion and working together and to have a clearer insight into the particular challenges of the north-east (NE) quadrant. • Moderation of NE Section 11 audit report submissions. • Established a forward plan to support agenda planning in advance of the meetings. • Through regular guest speakers/presentations, members have a greater working knowledge and understanding of support available for professionals, and can disseminate to their colleagues.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Clearer understanding of the challenges that the children in Surrey face, and the volume of work required to make a real difference. • Through full membership a significant multi-agency opportunity to discuss priorities and challenges specific to the north-east in addition to the county wide perspective. • Through wide level of expertise to not only raise awareness but agree an action plan going forward in order to offer to provide a positive impact for children in Surrey.
Challenges for the future
• Ensuring the area SSCB represents the SSCB on an area level – the current position is that there is little connectivity between the two. • Securing strategic social care membership to ensure the two education based chairs fully represent and supports the priorities of social care colleagues around safeguarding in the NE. • Discussion and agreement with regard to the NE priorities and to prioritise a **realistic** piece of work that can be **effectively evaluated** in the future and make a positive contribution to children in Surrey.
Next steps
• To identify local priorities which align with the OFSTED improvement plan and SSCB priorities in order to measure impact of interventions on children and families across the three NE boroughs. • To hold a workshop/conference event to raise awareness of these priorities with frontline practitioners.

North-west area group

Key achievements in 2014-2015
• North-west area group has led on work to understand and address the relatively lower level of engagement by safeguarding services with fathers. Recommendations on SSCB guidance and training made. Good practice highlighted and shared. • North-west area group has consistently raised the profile of CSE and has a successful and well represented MAECC as part of the CSE Strategy and is attended by senior leaders. • North-west area group has consistently raised and promoted the early help strategy and its application in north-west.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Improved confidence of practitioners in engaging fathers. • Improved safeguarding of children and young people at risk of CSE. • Improved knowledge and access to early help services in north-west. • Beginning to see reduction in child protection and looked after children.
Challenges for the future
• Developing local knowledge and responses in relation to perpetrators of CSE. • Schools consistently being willing to act as lead professionals where appropriate. • Consistent agency representation at north-west area group especially police and probation.
Next steps
• Greater focus with partner agencies on perpetrators of CSE as well as victims. • Continue to embed early help in north-west and identify success through less child in need cases.

South-east area group

Key achievements in 2014/2015
• Set up workshops for the safeguarding partnership in the south-east focused on learning and barriers to learning in serious case reviews. • Developed joint safeguarding supervision with the safeguarding partnership where cases are 'stuck' or where multi-agency working practice requires improvement. • Development of area multi agency CSE champions group facilitated by Children's Services. • Development of a safeguarding board course focused on professional challenge following on from learning from SCR child AA. • Development of a glossary explaining role of Children's Services in care proceedings to assist partner agencies in understanding. This followed discussion about children subject to child protection plans in excess of two years. This was subsequently shared across the county. • Following on from discussions about join up between MARAC and MAPPA, held meetings with key partners to develop more effective protocols in discussing both victim and perpetrator. • Workshops on e-safety undertaken across safeguarding partnership in the SE. • Development of an e safety conference for the SE. • Local partnership case review held with recommendations to the strategic serious case review group. • Proposed multi-agency audit on children on child protection plans for two years or more. • Progressed request for partner agencies to take minutes at core group meetings and made recommendations to SSCB operations group. • Development of an early help pilot in the SE. • Key messages and themes coming out from SE MAECC circulated and discussed. • Multi-agency learning event held to address actions from serious case review Child AA.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Shared learning and understanding of safeguarding responsibilities across the partnership in the SE which directly impacts on appropriate referrals to

Children's Services. • CSE champions in the partnership ensure children at risk of CSE are safeguarded effectively and appropriate risk assessments undertaken. • Local partnership reviews identify areas of learning and ensure that cases with future risk and need factors are considered. • Joint supervision has a direct impact on the child's journey through the safeguarding system. • Countywide impact on children through the development of effective communication channels. • Greater understanding of the use of social media to influence effective safety planning for children.
Challenges for the future
• Assessing impact of the SE safeguarding group.. • Ensuring the clear join up between the levels of need processes and the early help offer to children and families. • Ensuring the direct links with adults services and their responsibilities under the Care Act. • Ensuring communications are effective with the developing MASH and its implications for the safeguarding system.
Next steps
• Refresh the local priorities. • Develop an e-safety conference for local partners. • Build on the joint supervision arrangements as described.

South-west area group

Key achievements in 2014/2015
• Dissemination to all partner agencies of SSCB information especially the priorities and SCRs and any new processes in response to OFSTED report. • Baseline assessment of partner agencies regarding how they embed serious case review leanings in their practice. • All agencies including the police attended area group meetings consistently and regularly and the representatives from these agencies feed back to their own organisations this information. • Godalming Project. • Regular Safeguarding Partners Information Meetings (SPIM) held and these have benefited health by enabling them to complete a recommendation from a deep dive audit by the CCG regarding minutes of strategy discussions uploaded to their RIO records. • SPIM meetings have also monitored the effectiveness of strategy discussions and ensured that they are chaired appropriately and remain child focused.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Partner agencies now receive agenda for strategy meeting consistently on the day before so that research on children at risk is carried out by police and health and there is more information sharing and effective risk assessment. For health practitioners we also now receive minutes of the strategy discussions and these are now uploaded. • Better communication with partner agencies in terms of feeding audits, SCRs, information regarding CSE to take to their front practitioners to embed into practice during assessments at home visits and during supervision. This enhances their decision making during assessments and directs benefits assessment of children.
Challenges for the future
• Working together and communicating effectively through the changes and keeping focused on managing the risks to children and families. • Challenges of the media and the number of children exposed to CSE and sometimes how one individual has access to so many vulnerable children and the number of strategy discussion arising from this.
Next steps
• Regular feedback about how SCRs are embedded in practice and any audits completed and share learning. • To obtain feedback regarding any audits done by partner agencies and share learning.

