Surrey Safeguarding Children Board (SSCB)

Annual Report 2015 – 2016

Foreword from the Independent Chair

I am delighted to present the Surrey Safeguarding Children Board (SSCB) 2015 – 2016 annual report, having taken over the role of Independent chair from Alex Walters in October 2015.

At the time of writing this report considerable improvement has been made to safeguarding practice across the partnership in Surrey. In particular much effort has been made to ensure that strong leadership is in place, providing improved management oversight and governance. An open and supportive relationship has developed between Children's Services, Health, Police and SSCB senior leaders and the improvement process continues to have strong political and corporate leadership.

However, this has been a challenging report to present because it is underpinned by the OfSTED inspection of services for children in need of help and protection; children looked after and care leavers.

The overall OfSTED judgement was that children's services were inadequate, and the inspection report cited failures in leadership, management and practice. The inspection took place in November 2014, and the report was published in 3 June 2015.

The inspection report for the Local Safeguarding Children Board was published in August 2015. OfSTED found that the arrangements put in place by the SSCB to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children required improvement.

As part of its annual inspections into police effectiveness, efficiency and legitimacy (PEEL), HMIC assessed Surrey Police in December 2015. At the heart of this inspection is the protection of people who are vulnerable. This inspection focused on 4 areas including how well the force responded to and safeguarded missing and absent children & victims of domestic abuse and how well prepared it is to tackle child sexual exploitation. HMIC found that Surrey Police were undoubtedly committed to protecting vulnerable people, but there were serious weaknesses in the force's arrangements for protecting vulnerable people from harm and supporting victims. Surrey Police were graded as inadequate.

The council established an Improvement Board, chaired by the deputy leader of the council with political cross-party membership in November 2014. An Improvement Plan was published in September 2015 and the membership of the Improvement Board widened to include key representatives from partner agencies (Police, Health, Schools) and the Chair of the SSCB

The Improvement Board, SSCB, SCC, Police and partners have worked hard to improve their understanding of the needs of vulnerable children and professionals in Surrey. Partners have taken on board the need to learn from the inspection reports and build on the things they do well to ensure they are applied to all aspects of their work.

During 2015 – 2016 the SSCB developed its own improvement plan and carried out its statutory functions to enable it to achieve its objectives under Section 14 of the Children Act

2004. SSCB's core function is to: co-ordinate 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. Through its own work, and its representation on all key Surrey Boards, SSCB has supported, challenged and influenced the improvement journey in Surrey.

Whilst this report necessarily points out the shortcomings found in services during 2014 – 2015 and 2015 – 2016 inspections, readers are to be assured that the building blocks for improvement are in place. It is sincerely hoped, and anticipated that the 2016 – 2017 annual report will show evidence of improved services for children in Surrey.

Against this background I would like to thank everyone involved in working so hard for the future of Surrey's children and wish them well for the coming year.

Elaine Coleridge Smith
Surrey Safeguarding Children Board

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Who are we and what do we do?

What is the Surrey Safeguarding Children Board (SSCB)?

The SSCB is the key partnership body overseeing multi-agency child safeguarding arrangements across Surrey. The Board is governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006. SSCB members are senior leaders from a range of different organisations committed to ensuring the effective operation of the SSCB.

The Board's two basic objectives are to **co-ordinate** the safeguarding work of agencies and to ensure that this work is **effective**. These objectives are defined within the Children Act 2004.

SSCB coordinates local work by:

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

SSCB ensures the effectiveness of local work by:

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

Key roles and relationships

The Independent Chair

During 2015 – 2016 the SSCB had two Independent Chairs. Alex Walters was Chair from April – August then Elaine Coleridge Smith took over the role from September 2015.

The Chair is supported by a Board Manager and a dedicated team. The role of the Chair is to provide strong leadership and ensure that the Board fulfils its statutory objectives and functions; this is done by encouraging challenge and scrutiny across all partners with regards to their safeguarding arrangements.

The Independent Chair is accountable to the Chief Executive of Surrey County Council and has met regularly with the Chief Executive and the Deputy Chief executive, Julie Fisher who is also the Director of Children's Services.

Board members and attendance

The Board met six times during 2015 – 2016, including a development event following the May meeting. The membership of the SSCB is made up of representatives from all statutory partners and others concerned with safeguarding children.

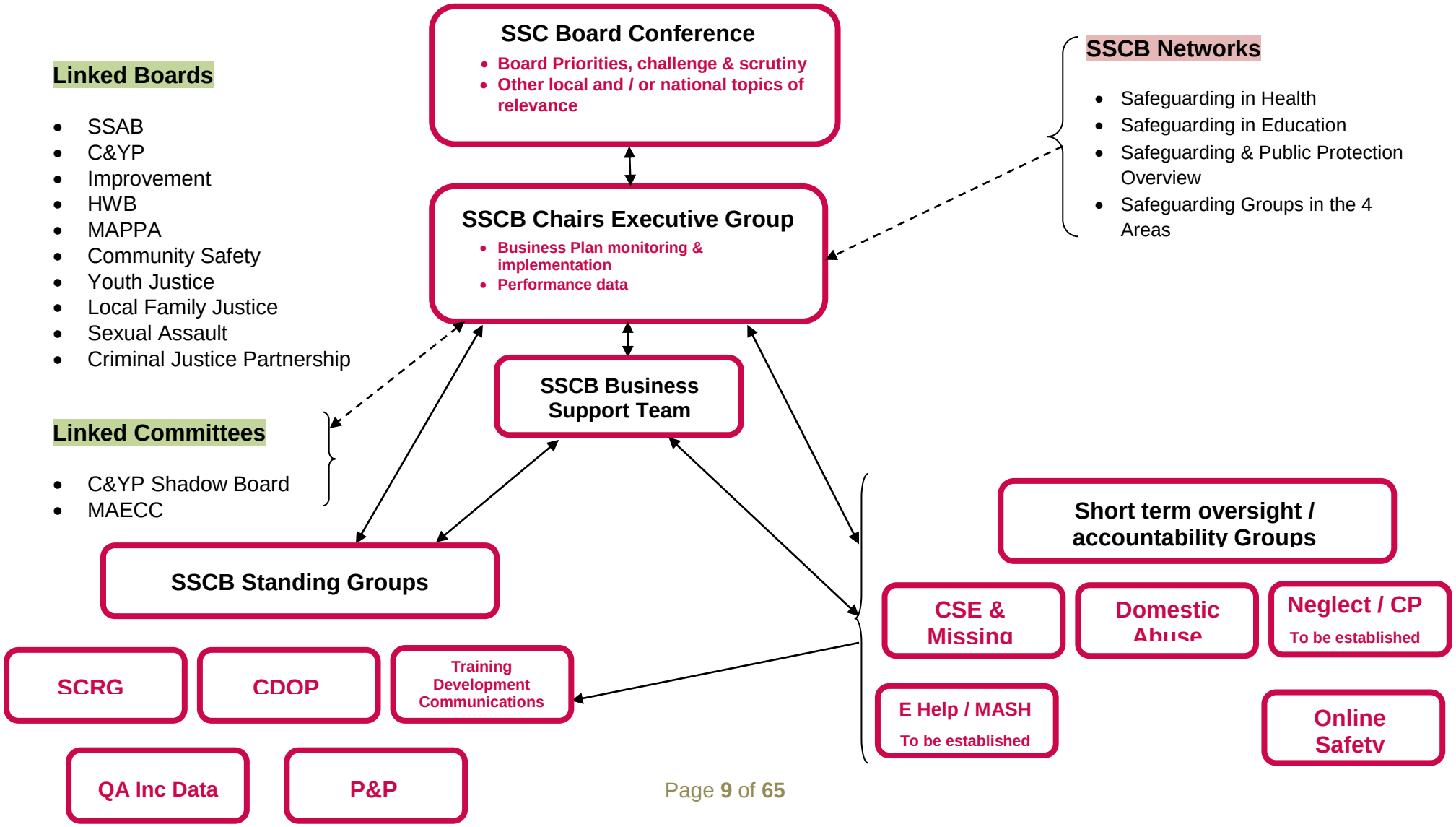
The attendance rates by agency for 2015 -2016 Board meetings are set out below

Independent Chair	100%
SSCB Board Manager	100%
Borough & District Rep	67%
Cafcass	67%
Central Surrey Health	50%
Community Rehabilitation Company	50%
Designated Doctor	67%
Designated Nurse	100%
Education: Primary Phase Council	83%
Education: Secondary Phase Council	67%
Education: Special Phase Council	83%
First Community Health & Care	100%
Further Education	33%
HM Prison	17%
Lay member	86%
Lucy Faithfull Foundation	17%
National Probation Service	83%
NHS Acute Hospital	67%
NHS CCG	100%
NHS England	17%
NHS Mental Health Services	50%
SCC AD Children's Services	83%
SCC AD for Young People	83%
SCC AD Schools & Learning	67%
SCC Director Children's Services	83%
SCC Director of Public Health	67%

SCC Head of Early Years	67%
SCC Head of Family Service	83%
SCC Head of Safeguarding	67%
SCC Lead Member	67%
SCC Principal Solicitor	67%
Surrey Safeguarding Adults Board	33%
Surrey Police: Assistant Chief Constable	83%
Surrey Police: Public Protection	83%
Surrey Youth Focus	83%
Virgin Care	83%

Board Structure (as at 31 March 2016)