SSCB policy and procedures group

Key achievements in 2014-2015
• Further development of the bruising protocol and leaflet for parents. • Embedding of learning from serious case reviews into policies and procedures. • Supporting the development of procedures to enable information sharing between police and education relating to children coming to the attention of police. • Revision of domestic abuse guidance to reflect the needs of children. • Using feedback from young people and carers to redesign and inform the leaflets for Section 47 enquiries, child protection conferences and information for parents which are used to support published procedures.
How these achievements have impacted upon children in Surrey
• A current SCR reflects that the escalation procedure was implemented effectively and that although the outcome for the child in this case was not affected it did enable professionals to manage the inter agency conflict and reflect upon the most appropriate actions to take to protect the child. • The bruising protocol has raised awareness particularly amongst health professionals to challenge bruising in non mobile infants and to use professional curiosity to discover more information. The SSCB has received feedback from a wide range of professionals and the protocol is currently being updated to reflect/clarify practical application of the protocol • Greater awareness raising of what to expect at child protection conferences.
Challenges for the future
• Ensuring that changes to procedures and new procedures are widely communicated beyond the immediate sub groups and information sharing networks of the board. • Supporting partners effectively to ensure that procedures are widely communicated and implemented into practice. • Evaluating the impact of procedures on practice. • Working in partnership with a number of boards to develop the multi-agency level of need document.
Next steps
• Development of the SSCB communication strategy to include named professionals in all key agencies who will be responsible for ensuring that information is circulated appropriately in a timely manner. • Defining and publishing the good practice principles for managing risk to support learning across audits and case reviews. • Developing more formalised systems to provide feedback on new policies and procedures through use of electronic media/SSCB website.

SSCB education group

Key achievements in 2014/2015
• Review of membership. • Establishment of core agenda with standing items and forward plan. • Securing representation from all phase schools, including the Independent sector. • Annual protecting children on and offline conference in partnership with the Police and Crime Commissioner's Office. • First annual review of safeguarding audit for all education providers – resulting in a 69% return rate. • Creation and sign off of a model child protection policy in line with Keeping Children Safe in Education (March and July 2015). • Creation and sign off of a model staff conduct policy. • Agreement for a child sexual exploitation (CSE) awareness training programme to be offered to all schools following CSE train the trainers roll out in education offices across the county. • Quality assurance document for alternative education providers which links to the OFSTED framework. • Monitoring of and agenda planning for all designated safeguarding lead (DSL) networks to ensure consistent delivery of key messages and training across the county.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Membership is fit for purpose, includes head representation from each quadrant to ensure dissemination of key messages to all schools. Inclusion of the Independent sector is key to being able to evidence safeguarding is monitored and quality assured in our Independent schools. • The annual safeguarding audit has enabled us to identify key focus areas where schools have evaluated practice as needing development. It has also provided evidence of good practice so that this can be shared across the school community. • CSE has become a priority standing item; risk screening tool and mechanisms for identifying and intervening have been disseminated. • The model child protection policy has provided schools with a comprehensive information document which is in line with current policy and practice and OFSTED compliant.

- The model staff conduct policy covers all aspects of staff behaviour, including conduct, use of social media and record keeping. This will provide all staff working in educational establishments or teams with clear guidance and expectations whilst in the employment of Surrey County Council (SCC) and schools.
- The annual protecting children on and offline conference was well received with positive evaluations, providing information around current challenges in keeping children safe in the digital world. The event included a session on Prevent, female genital mutilation (FGM), Childline, a drama production of a primary age theatre regarding internet use and session from the Police and Crime Commissioner to introduce the availability of online resources for professionals working with children, young people and their families.
- The DSL networks are now aligned and whilst delivered in quadrants for the schools in each geographically located area, the consistent agenda and delivery means that DSLs can attend their nearest or most convenient session. These sessions are open to all education providers in Surrey and currently free of charge.

Challenges for the future

- In 2015-2016, the annual safeguarding audit will be an online audit. With just under 500 responses possible, we need to determine how these audits can be quality assured or moderated to check the self assessment of each education provider is accurate and in line with others submitted. We also need to ensure feedback is given to each audit submitted and good practice identified is actively shared to ensure providers can learn from others in order to improve their practice.
- Capacity of the education safeguarding team requires reviewing as requests for school based training – for example inset days and parents evenings – are not sustainable.
- DSL training is currently a half day session delivered by Babcock – commissioned by SCC. The need to expand this training to include CSE, workshops to raise awareness of Prevent (WRAP), FGM and understanding of early help through to court proceedings as a referral pathway requires urgent review as the need to skill up the workforce in wider safeguarding issues becomes more pressing.
- Online safety and the links to CSE are increasingly featuring in cases discussed at area missing and exploited children conferences (MAECCs) – educating children and their parents needs to be a key focus over the next year, especially engagement with parents in awareness events which is currently low.
- The Goddard Inquiry and impact on how records are kept requires a review.

There has been a noticeable increase in historical allegations and schools often do not have the records of either staff or children as far back as are being requested. • Elective Home Education continues to be a challenge due to the current restrictions on the local authority's ability to investigate the provision and identify where children are not being adequately educated. These young people may not have access to the education around keeping themselves safe which is available and discussed in schools as part of the personal, social and health education (PSHE) curriculum and pastoral support. • To understand how the educating safeguarding group can continue to the OFSTED improvement plan and SSCB improvement plan.
Next steps
To action all above challenges as part of an education safeguarding business plan.

SSCB health group

Key achievements in 2014/2015

- The SSCB health and child safeguarding group has successfully provided a conduit and forum for senior lead health professionals with key responsibilities for safeguarding children across the Surrey health economy, to come together to take forward the safeguarding children agenda. It continues to influence the strategic direction in relation to the planning, commissioning and delivery of services to vulnerable children.
- The group has developed an action tracker which gives assurance that key safeguarding actions are being taken forward by all members and provides a robust mechanism to hold members to account.
- The group has been key in coordinating the response from health providers to inspections carried out by OFSTED and the Care Quality Commission (CQC), developing robust action plans which are monitored through the group to create change and improve practice.
- The group has played an important role in disseminating key national and local guidance such as the SSCB escalation policy to health providers. It enables discussion to achieve a uniformed approach to understanding the implications.
- The group are currently developing a more effective interface between adults and children's safeguarding groups by bringing together the two groups to discuss common agenda items.
- The group has played a key role in the dissemination of learning from recent serious case reviews and case reviews.
- The group has continued to monitor health organisation action plans from SCRs and case reviews, providing a forum for discussion and has been effective in holding providers to account.

The effectiveness and impact of the group has been significantly improved over the past 12 months with:

- Evidence of good representation and engagement at the appropriate senior level from both health commissioners and health providers.
- Robust systems being introduced to monitor and hold members to account.
- The group takes responsibility for directing the strategic safeguarding children agenda.

How have these achievements impacted upon children in Surrey (positively and negatively)
• The group enables change to practice to be implemented through the collaborative working relationships of senior professionals from health providers, for example the improved communication process between midwifery and GPs when there is a safeguarding concern. • The group has provided a forum where best practice can be shared and implemented more widely.
Challenges for the future
Ensuring key messages are disseminated effectively across a complex health economy.
Next steps
To continue to establish a strong and effective working relationship with the SSAB health sub-group.