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



Financial arrangements

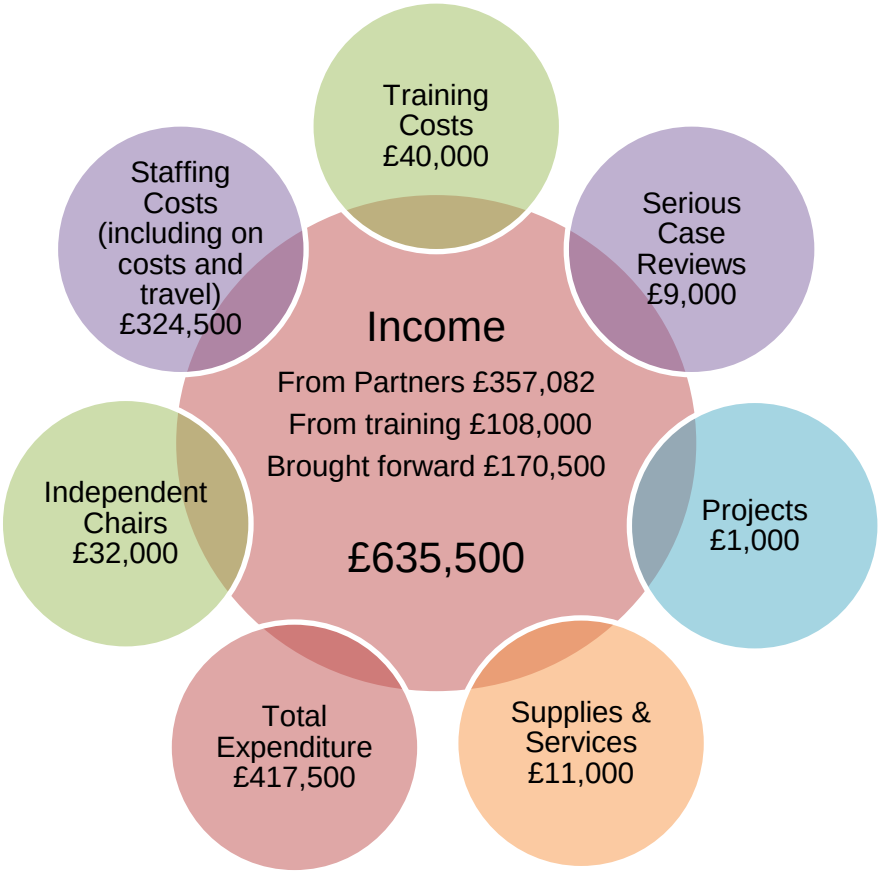
SSCB is adequately funded by partner agencies and has negotiated marginally increased funding for 2016 – 2017.

During the period, financial contributions from partners totalled £357,082 with Surrey County Council contributing 46.52%, the CCGs contributing 36.92%, NHS Trusts 3.5%, Surrey Police 7.78%, Boroughs & Districts 3.08%, combined probation total 2.05% and Cafcass 0.15%. As well as contributing financially, SSCB partners contribute 'in kind' providing staff time, venues for training, trainers and hosting arrangements for the support team.

Income from training during 2015 – 2016 totalled £108,000. Training costs were £40,000. Venue costs accounted for £23,000, Training Consultants £16,000, and refreshment costs £1,000. This resulted in a net contribution from the training team of £68,000.

Other expenditures were attributed to the following: serious case reviews, domestic abuse project, supplies and services, Independent Chairs which included additional work in respect of the OFSTED inspection, staffing costs and vacancies in the board team.

An under spend of £170,500 was carried forward from the previous financial year making the total income to the Board £635,500. This enabled the cost of running the Board to be fully met during 2015 – 2016.



"What our lay member says?"

Two lay members were recruited during 2015 – 2016 unfortunately one resigned in February 2016 due to pressure of other commitments. The attendance of lay members at the Board meetings was 83% and their presence brought helpful challenge at the meetings. The current lay member is keen to help the board to have strong links in the community and is very committed to her role and her comments are noted below. Work is underway to recruit at least one other lay member.

> The new Chair Elaine Coleridge-Smith who joined the Board at the same time as myself has brought new direction to the Board and is challenging the different agencies to take responsibility to safeguard the children in Surrey.
>
> As a Lay Member I am keen to help make links between the SSCB and community groups and this is something I would like to focus on during my second year on the Board. I feel there should be stronger public engagement in local child safety issues and improvement in public understanding of the SSCB child protection work.
>
> I have recently attended a development day for Lay Members held by Brighton and Hove LSCB where all the delegates have the same passion as me to help promote the effectiveness of their relevant Boards and to maintain the importance of "the voice of the child".
>
> My commitment to the children of Surrey to help their voice to be heard and how important the communication to the local communities on how they need to safeguard and promote welfare of children is now one of my challenges which I bring forward to my second year on the board.
>
> I believe that every question / challenge is important and it is the Lay Members responsibility to be the voice of the local community."

Communication

Newsletter

The SSCB has published a newsletter quarterly throughout the year focussing on topical safeguarding issues. Feedback received has been very positive.

Commissioning of new website

During the period significant work was undertaken to develop a new website for the SSCB with the aim of improving both the communication and training function of the board:

The new site is due to go live in May 2016 (www.surreyscb.org.uk) and it is anticipated that a dedicated website will:

- Raise the profile of SSCB amongst professional, the public and children

- Support the Board to meet its safeguarding function more effectively and help to meet increasing demands for training, incorporating e learning.
- Facilitate access to the SSCB procedures manual for professionals.
- Increase cost effectiveness.

Development of SSCB Information Leaflet

- The Board has developed and circulated an Information Leaflet with input from a number of young people

Awareness raising at events

- The Board members have held market stalls at a number of events across Surrey, raising awareness of the Board's work by sharing key messages and campaigns, and promoting multi-agency training opportunities
- The training and communications team have been very active in planning for a Surrey wide SSCB conference in November 2016 entitled 'Off the Radar'.

Surrey in Context

Demographics

Surrey has around 283,099 0-19 year olds of which 256,383 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. However, approximately 5,500 are children in need, 860 are Looked After Children and an estimated 28,000 are children living in poverty.

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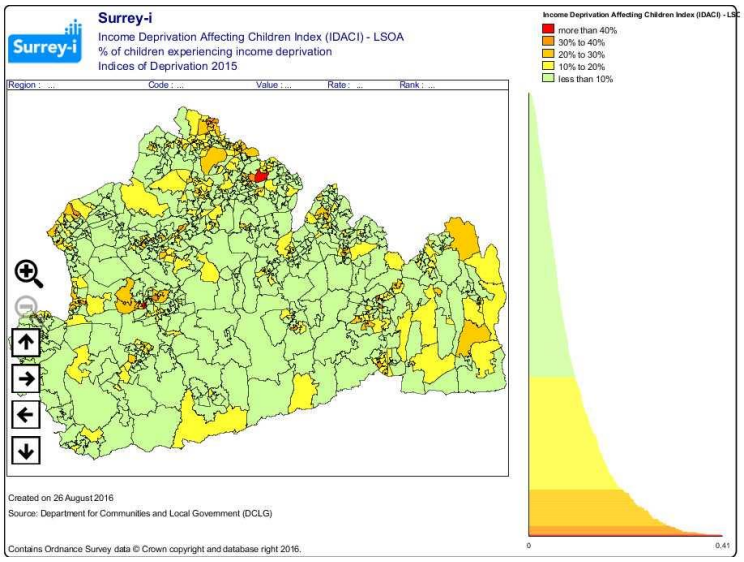


Surrey has one of the lowest rates of **child deprivation** in the UK, with the most recent data indicating that there are approximately 9% of children and young people in Surrey, aged 0-19, living in low income households. Over a quarter of children living in certain areas of Spelthorne and Guildford are living in poverty. There are indications that the current economic climate and welfare reforms are likely to increase family stress and hardship

Overall, Surrey has high standards of educational achievement and, 88% of schools were rated as good or above by OFSTED (2015). However there are educational inequalities associated with socioeconomic deprivation. 500 (2%) of 16-18 year olds in Surrey are not in education, employment or training. This is substantially lower than in the South East (4%) and in England (5%). One fifth of Surrey's pupils are educated in independent schools and there are 800 home-schooled children in Surrey.

The proportion of children entitled to free school meals in primary schools is 9% (the national average is 18%) and in secondary schools is 7% (the national average is 15%).

Children from minority ethnic groups' account for 18.6% of all children aged 0-15 living in the area, compared with 26.1% in the country as a whole. The largest minority ethnic groups of children in the area are Asian and mixed. Surrey is home to the 4th largest Gypsy, Roma and Traveller community in Britain.

The Child's Journey 'feeling safe – being safe'

The OfSTED Inspection of services for children in need of help and protection, children looked after and care leavers was published in June 2015, and found Children's services in Surrey to be **inadequate**. Recommendations for improvement covered every aspect of children's services.

The HMIC inspection in December 2015, found serious weaknesses in Surrey Police's arrangements for protecting vulnerable people from harm and supporting victims, and judged them to be **inadequate.**

The OfSTED Inspection found that the arrangements in place by SSCB to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children **require improvement**

This annual report paints a picture of the situation in Surrey during 2015 – early 2016. During this time considerable efforts were being made to improve all aspects of safeguarding work, however very little was embedded and able to show positive outcomes for children.

Early Help

Contacts, Referrals and Assessments

During the period of this report practice weaknesses were evident at the Referral Assessment Intervention Service (RAIS)

Caseloads of individual social workers in RAIS were high and remain too high. This compromises the quality of practice and the timeliness of assessments. These issues remain more acute in the east of the county where there are challenges with managing the demand and workload due to the high level of vacancies and the necessity to use locums.
At the time of this report there were a number of cases held at the 'team around the child' (early help) level, where risk was not appropriately assessed, identified or managed and a multi-agency statutory response was absent. This left children at actual and potential risk.

Developing the MASH and a coordinated and coherent Early Help offer is key to the development of a longer term and more sustainable solution to the demand pressures and quality issues in the RAIS.

Thresholds – Levels of Need

The OfSTED Review of the effectiveness of the Local Safeguarding Children Board stated that the SSCB thresholds document 'Early help: multi-agency levels of need' does not meet the requirements of statutory guidance. It did not provide clarity about the types of need that can be met through early help, and those requiring a statutory social work service and did not support the staff working in the RAIS.

Surrey SSCB, in collaboration with partners and the newly appointed AD for MASH & Early Help development, has reviewed the threshold guidance. Following completion of the trial period and further training, the document will be approved in autumn 2016.

During this period SSCB has seen improvement in the effectiveness of management oversight within the referral, assessment and intervention service (RAIS). Supervision is improving and poor practice is identified and challenged.

The Multi Agency Safeguarding Hub (MASH)

Surrey MASH is being developed to provide a single point of access ('front door') for both professionals and the public requesting help for a child or adult, where there is a safeguarding concern, and to ensure that the appropriate help is provided based on an agreed level of need.

During the period of this report an independent Consulting company provided leadership and guidance to Surrey. Whilst initial progress was positive, the pace of change in making progress against a number of key areas for the development of the MASH was slow and much remained to be done to improve the quality of front line practice and sufficiently engage partners.

Following the restructure of the SCC leadership team an assistant director took over responsibility for the MASH project, and the scope was expanded to include early help. To date the MASH and Early Help Programme has progressed well and with pace. Strong partnership commitment means that the Surrey MASH will be operational from October 2016.

Surrey partners have agreed for the location of the new MASH to be Guildford Police Station

Children in Need

The OfSTED inspection report found that a number of cases held at the 'team around the child' (early help) level, risk were not appropriately assessed, identified or managed and that a multi-agency statutory response to children in need was absent

Significant work has been undertaken to address these findings. In particular the local authority has introduced revised Children in Need operating model , which became operational in January 2016.

These changes were preceded by clear communications with key partners including health colleagues, schools and police.

The effectiveness of the new model is being monitored through the Surrey Improvement Board, and will be further reviewed by SSCB during 2016 – 17.

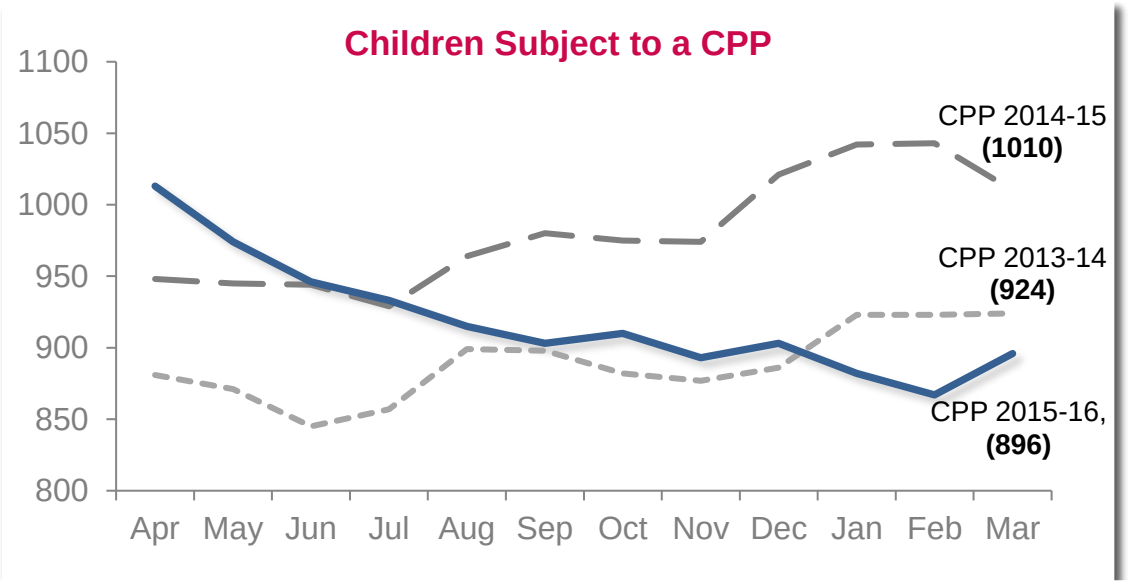
Child Protection

Children find themselves subject to **Child Protection Plans** because they are considered to be in need of protection from neglect and / or physical, emotional, or sexual abuse.

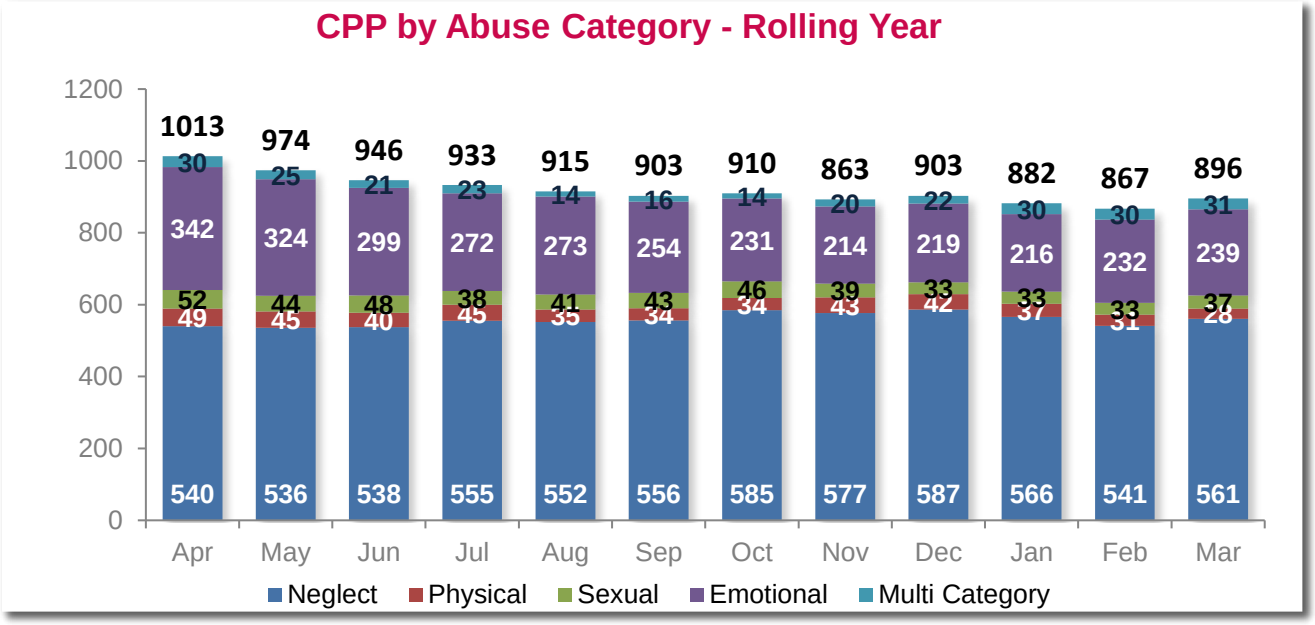
Across Surrey, case loads were high and quality of practice was poor. These Ofsted findings were supported by several audits of Core Groups undertaken by SSCB during the period.

Ongoing areas of concern include

- Quality of Recording
- Attendance
- Timescales
- Engagement of fathers
- Child's Views
- Quality of Child protection plans and use of language
- Specific practice issues that were fed back to children's services teams and to relevant agencies

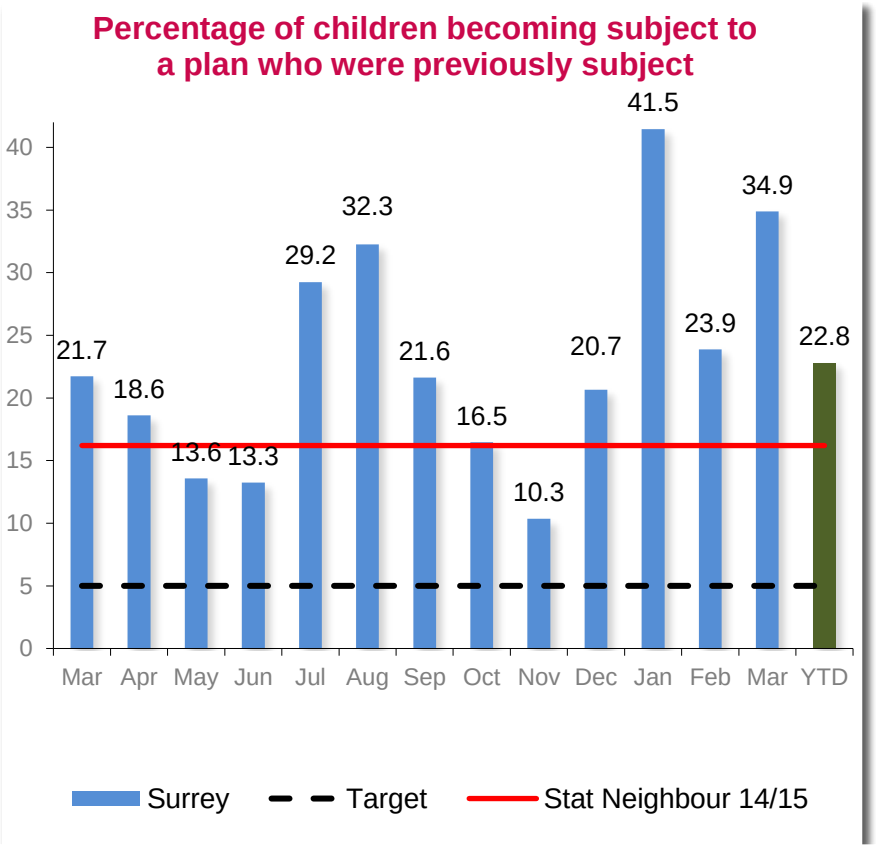


As at March 2016 881 children were subject to a child protection plans compared with 995 in 2014. Of the 881, 457 were male, 403 female and 21 related to an unborn child