SSCB learning communication development group

Key achievements in 2014/2015
• Delivery of comprehensive training programme of foundation and specialist courses responding to SCR learning, local priorities, audit findings and national priorities. • Increased range of training courses are either available or in the process of being developed (professional challenge, pre-birth assessment, honour based violence (HBV), Prevent, CSE training). • The implementation of charging for all training has generated increased revenue to enable the development of new training opportunities. • There is evidence of actions within the current learning, development and communication strategy being met. • Developed and implemented an impact/evaluation tool (learning action plans) following completion of Foundation Module 1 training. • Action plans for all SSCB and single agency training to measure impact agreed. (Response to recent OFSTED report). • Training needs analysis for 2016-2017 commenced. • Development of training pathways and consideration being given to the embedding of key issues within SSCB multi-agency and single agency training, e.g. Prevent, DA, CSE, FGM.
How have these achievements impacted upon children in Surrey (positively and negatively)
• Charging policy and system for payments has created difficulties for partner agencies and may be a deterrent to some people accessing training. It has also caused administrative challenges for the training team and may have negatively impacted on partnerships. This is currently being addressed • Challenge to provide sufficient training places on foundation safeguarding modules. Staff are unable to access training in as timely manner as we would like. • Opportunities for development of the training offer due to increased revenue. For the future this will enable the multi agency team to develop enhanced knowledge and skills within safeguarding. • Increasing awareness of national and local key training priorities (see final bullet point above) across partners. • Increased awareness of safeguarding issues for staff across partner agencies.

Challenges for the future
• Meeting demand of foundation and specialist training to meet the needs of the workforce across Surrey; particularly foundation modules 1 and 2. • Managing increasing demand on agencies and individuals to attend training and keep abreast of current knowledge requirements across all safeguarding areas. • Ensuring consistency in training across all partner and non-partner agencies. • Reaching more staff in agencies including boroughs and districts. • Ensuring all agencies are offering the correct level of training to meet needs of different groups of staff. • The challenge of measuring the impact of training on children and young people and their families and the quality of the safeguarding response. The learning action plan for Foundation Module 1 aims to achieve this. Further action plans and sampling to be developed. • Consistency of messages and training across professional groups. • Evaluating single agency and refresher training. • Ensuring local and national learning is disseminated across all agencies in a meaningful way to inform and enhance practice.
Next steps
• Undertake a training needs analysis in Autumn 2015 to evaluate current offer and inform learning development and communication strategy 2016-18. • Update learning development and communication plan. • Collection of accurate data regarding outputs and outcomes of training, to assess impact both in the short and long term.

SSCB CSE strategy group

Key achievements in 2014-2015
• A complete multi-agency review has been undertaken by the SSCB partnership to review the structure of sub groups of the board, governance arrangements and reporting structures across the county. This followed an audit undertaken by the SSCB and the findings of the local authority OFSTED inspection in November 2014. • New group structures have been agreed and widely communicated that support effective assessment of children who are considered to be at risk of CSE. These are subject to constant review as more information becomes available to inform service development. • Key partners have reviewed all cases of children reported/known to be at risk of CSE and have developed a single CSE list which is pro-actively managed and updated. • A new screening tool is being developed, together with supporting guidance, to enable frontline practitioners to be increasingly alert to a number of risk factors that could indicate CSE. • Awareness raising campaigns have continued across the county and campaigns have been evaluated to measure impact. • A CSE audit has been undertaken by the board to provide a baseline from which further improvements can be made. • The extent of CSE in Surrey is currently being evaluated to build on information already held by partners on key hot spots and geographical areas of concern. • The theatre production, Chelsea's Choice, has been widely commissioned and delivered to schools in Surrey. • Multi-agency CSE strategy has been updated and re-launched. • A revised CSE strategy group work plan, based upon thematic review of nationally published reports and thematic inspections has been developed; this is a live document subject to bi-monthly review and reporting.
How these achievements have impacted upon children in Surrey
• During 2015, 214 cases of children/young people known to be at risk of CSE were re-assessed. • At 01 April 2015, 164 children were identified as being at specific risk of CSE within which 20 are high risk, 60 medium risk and 84 low risk. 50 cases were archived as being no longer at risk of CSE.

- Since the new arrangements were put in place 14 children have been brought into care, 11 made subject to child protection plans and regularly 80 children have their protection plans quality assured to make sure that all partners are doing everything that they can to keep them safe.
- Wider more targeted awareness raising campaigns are supporting young people with posters in key locations accessed by children including railway stations and bus shelters. Along with a short TV advert played through Sky Boxes aimed at perpetrators.
- Chelsea's Choice feedback suggests that a powerful message has been delivered to children and professionals about being alert to concerns and the impact of CSE.

Challenges for the future

- Understanding the scope of CSE in Surrey.
- Raising awareness and supporting professionals in their work with families affected by CSE.
- Greater engagement of the board with hard to reach groups of young people and some minority ethnic groups across Surrey.
- Implementing and embedding new tools and operating procedures into front line practice across all key agencies as a matter of priority.
- Engaging with young men in Surrey who are at risk or victims of CSE who form a disproportionately low cohort of young people at risk in current data sets.
- Develop comprehensive data sets to allow targeted analysis and reporting.

Next steps

- Continuing scrutiny, monitoring and challenge at the board to ensure that partners achieve the specific objectives of the CSE work plan.
- Development of a Surrey wide operating protocol.
- Completion of the joint work of children's social care and police to scope the extent of CSE in Surrey.
- Circulation of the CSE screening tool and guidance to partners.
- Finalising the SSCB communication strategy and tier 2 information sharing protocol to enable two-way pro-active sharing of information between agencies.
- Audit on the use of screening tool/submission of completed screening tools to the referral assessment and intervention services (RAIS) teams/Multi-Agency Safeguarding Hub (MASH) to inform future service delivery/development.

SSCB e-safety group

Key achievements in 2014/2015
• The effectiveness and impact of the group has been significantly improved over the past twelve months with a strong multi-agency representation. • Protecting children on line and offline planning for conference in June 2015. • Taking forward the key messages from a serious case involving the death of a teenager to raise awareness in schools. • Raising awareness of radicalisation through use of social media. • Work with schools on filtering and monitoring networks for safeguarding issues.
How these achievements have impacted upon children in Surrey
E-safety training for schools, social work teams, foster carers have also included the dangers of children interacting during online gaming. The training has included awareness of grooming, coercive and intimidating and bullying behaviour. The training has linked with child sexual exploitation (CSE) and the Prevent duty.
Challenges for the future
• Raising parental awareness of the benefits and risks of the internet. • Continuing to respond to the sophisticated methods employed by perpetrators to groom children and encouraging a proportional response. • Ensuring that professionals respond to the changing climate and try to 'stay ahead' in their knowledge of digital and social media.
Next steps
• We will create a training programme (CPD) for professionals working with children and young people about online risks. • Hold a multi-agency conference for professionals about how to protect children online. • Ensure schools make the best use of network filtering and monitoring to identify safeguarding issues and concerns. • Continue to raise awareness of online risks to parents and foster carers.

SSCB child protection (CP) dissents group

Key achievements in 2014/2015

• Embedding the role of the CP dissents group into practice.
• Reporting to operations group from June 2014.
• Enabling independent multi agency review of 11 professional dissents during 2014/15.
• Ensuring that chairs decisions are audited and any good practice or learning identified.
• CP dissent outcomes inform learning for future conferences.
• Analysis of the reasons for professional dissent which showed that:
  ○ 80 % of dissents related to either a child not being put onto a CP plan or a decision being made to continue with a CP plan.
  ○ 50% of cases were referred due to the chair over ruling a majority decision.
  ○ In 9 of the 10 cases reviewed CP dissents group upheld the decision of the chair.
  ○ In 1 case the decision of the chair was not supported and the case was referred for an internal review.
  ○ Positive feedback was provided to professionals around clear reports and minutes that brought both the child and situation 'to life'.
  ○ Advice was given to professionals to ensure that medical information is available to conferences particularly in cases where accidental injury is suspected.

How have these achievements impacted upon children in Surrey (positively and negatively)
• In the eight months to February 2015, there were 10 conference reviews. • 3 related to the same child, 5 arose following a CP review meeting and 2 related to initial conferences. • Outcomes related to children aged 0 to 17 years. • Professionals working with families are assured that a review of a chair's decision is available to allow a wider multi agency perspective to be reached – outside of conference. • Training issues relating to the dissent process have been raised with the SSCB training officer including raising awareness amongst partners of how the CP dissent process works.

• One case related to a looked after child (LAC) who was also on a CP plan and a recommendation was made that joint planning needs to be instigated in such scenarios. It was recommended that there should be joint LAC reviews and CP conferences.
Challenges for the future/next steps
• To continue to provide independent multi-agency scrutiny of cases where there is professional dissent at a CP conference and to do so in a way that improves practice, particularly in a time when professional anxieties are high.

SSCB overview of progress

Engagement and participation with children

Participation of children and young people and engagement with staff

The voice of children, young people and their families is crucial to the work of the SSCB. Increasing participation is a key piece of work undertaken in 2014-2015:

- A participation strategy has been drafted for implementation during 2015. A multi-agency steering group has been established to develop this work further and to consult with children and young people throughout its development. The strategy and ensuing action plans will work to ensure that the voices of children, parents and the workforce are embedded into the work of the SSCB.
- A consultation exercise has been undertaken in partnership with Children's Services to consult with children and young people who are subject to a child protection plan. This proved to be a complex and sensitive task, and contributions to the survey were limited with a low response level.
- Learning from this survey approach is that other methods have to be explored with partners, who work regularly with young people. As a result of this Surrey Youth Focus are now members of the SSCB and will support the SSCB in taking participation work forward in 2015.

The participation strategy work plan for 2015-2016 will explore how wider consultation can take place with children, for example, by involving them wherever possible in the design of board literature, building on the work undertaken in 2014-2015.

Key achievements of the SSCB partnership in 2014-2015

Overall 2014-2015 has seen a step up in the performance of the SSCB with increasingly robust challenge of partners to meet their statutory obligations. The board is appropriately resourced and well supported from partners in taking forward key pieces of work.

Increasingly effective relationships between the board and partners have resulted in the board responding positively to the challenge presented by OFSTED, firstly in embracing the opportunity to be part of the integrated inspection pilot and latterly in supporting fully the chair and the partnership support manager in taking forward a formal appeal against an un-evidenced inspection outcome in November 2014. The outcome of the appeal process whilst successful, was protracted and challenging for those directly involved and has without doubt led to work that would have been the day to day work of the support team being delayed.

Most notably there have been unavoidable delays in taking forward the development of a revised business plan for 2015-2018, which was further compounded by an OFSTED re-inspection shortly after the reporting year for the 2014-2015 annual report concluded.

In measuring the success of the SSCB in respect of its core business objectives there has been significant progress in 2014-2015:

- The learning and improvement framework is now beginning to embed into practice and work is underway to not only recognise but publish examples of good practice. The work of the CCG in conducting the deep dive audit into the impact of learning from serious case reviews is a key example of how single agencies are responding positively to learning recommendations.
- Some specific practice improvements have been informed by serious case review learning i.e. the early help strategy and MASH arrangements and whilst there are clearly improvement issues relating to both areas there is a strong platform upon which to build service developments.
- Through the dissemination of findings from the 2014 Section 11 audit further specific opportunities to engage with the boroughs and districts have arisen. The SSCB is continuing to build on the work in 2013-2014 with boroughs and districts in relation to their roles and responsibilities in housing, and we are delighted to report that this has led to an annual conference being planned by the borough and district councils for September 2015, representing a key opportunity to meet housing providers and deliver key messages.
- Health organisations across Surrey have pro-actively engaged in addressing practice improvements and are robustly addressing safeguarding concerns in

a private provider, demonstrating a high degree of professional scrutiny and challenge. Regular reporting to the SSCB provides updates and consideration of emerging challenges that the partnership faces and enables the SSCB to take forward national issues to NHS England.

- The SSCB performance scorecard has been further reviewed and developed and now incorporates commentary from agencies alongside their data. There remain challenges in obtaining housing data and CAMHS data, but partners are working to find a solution to overcome these gaps.
- A particular strength of the CDOP chair being the director of public health has become increasingly evident as key national messages and learning from both Public Health and CDOP can now be shared and disseminated through newsletters and the SSCB website to a wide range of subscribers and practitioners. All the CDOP processes have been subject to a formal review during 2014-2015 and a report will be presented to the SSCB meeting in July 2015.
- SSCB has commissioned two serious case reviews and published three serious case reviews in 2014-2015. This demonstrates an ongoing and continued commitment to learning. These reviews have used a variety of methodologies and have involved families, managers and practitioners.
- The completion of the first Section 11/S157/175 Audit with schools, developed during the last reporting year has been highly successful with over a 66% return rate. The independent school sector also responded positively to the initiative and there are proposals in planning to broaden the scope of future Section 11 Audits.

In addition, the SSCB has provided robust scrutiny of some specific issues within Surrey which have included:

- Monitoring of an independent provider of mental health services for young people where there have been safeguarding concerns.
- Continued monitoring of the outcome of the capacity and capability review of the current arrangements following the national changes to probation services.
- Increased reporting to SSCB on the performance of the processes which support children subject to a child protection plan, and the engagement of partner organisations.
- A continuing focus on the children's trust arrangements and the development of a children and young person's plan with shared strategic objectives.
- A continuing focus on the early help strategy and impact of the re-structuring of Children's Services which took place in April 2014.
- The effectiveness and fitness for purpose of the of the MASH.

- Leading and supporting the CSE arrangements and strategy in Surrey and developing a clear action plan and referral pathway.