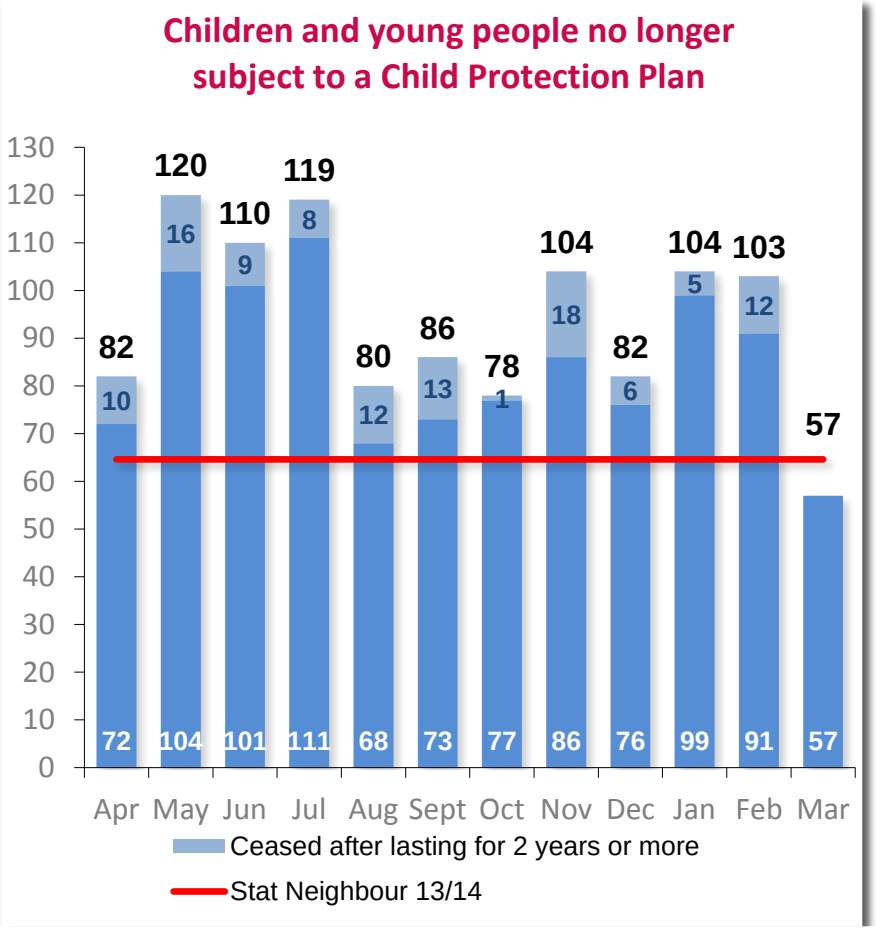


The category of abuse recorded during 2014 – 15 is as follows:

neglect (559), physical abuse (25), sexual abuse (35), emotional abuse (231) and multi category (31).



The number of children subject to a repeat plan has increased.
The percentage at the end of the 2015-2016 reporting year is 23.1%, compared to 17%, in 2014-2015.



The numbers of children whose plans ended after being the subject to a child protection plan for more than two years was 9.9% in comparison to 6.5% in March 2015.

Safer Surrey

SSCB has fully supported the significant amount of work that has taken place to introduce '**Safer Surrey'**. Work is being undertaken to embed skills and tools across the children's social care teams and engaging more widely with practitioners from other parts of the council and partner organisations.

It is encouraging that there are some positive examples of the Safer Surrey approach being used by practitioners, with evidence of good engagement, decision making and outcomes for children.

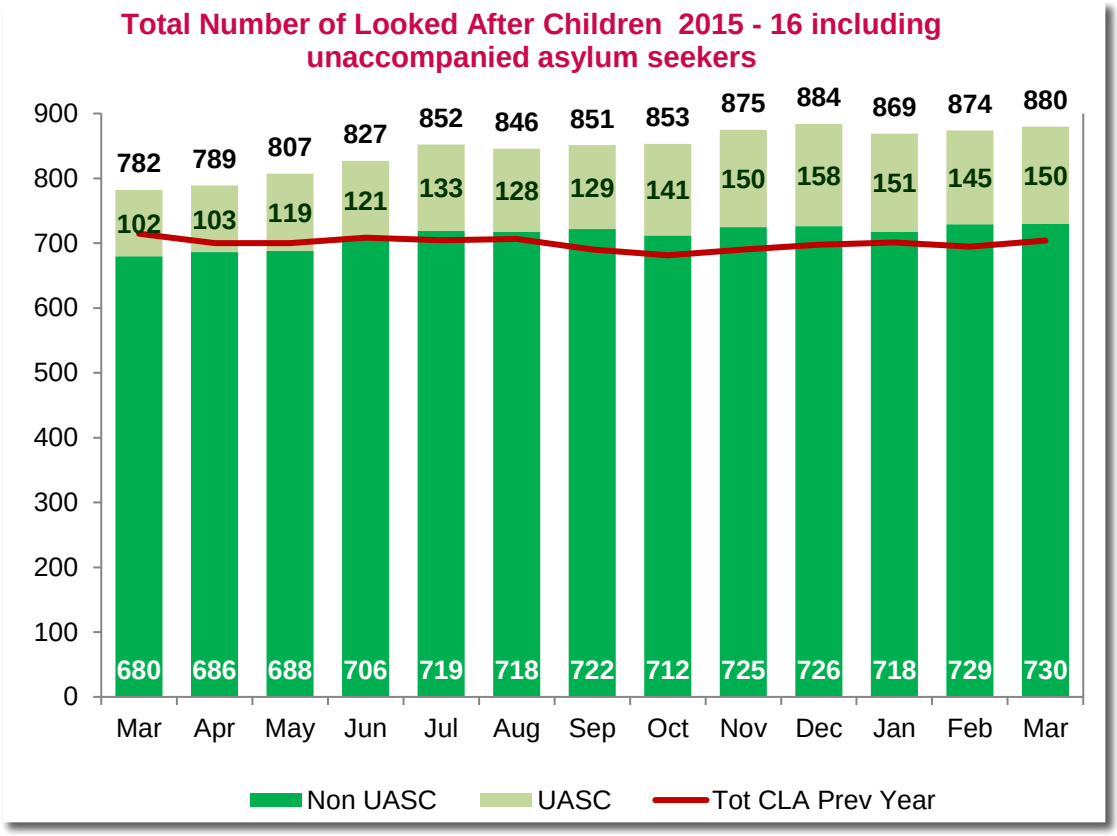
The Safer Surrey approach to practice is not yet widespread and embedded and there remain challenges with the consistency of practice across the county

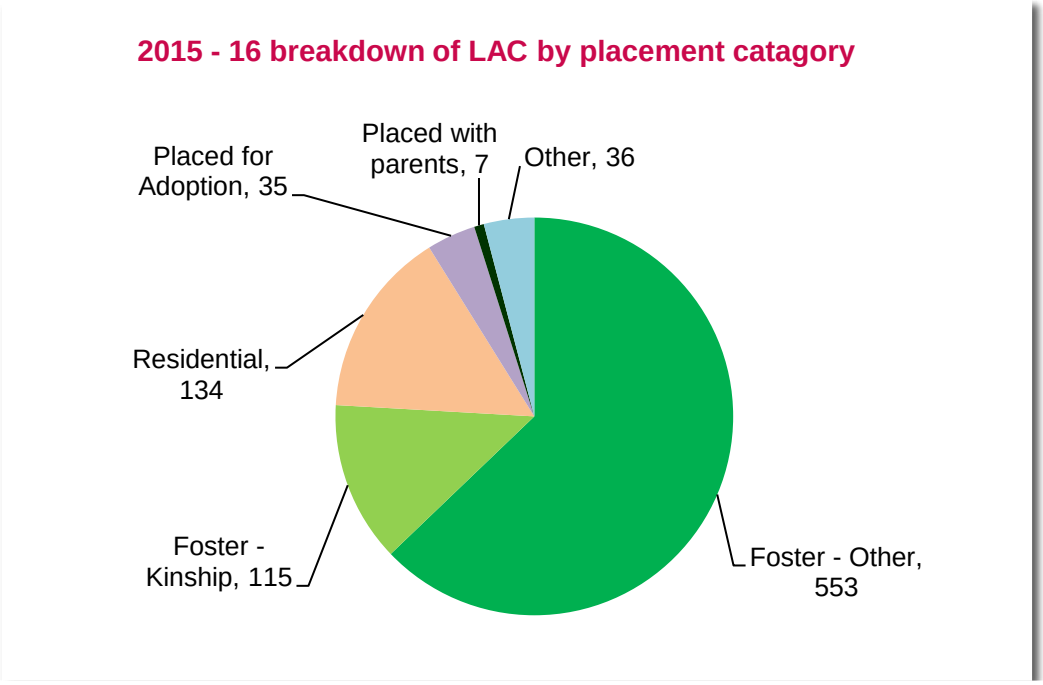
Looked After Children

A child who is "Looked After" is in the care of the Local Authority for a number of reasons, including unaccompanied asylum seeking children, risk of significant harm, or parents struggling to cope.

In Surrey, majority of looked after children have stable relationships with social workers, who visit them regularly and know them well, however decisions for children to become looked after are not always timely and the quality of assessments, care plans and pathway plans requires improvement so that these consistently identify children's needs and how these needs will be addressed. . (OfSTED)

- As at 31 March 2016, 876 children were looked after children compared with 779 in March 2015.
- As at March 2016 there were 152 unaccompanied asylum seeking children compared to 102 at March 2015.


Total Number of Looked After Children 2015 - 16 including unaccompanied asylum seekers
900
800
700
600
500
400
300
200
100
0
782 789 807 827 852 846 851 853 875 884 869 874 880
102 103 119 121 133 128 129 141 150 158 151 145 150
680 686 688 706 719 718 722 712 725 726 718 729 730
Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Non UASC
UASC
Tot CLA Prev Year


2015 - 16 breakdown of LAC by placement catagory
Placed for Adoption, 35
Placed with parents, 7
Other, 36
Residential, 134
Foster - Kinship, 115
Foster - Other, 553

Surrey's improvement journey in 2015 – 2016

Following the multi-agency inspection of Surrey County Council and its partners in October 2014, The SCC Improvement Board was established to act on behalf of the county council to oversee improvements to children's services The Improvement Board is chaired by the deputy leader of the council and has members from the council's main political groups. Since December 2015 membership of the Improvement Board was extended to include key partners and the SSCB Independent Chair.

Both Surrey CC and the SSCB acted immediately on the priority areas highlighted by Ofsted to ensure children are safe. However unnecessary time was spent negotiating the outcome of the inspection reports with OfSTED, significantly delaying the start of the improvement work required in Surrey.

Once underway, the SCC improvement plan outlined the stages of improvement required to take children's' services and partners from where they are at the time of this report, to an embedded culture of practice where all partner agencies, are consistently and confidently doing the right things for children, in the right way.

At the time of writing this report considerable improvement has been made to safeguarding practice across the partnership in Surrey. In particularly much effort has been made to ensure that strong leadership is being put in place, ensuring improved management oversight and governance. An open and supportive relationship has developed between social care, health service, police and SSCB senior leaders and the improvement process continues to have strong political and corporate leadership

Restructuring and refocusing the work of the SSCB has contributed to a more effective working relationship with improved levels of challenge. The SSCB needs to strengthen its leadership and QA responsibilities to support the improvement journey in Surrey.

Leaders across the partnership are now clearer in their expectations and this is beginning to impact on the ability to improve practice and tackle poor performance.

Importantly several necessary processes and frameworks are being implemented including:

- The e-aligning of the Children, Schools and Families Directorate Leadership Team roles and responsibilities to reflect the strategic shift needed to strengthen preventative and early help work with partners and manage Children in Need cases more effectively.
- The recently developed thresholds document,
- The introduction of the Safer Surrey approach
- The newly formed Sexual exploitation and abuse management board.
- The use of practice coaches in order to identify specific areas of improvement and provide practical support to practitioners.

This learning process has enabled us to identify the sequence of actions we will take in Children's Services, across the whole organisation and Surrey to build a sustainable and effective service model for children.

A strong one team approach is essential to achieving our ambition for children and achieving the quality of improvement we need, at the pace we need. We will continue to build on the relationships with all our partners to deliver better services and engage effectively with children and families to shape these services

Surrey Safeguarding Children Board Priorities 2014 – 2015

In 2015 – 2016 SSCB prioritised 4 key areas for consideration and scrutiny. Work was carried out through a number of subgroups and progress can be seen in the tables below.

Priority 1:

To work with partner agencies to reduce incidences of **domestic violence** and the impact this has on children and families

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**

Priority 3:

To ensure that professionals and the **child protection** processes effectively protect those children identified in need of protection.

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 and families.

Work of the sub groups

Domestic Abuse

Domestic abuse is a shared priority with the Surrey Safeguarding Adult Board. The work is overseen by Community Safety Board.

Safeguarding children exposed to domestic abuse (DA) has been a priority for SSCB due to the risks posed to children living with DA and its prevalence.

In 2009, the National Society for the Prevention of Cruelty to Children (NSPCC) conducted research with young people aged 13-17 which examined their experiences of physical, emotional and sexual violence in their partner relationships.

The research found that:

- 25% of girls and 18% of boys had already experienced some form of physical abuse at least once in their lifetime.
- 75% of girls and 50% of boys reported experiencing some sort of emotional abuse at least once in their lifetime.
- 31% of girls and 16% of boys reported experiencing some form of sexual violence at least once in their lifetime.

Further research by the NSPCC in 2011 showed that behaviours (which are known to escalate into physical abuse) such as checking a partner's phone, telling them what to wear and controlling who they can or can't see or speak to, were common within teen relationships. In the same year the Crime Survey for England and Wales found that 16 to 19 year olds were more likely to suffer partner abuse than any other age range.

A year later in 2012 – at the same time as the definition of DA was broadened - the age of those who could experience and perpetrate DA was lowered from 18 to 16. This change coincided with the launch of the Home Office campaign 'This is abuse' which aimed to encourage 13-18 year olds to re-think their views of violence, abuse or controlling behaviour in relationships.

Surrey Police received the highest number of reports from women aged 29 over the past year.

Key achievements in 2015/16
IRIS – East IRIS project has produced some good results seeing a 5 fold increase in referrals to DA Outreach services from GPs in the East in 2015 – 2016. Health are currently

reviewing a wider rollout of IRIS across Surrey

DA Communications – Two key events were delivered in 2016. The first in March to mark the change in legislation regarding coercive control which came into law in December 2015,; the second event in May, Behind Closed Doors, to launch the communications campaign highlighting the change in law and to call to action to Surrey businesses to implement Staff Policies on DA. Around 700 people attended across these 2 events.

A DA communications strategy was adopted by the Board and the autumn campaign and Communications week will focus on reaching out to young people:

DA Training – Multi agency courses continue to be delivered and positively received. Bespoke training has also been delivered for Health staff, GPs and Surrey Police, focussed on raising awareness and improving signposting.

Links with other Strategic Boards - Links continue to be strengthened with representation or presentations to each of the Boards regarding DA (SCSB, Surrey Safeguarding Adults Board, Children & Young People's Partnership on behalf of Community Safety Board and the DA Management Board). Presentations have also taken place to the Children's Lead Members and Officers group which has representation from Surrey County Council and Boroughs and Districts.

Domestic Homicide Reviews – The Community Safety Board have agreed an oversight role for DHRs. Both Adults and Children's Safeguarding have been involved in the changes implemented in process and will be part of the lessons learned work going forward. SSCB has been involved in a combined DHR / SCR and ensures participation in DHRs where children have been involved.

How these achievements have impacted upon children in Surrey

- Healthy Relationship packages are being delivered in schools and other educational settings, to support children's services professionals, and children witnessing DA. This has been running since June 2015 and will be reviewed after 12 months in June 2016.

Challenges for the future/next steps

Implement learning from the recent audit undertaken by SSCB.
The main objectives of this audit were to:

- Evaluate the effectiveness of multiagency working to safeguard and promote the welfare of children who are exposed to violence
- Raise awareness of DA amongst service providers
- Explore provisions in safeguarding children and promoting their welfare

Operations Group

Key achievements in 2015/16

- 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.
- It provides a forum to raise issues local 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.

Strategic Case Review Group

Key Achievements in 1 April 2015 – 31 March 2016

- The SCRG coordinated the completion of two SCRs (SCR Child AA and SCR Child BB) that had started in the previous year. Although publication of the reports had to be delayed due to criminal proceedings and Coroner's Inquest, the learning from both cases has been widely disseminated and embedded in the core safeguarding training delivered by the SSCB.
- Two action plans in relation to SCRs from the previous year (SCR Child Y and SCR Child BB) have been completed and signed off.
- Rigorous monitoring of learning from single agency and partnership reviews .
  - The SCRG requested and received the report from a SI investigation in health and also the follow-up audit report and memorandum of understanding between NHS hospitals and a private hospital providing mental health services to young people in Surrey.
  - The Quality Assurance Officer of the SSCB attended SCRG meetings to present findings from audits commissioned following recommendations from partnership and/or single agency reviews.
- . SCRG monitored SCR action plans including the Early Help re-audit in autumn 2015 to ensure that issues from SCR Child AA were included.
- A 'good practice' report was completed and published in autumn 2015 highlighting good practice from partnership reviews during the last five years.
- The process for sharing learning from DHRs and SARs has been streamlined with quarterly meetings taking place between SSAB, SSCB and the Community Safety Team.