The SSCB business plan is currently being developed and it is proposed will include broad priorities relating to:

- early help
- safeguarding adolescents
- child sexual exploitation
- domestic abuse.

Targets will include specific monitoring of the areas for improvement identified by OFSTED and those identified through the learning and improvement framework.

In the wider context the SSCB is driving forward the expectation that the relevant partnership bodies develop and implement strategies that will improve outcomes for children and receive regular reports of progress, providing opportunity for discussion and challenge to inform progress.

Looking forward: 2015-2016

Continuing targeted priorities:

Targeted priority 1 To monitor and challenge the effectiveness and impact of the domestic abuse services in reducing the incidences of domestic abuse and protecting children and young people from harm.

Targeted priority 2 To challenge, scrutinise and support the effectiveness of the delivery of early help for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Services.

Targeted Priority 3 To assess, evaluate and report on the response and impact of partners work to protect children and young people at risk of CSE.

Targeted Priority 4 To hear the voice of children and young people and ensure that this contributes to the work of the SSCB.

Additional areas of focus for Surrey Safeguarding Children Board in 2015-2016

1. Increased engagement with the voluntary, community and faith sectors across Surrey to raise awareness and to begin the process of assuring the quality of safeguarding processes will be carried forward to 2015-2016. There has been some limited progress with engaging the voluntary sector in board activities and with sub-groups, however the engagement with the faith communities requires significant further development beyond the engagement of the Anglican faiths.
2. To continue to improve formal participation by children, young people and their families and staff in the work of the SSCB to ensure the priorities are appropriate and that services are of good quality.
3. To support and monitor the improvement activities of partner agencies in their response to inspections. To ensure that the SSCB is effectively providing challenge and scrutiny to the local authority improvement plan and monitoring the progress against action plans developed by Surrey Police, health and Probation and Youth Justice agencies and that there is synergy and alignment.

Key messages for 2015-2016:

Key messages for partner agencies and strategic partners

- To ensure that efforts are made by all partners (including those working with adults) to secure effective early help for families and those children in need of protection are identified quickly and receive appropriate support.
- To ensure staff across all a partner agencies share information at the earliest opportunity and proactively challenge decisions that fail to adequately address the needs of children, young people and/or their parents/carers.
- To ensure that work continues to address domestic abuse and that the evaluation of the local strategy and interventions being made inform future planning of initiative and interventions.
- To ensure substance misuse services continue to develop their role in respect of safeguarding children and young people and that greater evaluation is undertaken in regard to the links between parents/carers substance misuse and the high number of children and young people at risk of significant harm.
- To ensure work being undertaken to tackle neglect is evaluated and evidence of its impact on children and young people informs both strategic planning and service delivery.
- To ensure that the priority given to child sexual exploitation by the SSCB is reflected within strategic planning and in partner agencies support for the ongoing work of the board's sub-groups.
- To ensure that the role of voluntary organisations and faith groups is recognised and increased support is made available to ensure they play their part in safeguarding children and young people.

Key messages for chief executives and directors:

- To ensure that the protection of children and young people is considered in developing and implementing key plans and strategies.
- Ensure the workforce is aware of their safeguarding responsibilities and can access SSCB safeguarding training and learning events.
- The contribution of your agency to the financial resourcing and work of the SSCB is categorised as a high priority. Every agency must ensure that it takes into account the priorities within the SSCB business plan and the agency's own contribution to the shared delivery of the SSCB's work.
- The role of each agency in meeting the duties of Section 11 of the Children Act 2004 is clearly understood and accurate returns are submitted in a timely manner.

- Each agency is able to contribute to the work of the SSCB with appropriate resources and personnel.
- Ensure the SSCB remains informed about any organisational restructures in order to understand the impact of restructure on capacity to safeguard children and young people in Surrey.

Key messages for the children and adult's workforce:

- Support the SSCB in seeking to ensure that the wishes of children are recorded and inform decision making.
- Ensure you are booked onto, and attend, all safeguarding courses and learning events required for your role.
- Be familiar with, and use when necessary, the SSCB threshold and safeguarding procedures to ensure an appropriate response to safeguarding children and young people.
- Be clear about who is your representative on the SSCB and use them to make sure the voices of children and young people and frontline practitioners are heard.
- Ensure you raise concerns and challenge any safeguarding decisions you feel are inappropriate and are familiar with the SSCB escalation policy.

Financial resources

Financial contributions to the SSCB budget for the financial year 2014-2015 remained the same as the previous year, totalling £310,177.00.

The board support team restructuring was agreed and implemented during 2014-2015 to support the key functions of the board. The support team consists of a partnership support manager, quality assurance and evaluation officer, training development and commissioning officer, a case review officer, a child death coordinator and administrative support.

Contributions to 2014-2015 budget

Organisation	Contribution	Percentage of total
CCGs	131,852	42.52
Surrey County Council	118,195	38.11
Surrey Police	27,765	8.95
NHS trusts	13,500	4.35
District and boroughs	11,000	3.53
Probation	7,315	2.36
Cafcass	550	0.18
Total	310,177	100.00

Costs associated with the SSCB

Cost heading	Expenditure 2014-2015	Expenditure 2013-2014
Employee related costs	274784	324083
Staff expenses	9449	6092
Training expenses	24631	71219
Other costs	3082	6601
Independent reviews/case reviews	23447	51576
Independent chair	24631	31064

Report contributors

- SSCB Independent Chair
- SSCB Partnership Support Manager
- SCC Head of Safeguarding
- SSCB Quality Assurance and Evaluation Officer
- Designated Nurse Safeguarding Children
- Director of Quality and Governance, Guildford and Waverley CCG
- Chairs of SSCB Sub Groups
- Surrey Police Public Protection Unit
- Surrey Police Diversity Crime Unit
- SSCB Training and Development Officer
- Director Surrey and Sussex probation trust – is this right?
- Early Help Partnership Manager
- REMA Lead teacher (West)
- Elective Home Education
- SSCB Area SEND Programme Leader
- Assistant Team Manager - Family and Friends Team
- Head of Community Partnership & Safety
- Director of Public Health

Appendix A business plan review

March 2015 SSCB business plan review and impact summary

Surrey Safeguarding Children Board (SSCB) was established as a statutory board under Section 13 of the Children Act 2004, Working Together to Safeguard Children (March 2015). Section 14 of the Children Act sets out the objectives of the local safeguarding children board (LSCB):

i. To co-ordinate and,
ii. Ensure the effectiveness of, what is done by each person or body represented on the board for the purpose of safeguarding and promoting the welfare of children in the area.[1].

The SSCB provides a strategic framework for partner agencies in order to maintain a focus on their responsibilities to safeguard and promote the wellbeing of all children and young people.