- SSCB is notified of DHRs when there are children in the household.
- The SCRG regularly monitors national learning from SCRs. During the last year it considered 4 SCRs from other areas to identify learning relevant to Surrey.
- SCR process and toolkit were developed and launched with a comprehensive communications plan to ensure wide dissemination. Referral form has been reviewed and referral process has been streamlined.
- SCRG membership was reviewed in February 2016 to ensure appropriate agency representation.
- SSCB Independent Chair stepped down from chairing SCRG in March 2016 and the representative from SCC Schools and Learning was appointed as chair of SCRG to ensure transparency.
- The SCRG has stopped acting as panel for all reviews. An independent panel is set up for each review with appropriate representation from relevant agencies. Chairing of each panel is shared among SCRG members to ensure SCRG has oversight of cases.
- Terms of reference for SCRG were updated in March 2016.
- SCRG considered nine referrals of which two resulted in SCRs, one in a joint DHR/SCR, two in partnership reviews, one in a thematic review and three in no further action.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- The SCRG was kept informed about out of area reviews that involved Surrey agencies and actively considered learning. SCRG requested and received the report of partnership review Child J from Merton LSCB. Learning was shared in relation to children with complex needs placed out of county by Education. SCRG requested relevant working group within SCC Schools and Learning to consider planning and commissioning arrangements.
- As a result of multi-agency audit on bruising, which was the most common theme in recent SCRs, the SSCB has reviewed the bruising policy. The bruising policy was re-launched with a comprehensive communications plan to ensure professionals are familiar with their new responsibilities for referral as well as the referral pathway. Bruising in disabled children was addressed in the updated policy on disabled children.
- Challenge was made to agencies in relation to their actions emanating from reviews. SABP was challenged by the SSCB Independent Chair regarding actions around management oversight when a practitioner is unexpectedly absent from work. (Recommendation from SI investigation Child ML).
- At the request of SCRG the Policies and Procedures group of the SSCB, SCRG undertook review of pre-birth procedures in January 2016 to ensure pre-birth planning for premature babies is addressed (recommendation from SCR Child AA).
- Likewise audits have been undertaken as a result of recommendations from reviews (bruising, early help).
- Regular workshops are arranged for front line practitioners to disseminate learning from SCRs, other learning reviews, DHRs and audits.

How do you ensure that your work is informed by the voice of children?

- Where the age of the child/ren allows, their views are sought and listened to as part of the SCR process.
- SCRG ensure that SCRs that have incorporated messages from children are included in SSCB core training. Messages from the Brooke review have been incorporated into CSE Level 2 and the SCR workshops.

Challenges for the Future

- Ensure that children are involved and provide their views as a matter of course in all learning reviews.
- Strengthen ties with DHR process to ensure that any learning from these reviews informs future activity of SSCB appropriately.
- Ensure commitment from agencies in embedding learning from reviews into practice in a timely manner.
- Agencies to provide evidence of embedding learning in practice and how this has improved practice.

Next steps

- Ensure that SCRG continues to robustly monitor how learning from reviews is embedded in practice and challenge appropriately if necessary.
- Ensure that learning from reviews is incorporated in regular safeguarding training to front line staff.
- SSCB is represented in DHRs when there are children in the household to ensure learning is shared in a timely manner.

Child Death Overview Panel (CDOP)

Key Achievements in 1 April 2015 – 31 March 2016

The statutory function of the CDOP panel is to review the deaths of all children under the age of 18 who are resident in Surrey, on behalf of the local safeguarding children boards (LSCBs).

The purpose of the review is to systematically gather comprehensive data on children's deaths, to identify notable and potentially remediable factors, to learn lessons and make recommendations to safeguard children and to reduce the risk of future child deaths.

Key Achievements in 1 April 2015 – 31 March 2016

- In January 2016, there was a change in the independent chair of CDOP; the new chair is Ruth Hutchinson, Deputy Director of Public Health.
- CDOP has held 9 meetings in the past year (including four neonatal panels, of which one was a full day meeting).
- Between April 2015 and March 2016, CDOP was notified of 66 deaths of which 54 were children who were resident in Surrey which is a decrease in actual numbers of deaths

since the previous year when 79 children were notified of which 62 were from Surrey.

- There were 21 unexpected deaths between April 2015 and March 2016 which warranted a Rapid Response. The aims of the Rapid response are to:
    - **a)** establish, as far as is possible, the cause or causes of the infant's / childs death
    - **b)** identify any potential contributory or modifiable factors
    - **c)** provide on-going support to the family
    - **d)** ensure that all statutory obligations are met
    - **e)** learn lessons in order to reduce the risks of future infant deaths
- CDOP has reviewed and closed a total of 80 deaths during 2015/16.
- Of the 80 deaths reviewed between 2015 and 2016, 16 (20%) were identified as having modifiable factors to reduce the risk of future similar deaths.
- Two deaths were referred to the Serious Case Review Group, of these, 1 went to SCR
- Themes/learning identified through Surrey child death reviews in 2015/16 included:
    1. The importance of recognising sepsis early,
    2. SUDI (Sudden unexpected death in infancy) - known risk factors need to be reinforced by Health Professionals and the 'Safer Sleep' assessment to be completed by Midwife in the Red Book.
    3. Road traffic accidents (RTA)
    4. Neonatal deaths

The four national CDOP themes for 2015/16 reflect the picture in Surrey. They are:

1. Greatest risk of death for children is in the first year of life
2. Recognition of sepsis early so appropriate treatment can be commenced
3. Safe sleep
4. Accidents and Suicide

- The Specialist Nurse has developed and distributed a CDOP booklet for use in all of the 5 Acute Hospitals in the event of the unexpected death of a child.
- All five acute hospitals now have hard copies and electronic copies of this CDOP booklet in A/E, Children's wards, Maternity, SCBU and NICU. The CDOP booklet has also been shared with Community providers, GP's, Children's services, Police and the Coroner. This booklet will be kept under review by the Specialist Nurse to ensure that it is kept up to date and any changes or improvements will be incorporated following feedback from the hospital
- The Specialist Nurse completed an audit of the Safe sleep assessment in the red child health record books (31.03.16). The purpose of this audit was to measure:
    - Completion, effectiveness and quality of the Safe Sleep Assessment
    - Identify good practice
    - Identify areas for improvement
    - To provide assurance that the lessons learnt from Child Death Reviews are embedded in practice to protect other children and prevent future deaths

Recommendations for improvement were identified and a re-audit is planned for January/February 2017

- The Specialist Nurse completed 5 sessions of joint CDOP training with Surrey Police in November/December 2015 to raise awareness of the importance of a joint visit to the family during a rapid response to an unexpected death
- Surrey CDOP joined the National network of CDOP's (NNCDOP) and the Designated Paediatrician and Specialist Nurse attended the 2nd NNCDOP conference in February 2016

How have these achievements impacted upon Children in Surrey (positively and negatively)

- Following each CDOP panel meeting, a paper highlighting the identified learning from child deaths is created and shared with all the multi agencies for further dissemination to staff. Modifiable factors are highlighted and recommendations made to prevent future similar deaths.
- The CDOP booklet (electronic and hard copy) is available to all 5 acute settings in Surrey with detailed information of how to respond to an unexpected death, who to contact and up to date bereavement support for families. This has resulted in an improvement in the early notification of child deaths, the timely initiation of the rapid response and improved information to support families.
- The joint training with Surrey Police has resulted in more timely communication with the Specialist Nurse and negotiation regarding a joint visit. This multi-agency approach is key to the effective investigation of an unexpected death and support for the family.
- Becoming a member of the NNCDOP will help to improve the communication and sharing of information regarding child deaths on a national level.

How do you ensure that your work is informed by the voice of children?

- Parents are informed and enabled to contribute to the CDOP process in Surrey.
- This is facilitated by the specialist nurse for child deaths who directly contacts all families of unexpected child deaths and all expected child deaths aged over 1 month old.
- The arrangements for expected neonate deaths are slightly different however these parents are also given the contact details of the specialist nurse for child deaths and can contribute via her to the review process if they wish.
- Information regarding the child including their views/voice is systematically gathered from all professionals who were involved with the child.

Challenges for the Future

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

- Providing training for all staff involved in the CDOP process – this is on-going and CDOP training is to be included in the SSCB training calendar in the near future
- 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.

- On-going audits of rapid response arrangements to gauge their effectiveness. A re-audit of Rapid response was completed in September 2015 to monitor the effectiveness and quality of the rapid response in Surrey. The results of the audit were shared with SSCB. A further audit is planned for April 2017.
- A re-audit of safe sleep assessments is planned for January/February 2017 to monitor and provide assurance that the lessons learnt from Child Death Reviews are embedded in practice to protect other children and prevent future deaths
- Continuing to build on the relationships with the Coronial service and the Police to improve and maintain the quality of the rapid response in Surrey.

Next steps

- As the numbers of deaths with modifiable factors are relatively small (42 over a five-year period) and are from a number of causes it is often 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. When modifiable factors are identified in a child death, the Specialist Nurse will discuss with Nicola Mundy, Public health Lead for CDOP who will research and analyse the national picture. As a result, patterns, themes, trends and appropriate recommendations can be identified and consideration will be given to what action could be taken locally and what action could be taken at a regional or national level.
- The review carried out by Alan Wood in March 2016, which was submitted to the Government suggests that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. It also suggests that regionalisation should be encouraged and that consideration should be given to establishing a national-regional model for child death overview panels (CDOPs).
- Surrey CDOP plan to approach Kent and Sussex CDOP's to discuss the way forward to be enable sharing of learning and identification of patterns, themes and trends in child deaths on a regional basis

CP Dissent Group

Key Achievements in 1 April 2015 – 31 March 2016

The SSCB Child Protection Dissent Group (CP Dissent Group) is a multi-agency audit group which meets on a monthly basis to discuss cases where professional dissent occurs at a Child Protection Conference (CP Conference), on average around two per month. The group reviews the conference reports, considers the nature of the dissent and evaluates the decision of the CP Conference Chair.