This document is designed to summarise SSCB's strategic business plan priorities, desired outcomes for children and young people and some associated measures of success for the coming three years with annual review (i.e. April 2012 to March 2015).

The SSCB is committed to working closely with other themed partnerships (including Community Safety Partnerships, the Health and Wellbeing Board and Surrey Children and Young People's Partnership) to ensure strategic co-ordination around common priorities and effective use of limited partnership resource.

Regulation 5 of the local safeguarding children boards' regulations 2006 sets out the functions of the board in relation to its objectives set out above.

1. Overarching priority:

To ensure the SSCB is able to deliver its core business as identified in Working Together 2015. In order to do this it has five core business objectives:

- Optimise the effectiveness of arrangements to safeguard and protect children and young people.

1 Working Together to Safeguard Children, 2015 Chapter 3.

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

Targeted priorities: In addition to the delivery of core business the SSCB has identified four areas of need on which to focus its attentions and resources which are reported upon in this review:

Targeted priority 1 To work with partner agencies to reduce incidences of domestic violence and the impact this has on children, young people and families.

Targeted priority 2 To ensure sufficient, timely and effective early help for children and families who do not meet the thresholds for children's social care.

Targeted priority 3 To ensure professionals and the current child protection processes effectively protects those children identified in need of protection and who are looked after.

Targeted priority 4 To work with partnership agencies to develop, agree and implement a multi-agency child sexual exploitation strategy capturing and developing work undertaken CSE/missing children work plan.

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

1.1

	Action	Progress to 31 March 2015	Impact
1.1.a	Ensure there is a robust process in place for multi-agency audit and case review	• An analysis of audit findings and learning from case reviews has identified audit themes	• Annual plan for audit in place enabling better multi agency planning.

	Action	Progress to 31 March 2015	Impact
	informed by SSCB review of current quality assurance (QA) arrangements. These should link with SSCB strategic priorities: a) domestic abuse b) impact of early help c) children who are subject to child protection plans (CPP)/looked after children (LAC).	for 2015-2016. • Domestic abuse audit findings have been disseminated. Communication links between DA strategy work/DA website and SSCB website and Community Safety Partnership to signpost partners and workforce to appropriate resources. • Early help strategy roll out to partner agencies through targeted workshops and early help networks has continued throughout 2014/15. The impact of the changes was reported on 10 March 2015 and further areas for development identified. • Early help audit on quality of early help assessments and team around the child; includes partners file review role of lead professional and step up/step down process has been undertaken and actions arising are being taken forward through the early help governance board.	• SSCB website updated to include links to DA website. DA guidance reviewed and updated to signpost to agencies. • See minutes of SSCB 10 March 2015 and actions arising. Business plan 2015-2018 to pick up ongoing concerns. • Findings of EH audit and audit of step up step down identified fully reported upon – see SSCB minutes. Some significant concerns highlighted to be taken to e-help governance board.
1.1.b	To develop an effective performance management framework to measure outcomes and impact of the work of the SSCB through agreed partnership data and the performance information/measures identified in this	• SSCB report card: A revised and improved multi-agency data set has been developed and further areas for improvement have been identified. Missing children data, including data on return interviews will be included as an Annex	• More comprehensive data set developed. Some data still not provided by partners - housing data from BDCs is hard to obtain. • CAMHS data not available- highlighted as area of concern to be addressed. • Missing children return interviews are being

	Action	Progress to 31 March 2015	Impact
	business plan.	in the Q4 data set prior to incorporating into the full report in 2015-2016. The attainability of data, timing of data and frequency have all been considered. Partners, in addition to providing data, provide narrative to provide context to the reporting. • Data governance issues relating to health data have been resolved and there is an agreed health dashboard in place with Q1 and Q4 reporting.	undertaken for LAC children only. • Partners now providing context to data provided to avoid misinterpretation. • CCG have led on achieving an agreed dashboard reporting in Q1 & Q4.
1.1.c	To complete Section 11 audits and ensure this process is robust and pro-active in its responses to partner organisations and supports continuous improvement.	• 2014 S11 audit has been completed and reported to the January 2015 board. Workshops are being taken forward with key partners to disseminate learning and identify improvements. • Schools Section 11 document has been agreed by education phase councils and will be reporting in summer 2015.	• Minutes of SSCB 27 January record discussion. Woking BDC have not completed return- chased and being followed up. • Focused workshops to be undertaken to provide feedback and discuss next steps with key partners. • S11 returns from schools being collated reporting to July 2015 board.

1.2

	Action	Progress to 31 March 2015	Impact
1.2.a	Partner agencies and sub-group chairs to submit reports to the SSCB as and when required and at least annually. A proportion of these will be those identified in Working Together (e.g. CDOP, MAPPA)	• LSCB is informed of activity being undertaken by partners which supports the overarching priority of ensuring effectiveness. • A reporting calendar has been developed and is in place which ensures regular	• Reporting calendar informs agenda planning.

	Action	Progress to 31 March 2015	Impact
	but in addition annual IRO reports, complaints reports etc.	updating of the board from a wide range of agencies.	
1.2.b	SSCB produce an annual report for submission to the Surrey Children and Young People's Partnership and other identified agencies/partnerships in accordance with Working Together guidance.	• 2014-15 SSCB annual report is currently being written and will be published in September 2015. • The report makes recommendations to Surrey Children and Young People's Partnership, Community Safety Board and Health and Wellbeing Board and other relevant bodies to inform wider strategic planning and development.	• Information to contribute to the report is being collated. Reporting and governance arrangements in place. • Closer working arrangements between SSCB partnership support manager sits on CYPP operations group and regular meetings with democratic services leads to greater understanding of members' priorities.

1.3

	Action	Progress to 31 March 2015	Impact
1.3.a	Oversee and monitor the implementation of serious case review process and the CDOP processes.	• Serious case reviews and partnership reviews take place in accordance with the relevant guidance in Working Together 2015 and are mapped to identify recurring themes with DHRs. These themes inform board led activities through the implementation of the learning improvement framework. • Chairs of CDOP and SCR groups report quarterly to the operations group. • SSCB review recommendations of serious case reviews and agree actions and media publications to embed learning.	• Shared learning and issues arising shared with Community Safety Partnership Board. • Training programme and course content informed by learning. • Audits in place to check embedding of new/revised procedures and provide feedback mechanism. • Partnership review KH undertaken as audit of use of bruising protocol.

	Action	Progress to 31 March 2015	Impact
1.3.b	Ensure that learning from the review processes is: • shared with the children's workforce.	• SSCB learning improvement framework sets out the dissemination of learning. • Learning events and learning from serious case review leaflets are utilised to share learning through the SSCB newsletter. National and local learning informs training programmes and audit activities. • Work to overcome some of the barriers to learning from reviews transferring into practice has been undertaken and dissemination of learning has been reviewed with partners as part of ongoing work.	• Communication through sub groups effective-wider dissemination in single agencies less determinable. Communication strategy being developed to include named roles in each agency that external and internal communications will be sent to.
1.3c	Monitored through quality assurance processes to ensure that workforce understanding and confidence and subsequent support to children is improved as a direct result of the learning. Public health messages are effectively disseminated to the wider population.	• Measurements of the impact of improved learning and policy development as a result of serious case reviews/partnership reviews is being developed and a communication strategy will be published in summer 2015 identifying information leads in all partner agencies who will take responsibility for the circulation of new/revised policies and procedures to teams. • Measurements of the impact of serious case reviews on the broader safeguarding agenda and reducing safeguarding risks in respect of public health messages is not yet in place director of public health is now a member of the SSCB and also the chair of the child death overview panel. • Strategic case review group monitor and record progress against action plans and hold partners to account.	• As 1.2 above • Improved information sharing re CDOP modifiable factors and opportunity to influence commissioning of services. • See individual action plans for progress.

1.4

	Action	Progress to 31 March 2015	Impact
1.4.a	To move to a training commissioning model and monitor and review the implementation of the full SSCB training programme.	• E-suite processes have been developed further to include a revised and improved on line payment system. Discussions are continuing about the development of a training portal using the Surrey Academy Learning Platform. • A non-returnable booking fee to offset the cost of cancellations and no shows of £12 per booking has been agreed and will be implemented from 01 April 2015. • Development of training resources particularly the exploration of e-learning options and specialist courses has been a focus of work and partners are able to access Prevent, safer recruitment, CSE awareness through the Surrey Skills Academy.	• Online booking and payment system has reduced administrative input in support team: easy to use system for workforce. • Online payments system has removed need for invoicing and achieved improved use of resources by the SSCB. • Cost off set to cover administrative burden of 'no shows' will have positive impact on budget; some partners will need to review systems for refunding staff. • Links to e-learning in place for CSE; safer recruitment. WT 2015 to follow shortly - increasing accessibility to the wider workforce and provide flexible learning option.
1.4.b	Introduce a framework to monitor the impact of training on workforce competence and confidence and support to children and families.	• Evaluations from training programmes have been analysed and reported upon. An online system was implemented in December 2014 which is being widely used by partners. • Learning action plans are in place for all module 1 training programme delegates to aid planning of SSCB programmes.	• Online evaluation system working well. Ease of analysis reduces resource requirements for reporting purposes. • All course participants embarking on module programme have sign up and commitment to release for training from direct line manager. • Personalised feedback received tailored to individual.
1.4.c	To ensure the effectiveness of the role of the local authority designated officer (LADO) and current procedures for	• Senior officers in partner agencies have been identified as first contact with enquiries of workforce allegations. • Annual LADO report presented to SSCB in	• OFSTED highlighted good practice. • Additional resource now recruited and in post creating capacity to support the increase in referrals. • WT 2015 partially

	Action	Progress to 31 March 2015	Impact
	dealing with allegations against the workforce.	November 2014 highlighted the challenges and planned increase in capacity to meet increased reporting. • Working Together 2015 included a change in requirement for role of LADO which is being incorporated into practice.	implemented. National LADO group are not supporting title change of role as work undertaken to raise awareness of LADO role would be adversely impacted.
1.4.d	To review the impact of safer workforce training on agency practice.	• SSCB will be able to determine whether training is informing safer workforce practice and whether minimum standards are being met. Monitoring and measurement will be via the on line evaluation tool and the six monthly reporting to SSCB due September 2015 will include the first nine months evaluation data.	• See training reports to board and evaluation outputs.

1.5

	Action	Progress to 31 March 2015	Impact
1.5.a	• To plan and deliver regular newsletters and updates to all staff. • To agree a mechanism to ensure engagement of children, young people and their families in measuring the effectiveness of safeguarding arrangements. • To agree a mechanism to enable staff to measure the effectiveness of arrangements in safeguarding	• Newsletters raise awareness of key issues. Circulation broadened through link on SSCB website. Circulation list is increasing with each publication. Positive feedback received and contributions from partners are improving. • SSCB participation work is being developed and there is increasing evidence of partners seeking service user feedback on services received. • Work with families and children remains in the early stages of development as the views of service users are critical and provide a balance to data set analysis.	• Circulation increased significantly since re-launch. • Link on website. • Contributions received from parents/carers. • Participation strategy group set up to support the work of consulting with children's and families, currently looking at ways of engaging with young people and how to use social media effectively. • Developing some work to survey young people about CSE. • Young people and parents contributed to the redesign of child protection conference leaflets. • Regular use of surveys and

	Action	Progress to 31 March 2015	Impact
	services.		focus groups to support to seek views of work force as part of audit work.

TP 1	**To ensure sufficient work with partner agencies to reduce incidences of domestic abuse (DA) and the impact this has on children, young people and families.**

	Action	Progress to 31 March 2015	Impact
TP 1.1	To ensure all children and young people affected by domestic abuse have access to sufficient specialist service provision that meets their needs and this is demonstrated through audit activity.	• Area sub group work reflects the local initiatives to support victims and survivors of DA, however this remains a priority for 2015-16 as there is insufficient evidence of support for children and its impact. • The Linx programme in Surrey is being rolled out to support recognition of the real need to support young people who have witnessed domestic abuse. Funding of £48,000 was secured from the OPCC. The SSCB will receive updating reports of progress as part of DA updates. • Children's Services has commissioned and awarded a two year grant to Surrey DA providers to deliver support for children and young people affected by DA. This will cover Prevention (healthy relationships), early help (step-down community support) and intervention (support for CYP on a child in need plan or child protection plan). • The OPCC have provided 16k to each of the four DA outreach providers to deliver 1:1 support for children affected by DA. Outcomes will be reviewed at end of 2015.	• Some good practice in south-east quadrant to support children affected by domestic abuse (DA) through attendance at a weekend club. • 37 workers trained to deliver LINX, as at April 2015, have reported increased confidence in talking to young people about DA in their day to day work. The topic has been embedded in wider relationship and sex education programmes with groups of young people and within 121 work for those who are known to have witnessed domestic abuse or experienced poor treatment in intimate relationships. • This grant started on 1st June and has already seen referrals for early help, where the providers are embedding themselves in the RAIS teams and referrals for Interventions from CP teams. Updates will be available on a quarterly basis.