A review of the group has recently been undertaken by the SSCB and there is a desire to remodel the way we deal with professional disagreement at CP conferences such that professional disagreement is dealt with more promptly, informally and locally, and is referred for independent scrutiny only by exception where resolution cannot be achieved locally

The SSCB Executive's Group has thus endorsed a recommendation to disband the group

and put in place processes whereby that local problem solving can occur. Cases will then only be referred on where this is unsuccessful. Work is underway to put this into practice.

CSE Strategy Group (including Missing)

An OfSTED monitoring review in March 2016 focused on case audits where there was a feature of going missing and/or child sexual exploitation**.**
The findings were disappointing and whilst there were some signs of progress, significant concerns remained that some very vulnerable children had not been adequately protected. SSCB, alongside key partners commissioned the LGA to undertake a pilot peer review of CSE practice across Surrey. The review will take place in May 2016 and will be used to influence current work plans.

Key Achievements in 1 April 2015 – 31 March 2016

- An immediate focus was placed on the development of an agreed action plan and strategy to act as the basis for the partnership response to CSE in Surrey.
- The SSCB has appointed a Partnership Manager (CSE) funded by the PCC who will be leading on this work and the CSE Strategy Group will provide the required oversight and governance
- An SSCB audit of partnership response to CSE in Surrey was completed in May 2015. Findings were incorporated into the action plan and have led to a greater focus on disrupting perpetrators.
- A comprehensive problem profile was completed in December 2015 and considered by the CSE Strategy Group in February.
- An awareness raising event on national CSE day was attended by 300 professionals from across the children's workforce with a focus on CSE of boys. The event was supported by the SSCB.
- A SSCB screening tool and guidance was introduced across the children's workforce
- Surrey Children's Services have commissioned the national charity 'Missing People' to undertake return home interviews. Work is due to commence 1 April 2016

How have these achievements impacted upon Children in Surrey (positively and negatively)

- The problem profile and audit findings have been used to inform responses – especially in relation to disrupting perpetrators, but also in relation to the (re-)commissioning of services for children at risk of/suffering from CSE (STARS – the CAMHS offer)
- Use of screening tool enables practitioners who are concerned about a child to better identify those at risk of CSE.

How do you ensure that your work is informed by the voice of children?

- A CSE online Survey was conducted in November 2015 to gather the voice and views of children regarding CSE. Findings were fed into the strategy.
- 2 CSE related serious case reviews have been undertaken in this period, and the children have participated in the investigations.

Challenges for the Future

Focus is required on:

- better reflecting the voice of the child in existing processes and service development
- alignment of CSE action plan with the missing agenda
- developing an agreed set of data (dashboard) to be considered by the CSE Strategy Group
- a focus on disrupting perpetrators of CSE

- Ensuring training and workforce development activities have the desired impact
- Need for robust information sharing arrangements to support operational responses
- There has been some confusion between the triage, area MAECCs and MAECC Oversight Group and whilst the recent MAECC restructure has improved the sharing of information between agencies and therefore a reduction in delay work needs to be undertaken to maximise the effectiveness of the process. It has been agreed that a review of the MAECC process is necessary and this will take place during the summer of 2016

Next steps

- Begin to merge and align current CSE activities with related agendas – especially missing children, LAC and unaccompanied asylum seekers forming the Sexual Exploitation and Abuse Management Board, under police leadership, with SSCB oversight.
- Ensure that the newly formed SEAMB provides robust and effective leadership in addressing the issues highlighted above.

Work undertaken by Surrey Police in respect of CSE

Key Achievements in 1 April 2015 – 31 March 2016

- Surrey Police now have dedicated CSE teams on each division who investigate CSE and act as SPOC's (single point of contact for the victim).
- There are now robust supervisory footprints on investigations; staff within the Public Protection Standards Team carry out 7 day, 28 day and closing reviews on Child Abuse and CSE investigations.
- A Memorandum of Understanding with local authority and private children's homes has been created, to protect children and young persons living within those homes and those on out of area placements.
- Police and Children's Services have introduced weekly CSE triage panel meetings to discuss all new referrals and any medium or low risk case, where a lead professional believes the risk level should be increased. This meeting will also look at suspected perpetrators.
- A tactical problem profile in relation to CSE has been completed by Police and Children's Services.
- After applying for funding from the OPCC, we now have two full time WiSE (What is Sexual Exploitation) workers in post. They work with children or young people under 25 years, who have been identified at risk of CSE and they are not being supported elsewhere. They offer one to one support for children and help them identify what is happening and exit the exploitation.
- A CSE analyst (funded by the OPCC) has just been recruited to advise and assist in

all aspects of investigation by providing strategic and tactical analysis of multi-agency CSE intelligence, in order to identify offenders, series and trends, and to suggest problem solving prevention, disruption and intelligence gathering opportunities.

- A CSE Role of Community Partnership training event took place on the 24/02/16 with abound 80 delegates from various roles within the council. Training was delivered on CSE/Models/Grooming/Warning Signs.
- CSE Training to the Force Chaplains, Force Independent Advisory Group was delivered
- On the National CSE Day the 18/03/16 we held a CSE event for professionals. Over 300 professionals attended.
- Neighbourhood officers carried out some night-time economy work on this date, targeting locations and speaking to taxi drivers.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- Having a Memorandum of Understanding with children's homes in place will help prevent and identify instances of CSE and will ensure agencies work together to safeguard victims and potential victims of CSE.
- The introduction of the weekly triage panel meetings will enable the MAECC meeting to spend more time looking at the management and disruption of suspected perpetrators and offenders, thus protecting children from this abhorrent abuse.
- The tactical problem profile will be used to inform the terms of reference for the strategic problem profile and help build a picture of the prevalence of CSE in Surrey and any emerging trends and patterns.
- The new risk assessments we have in place ensure that safeguarding is our primary focus and help officer's identify secondary and tertiary victims that might have otherwise gone unnoticed.
- The new teams and roles we have in place will help strengthen our response to combating CSE.
- The ongoing Awareness Campaign is essential to ensure we work together to identify and disrupt the hidden crime of CSE.

How do you ensure that your work is informed by the voice of children?

- The views and voice of the child/victim has now been included in the PPST (Public Protection Standards Team) reviews. The voice of the child has been embedded within the investigation closing template.

Challenges for the Future

- To ensure we are all identifying "male" victims of CSE and thinking "victim" rather than the sex of the young person.
- To bring the wider community on board with us and increase referrals and intelligence from the voluntary sector, nigh time economy and the public.
- To meet with STARS who are part of CAMHS to see if we can interview and record a victim of CSE and learn from their experiences.

- To look at the ‘See Me Hear Me’ materials to see if we can incorporate these into our Child Abuse Policy and Procedures.

Next steps

- To have meetings with Health/Education/Children's Services and the Police to discuss datasets that holds information pertinent to CSE to cultivate intelligence and inform and enrich the CSE problem profile.
- To run a CSE training event in November to train officers on disruption tactics to tackle and prevent CSE, with an added focus on identifying male victims.
- To ensure that the Voice of the Child is clearly, heard, listened to and is at the heart of investigations.
- To ensure that the ongoing CSE Awareness Campaign is in the wider community, so that we increase knowledge to a larger audience of what sings to look out for and how to report abuse.
- To work with children’s services and education in developing the CSE training package that will be delivered in schools.
- To work with children’s services in ensuring that we have the right support services in place to sign post victims and their families to.

Education Group

Key Achievements in 1 April 2015 – 31 March 2016

- A school self audit for safeguarding was created titled “Audit of Statutory Duties and Associated Responsibilities” . This was aligned to Keeping Children Safe in Education 2014. The audit is mandatory to all maintained schools as it replaces the Annual Report to the Governing Body. The audit produced a 69% completion rate for all Surrey schools. A report was submitted to the Surrey safeguarding Children Board.
- Designated Child Protection Officer (now known as Designated Safeguarding Leads) network meetings were held each term in all the areas when safeguarding updates were given. Training was given in Child Sexual Exploitation and the Prevent Programme with Working to Raise Awareness of Prevent (WRAP). Mop up sessions were also held for those DSL’s who were unable to attend.
- A Headteacher from an Independent School now sits on the Education Safeguarding Group.
- The SSCB CSE screening tool was disseminated to all schools.
- The Education Safeguarding web pages are up to date and schools can access a wide range of services including mode policies for child protection and Staff Behaviour.
- A process was created where police “Child at Risk” reports were shared with schools in a timely manner. This process is under review.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- The safeguarding audit highlighted where training or further training would be useful. As

a result online safety training is now available to schools.

- The audit listed what is required in safeguarding policy and procedures to keep children safe. Schools were able to ensure that their policies and procedures were up to date, and if not to add this to their action plans.
- The sharing of police notifications impacted greatly on schools where any change in behaviour was flagged up immediately in order for teachers and school staff to make informed decisions.

How do you ensure that your work is informed by the voice of children?

- The majority of schools have a school council where the voice of the child is paramount.
- Future safeguarding audits will also challenge schools to ensure that such a platform is available to the pupils.

Challenges for the Future

- Fulfilling the role of "Lead professional" in cases where a Team Around the Family was required, impacts on their time as teachers.
- Safeguarding legislation and statutory guidance is constantly changing and schools are finding it difficult to keep up.