	Action	Progress to 31 March 2015	Impact
TP 1.2	To ensure a consistent holistic approach to children and young people affected by domestic abuse through the development of a skilled workforce.	• SSCB do not deliver DA training but link into the Surrey CC DA training programme, which is multi-agency in its delivery. SSCB have contributed to resource development and key representatives sit on the LCD sub group and policy and procedures group and provide a direct link to the DA development group. • Externally delivered DA training has been included in the SCC online training programme which will be broadened to capture other multi-agency delivery of partner organisations. Discussions are at an early stage to incorporate this into future SSCB training programmes.	• Comprehensive training offer provided through SCC. • E learning awareness programme available on skills academy.
TP 1.3	To monitor the domestic abuse strategy to identify if there are ways in which partners can work together more effectively to intervene early and mitigate the impact of domestic abuse on children and young people.	• Strategy published September 2013. DA development group leading on developing an implementation plan with regular reporting of progress and challenges to the SSCB. • Partnership support manager sits on DA development group. • End of 2014/15 action summary and draft 2015/16 action plan update provided for May 2015, the future plan will be finalised and monitored via the DA development group. • DA pathways mapped, development of the MASH and phase two Family Support Programme to further develop earlier interventions and TAF approaches inclusive of DA.	• Regular reporting to SSCB. No formal action plan shared detailing implementation of actions.

TP 2	To ensure sufficient, timely and effective early help for children and families who do not meet the thresholds for children's social care

	Action	Progress to 31 March 2015	Impact
TP 2.1	To monitor the effectiveness of the Surrey Children and Young People's Partnership arrangements for early help through audit of cases which are subject to CAF/TAC processes and children subject to child protection plans.	• Early help update was presented to board on 10 March, the SSCB audit highlighted some areas for consideration by the EH governance group particularly around step up/down and the link between EH and Family Support Programmes. • Clarity is required on the routes/ access to services via the 'front door' and MASH. • Multi-agency levels of need document was updated in January 2015 to be more explicit about Children's Services involvement at Level 3. • QA officer monitoring the development of the e-early help assessment via audit. • SSCB report card details activity, quality and timeliness of decision making.	• Lack of clarity of interface between FSP and e-help. • Uncertainty of referral pathway and processes particularly how step up/step down is monitored and tracked. • MA level of needs document revision ratified through P&P group. • Follow up audit 2015/16.
TP 2.2	To undertake survey of children, parents/carers on their experience of early help provision to inform commissioning of appropriate services.	• The experience of children and families is not yet evidenced as informing service development. The participation agenda is a priority area of work for the QA group in 2015/16. A task group have started to engage young people and parents. • Task and finish group meetings have been held to identify approaches and planning for participation work. • Surrey Youth Focus has met with the SSCB and have agreed to support some of the participation work and will attend future board meetings.	• Targeted Survey of experiences of children accessing CP processes undertaken in March. Despite sending out 300 letters only three families interviewed with a total of 12 children. SSCB anticipate repeating this work in late 2015 early 2016. • Surrey Youth Focus representation to attend board from May 2015 to bring additional voice of youth.
TP 2.3	To comment on the early help strategy as it is developed to	See 2.1 above	• Ongoing monitoring reporting and audit raises significant concerns of how children in need are managed in Surrey and the effectiveness of step

	Action	Progress to 31 March 2015	Impact
	ensure that it has an effective needs analysis and sufficient services to meet need.		down arrangements. Board seeking additional assurances

TP 3	**To ensure professionals and the current child protection processes effectively protects those children identified in need of protection and who are looked after**.

	Action	Progress to 31 March 2015	Impact
TP 3.1	To monitor the effectiveness of arrangements by Children's Services and partners when children are subject to child protection plans or LAC through rigorous single and multi-agency audit activity to include quality of practice, management oversight, care planning etc.	• Single-agency and multi-agency case file auditing demonstrates that children are being safeguarding by effective multi-agency practice and identifies where improvements are necessary. • Audits have been undertaken and reported back to the area groups and quality assurance groups. • Corporate Parenting Board report and IRO reports on LAC forms part of board reporting calendar.	• Robust data in SSCB data set updates partnership and allows challenge and discussion re increasing number of children subject to CP plans, length of time on a CP plan. Trend of children staying on plans for longer identified and challenged • Partnership support manager attends Children's Services Improvement board meetings leading to increased understanding of challenges and data.
TP 3.2	To monitor the effectiveness of the arrangements for the conferencing of CP and LAC reviews and evidence of the quality of challenge and decision making.	• CP reports are provided to the board four monthly and IRO report annually. • Issues and challenges are discussed and actions identified. • SSCB report card data provides information relating to number, timing, and duration of activities including early help.	• Attendance at CP conferences subject of challenge and debate at SSCB. See minutes January 2015.

	Action	Progress to 31 March 2015	Impact
TP 3.3	To monitor the effectiveness of key partner agency professionals in the CP and LAC processes through IRO annual report, corporate parenting panel annual report etc.	• Auditing activity demonstrates some challenges in the effective engagement by partner agencies in CP and LAC processes and work identified to support improvement. • Reports are provided to the board as part of the reporting calendar.	• Engagement of GPs in providing reports and poor attendance at conference challenged named GP formally responded March 2015. SSCB minutes record discussions.
TP 3.4	To monitor the effectiveness of SCC's contact and referral arrangements and thresholds for children's social care.	• Multi-Agency Safeguarding Hub (MASH) has been established and regular reports are provided to the board together with impact reporting. • Multi-agency threshold document published and available on website. • Regular update reports are provided to the board.	• Concerns relating to up to six front doors to Children's Services is causing confusion. • Report on effectiveness of MASH suggests significant changes are required – MASH project board in place. Formal review recommendations being taken forward by partnership. • Multi-agency threshold document ratified and updated on website.

TP 4	**To challenge and scrutinise the effectiveness of the response and impact of partners work to protect children and young people at risk of Child Sexual Exploitation**

	Action	Progress to 31 March 2015	Impact
4	To develop and agree the implementation of a child sexual exploitation strategy.	• Multi-agency CSE strategy agreed and published. Communications plan agreed. • Membership of CSE strategy group and governance have been undertaken in light of nationally publish reports. A new structure. Terms of reference and membership will take forward work within Surrey from 01 April 2015.	• Published national reports have been reviewed and mapped. • CSE group structure, governance and membership reviewed and updated. • Terms of reference updated.
4.1	Implementation of strategy – key priorities identified and	• A revised work plan and implementation plan are being developed and overseen by the CSE strategy group. A CSE	• Action plan reviewed and updated. • Progress updated in minutes of CSE strategy group/task &

	monitoring procedures agreed.	Learning pathway is currently being developed together with a practitioners' toolkit by a short term task and finish group. • Data/monitoring procedures are being developed linked to missing children monitoring.	finish group and reports to SSCB.

Communication/publication of the SSCB annual report

- review and approval SSCB — 24 November 2015
- publication by SSCB following approval — 1 December 2015
- presentation of report to:
  - Cabinet — 22 March 2015
  - Surrey Children & Young People's Partnership — tbc
  - Health and Wellbeing Board — 10 December 2015
  - Social Care Services Board — 25 January 2016
- distribution of report