Next steps

- To use the analysis gained from the schools audit to shape future training and DSL network meetings.

Health Group

Key Achievements in 1 April 2015 – 31 March 2016

- The group has had consistently good attendance, allowing two way communication with senior officers from health commissioners and providers and the LSCB and there is evidence that key areas from LSCB and national publications have been shared, debated and acted upon.
- The coordination and delivery of a Surrey wide health conference to consider the embedding of learning from an SCR further to a learning event held the previous year. Exploring the embedding of learning from other reviews and from safeguarding inspection findings.
- An annual Deep Dive Audit assessed the SSCB priorities and learning from serious case reviews.
- The CDOP Safe Sleep Audit has been undertaken and presented. Between 2011 and 2012, there were 6 Sudden Unexplained Deaths in Infancy (SUDI) within Surrey which were reviewed by CDOP and modifiable factors were identified. As a result, a county wide Safe Sleep campaign was undertaken by the Specialist Nurse Child Deaths to raise awareness amongst professionals and parents of the risk factors that have been identified that increase the risk of infant deaths. The audit sample identified a total of 50 babies from across the county of Surrey, with an even distribution from each of the five acute settings

- Data collection through and health safeguarding dashboard which is regularly reviewed with clear reporting systems to CCGs and LSCB.

How have these achievements impacted upon Children in Surrey (positively and negatively)

Presentations at the health safeguarding conference evidenced practice change in response to review and inspection findings.

The findings of the Deep Dive Audit identified evidence of good practice:

- Communication
- Information sharing
- Working with resistant families
- Child focussed assessments – good documented evidence of the child's voice being heard.
- Risk assessment
- Involvement in multiagency processes.
- Improvement in the recording of supervision
- Evidence of improvement in professional challenge with the escalation procedure being used.
- Of the cases involving a looked after child only one showed good evidence that the LAC process had been followed and that there was a focus on the child
- Evidence of an increase in the recognition of child sexual exploitation and for the cases that highlighted CSE appropriate action was taken. It is recognised that the SSCB has developed its response to CSE and as the subjects in this audit were parents, current processes were not in place.
- There is an increase in awareness regarding domestic abuse and evidence that SSCB procedures and guidance have in most cases been followed in terms of routine enquiry and appropriate action taken.

The findings of the Safe Sleep Audit demonstrated:

- The responses of Mothers, who as part of the audit, were asked questions which were designed to assess their knowledge, of the advice given by health professionals in relation to the risk factors associated with co-sleeping demonstrated that there was good understanding of advice given.
- 77% of Red books contained evidence that the Safe Sleep assessment had been completed with a parent.
- 96% of the parents asked were aware of and able to identify the risk factors associated with co-sleeping.

How do you ensure that your work is informed by the voice of children?

The representatives on the group are from all Surrey health commissioners and providers and the work of the group is informed by a range of processes from within the agencies where the voice of the child is evident:

- Health Needs Assessments
- Health safeguarding dashboard evidence
- Safeguarding Supervision
- Lessons from SCR and messages from children incorporated into learning and development opportunities
- Quality Assurance Processes including assessment through the Deep Dive

Challenges for the Future

- Evidencing that information flow through this group is cascaded and reaches those within members' organisations.
- Agreeing an achievable approach to implementing developments, both national and those that have been agreed by LSCB across a complex health economy

Next steps

- To maintain a work plan that reflects the changing national and local requirements.
- Undertake the annual deep dive to evidence the changing local and national priorities have been acted upon

Learning, Development & Communication Group

Key Achievements in 1 April 2015 – 31 March 2016

- Scoping work to develop a new website to ensure effective communication in relation to the boards work
- Influencing and contributing to regular SSCB newsletters as a means of communicating national and local developments to improve children safeguarding practice.
- Preparatory work to establish a new training booking system to promote easier access to training by professionals
- Work streams with the components required to comply with the boards learning and improvement framework and support the development of a comprehensive SSCB Learning and Development Strategy and Toolkit
- Development of an SSCB Single Agency Training Quality Assurance process and pack
- Development of an SSCB Multi Agency Training Quality Assurance process and pack
- Piloting of an Impact Analysis has been completed
- A Four stage evaluation process has been implemented
- Development of specialist courses in response to national and local priorities eg Child Trafficking, CDOP has been progressed.
- Development of a support package for SSCB trainers has been completed.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- The Board's multi-agency training programme is regularly evaluated to ensure that the impact upon children's safeguarding practice is understood.

- The longitudinal approach to evaluation provides evidence of how the learning has been implemented in practice. Evaluation of course impact on practice consistently shows that participants become more effective by drawing on what they have learnt in the Board's multi-agency course.

How do you ensure that your work is informed by the voice of children?

- The voice of the child is routinely incorporated into all SSCB training.
- At L, D and C meetings local and national SCRs, case reviews, domestic homicide reviews and other national reports are tabled and scoped to ensure the voice of the child is clearly reflected in learning and development.
- An example of this was an SCR undertaken where CSE was the presenting issue. This report clearly presented the voice of the child in relation to inappropriate language used by professionals. The reports findings were used to review CSE course material to ensure there was a focus on professional language that serves to protect the child.

Challenges for the Future

Challenges for the future include:

- The need to constantly review learning and development materials to ensure they respond to the ongoing national and local developments
- Evidencing the uptake and impact of single agency training across the County.
- Evidencing the effectiveness of multi agency training across the County.
- Evidencing the effectiveness of communication strategies including the SSCB newsletter and newly developed web site.

Next steps

- Ongoing refreshing of the SSCB multi-agency training to include the changes in Surrey relating to Early Help, Safer Surrey and MASH developments.
- Completion of the review of CSE training material to ensure there is a focus on the risk to boys as well as girls.
- Completion of the work that is underway to develop training for taxi drivers and escorts to highlight CSE and other safeguarding issues such as trafficking.
- Review the learning from the pilot to evaluate the impact of multi-agency training and implement this to cover all courses.
- Organising and delivering the SSCB Conference 'Under the radar' , in November 2016

North East Area Group

Key Achievements in 1 April 2015 – 31 March 2016

- Membership is at its strongest for some time with a focus on ensuring there is a wide range of expertise represented and good attendance and that the group are using this foundation to become even more effective. Representation from a faith member is now secured and the police have now identified a replacement for the last police member

who left at the beginning of the year.

- The forward plan is working well to inform future agenda setting and updates are scheduled in with partners at the earliest point to secure availability and ensure specific issues remain a focus on our agenda (e.g. MASH/DA updates).
- At the May 2015 meeting Noreen Gurner gave a presentation on CDOP and how this process sat within the SSCB SCR processes.
- A verbal presentation from the NE children's outreach worker for Domestic abuse was received. Following this, a discussion was held where members expressed concern regarding the capacity of this work, specifically the lack of available capacity to address unhealthy teen relationships – which appears to be a growing issue, especially with potential links to CSE.
- The Chair of the NE SSCB and the SSCB QA Officer have also visited partner agencies to quality assure their section 11 submissions in 2014. This included visits to Bronzefield Prison, two NE boroughs and Health partners (SABP, Epsom and St Helier's Hospital trust and CSH). Overall this was an extremely useful exercise and provided an opportunity to visit partners in their workplace to talk through their respective safeguarding procedures, roles and responsibilities. The visit to Bronzefield was particularly interesting with some outstanding practice evidenced throughout the setting – which now holds the only mother and baby unit in the country.
- An update was received from Gordon Falconer in relation to the current work being undertaken on the prevent agenda. Useful discussions were held in respect of referral pathways and the use of local quadrant prevents engagement officers. One concern raised was how the statutory duty around agencies to have a Prevent plan was being monitored and moderated and whether consideration needs to be made as to this being part of the section 11 audit.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- Positive multiagency interventions from the group have directly impacted on children at risk of CSE

Challenges for the Future

- It is difficult to evidence that information received from the meeting is disseminated back in to agencies and also that agencies are aware of and use the opportunity to feed in safeguarding concerns. All members have therefore been provided with a form to complete in respect of roles, responsibilities and mechanisms for communication prior to and post meetings being held. This issue was an area questioned by the recent inspection and it is hoped the outcome of this exercise will help us identify any gaps in communication and also provide a useful evidence base in the future.
- To have a strategic Children's Services presence to ensure the group are not disadvantaged in addressing some of the issues other area groups may have more information about.

Next steps

- Planning for NE Area Workshops on 12 July 2016 – *Understanding and responding to Risk*

North West Area Group

Key Achievements in 1 April 2015 – 31 March 2016
• Consistent membership • Desire to re-establish the core purpose of the NW area group and how it relates/links to the full SSCB • A partnership commitment to multi-agency early help and CSE practice improvement, as part of the wider Surrey Children's Improvement Plan
How have these achievements impacted upon Children in Surrey (positively and negatively)
• A well functioning MAECC and MAECC Triage Panel that is better safeguarding children at risk of CSE through improved multi-agency working • A more coordinated, understood and accessed early help offer, which is starting to prevent children and families from requiring more acute safeguarding services
How do you ensure that your work is informed by the voice of children?
• This is a gap and we need to establish an approach to ensuring the voice of the child is captured and presented at the NW Area Group. Most services represented capture their own feedback but we don't collate and coordinate this at present.
Challenges for the Future
• Truly capturing the voice of the child across the safeguarding partnership and acting upon that feedback in terms of delivery and commissioning of services • Preventing the development of more acute safeguarding problems through an effective early help offer and responding effectively to children at risk of significant harm within a context of reduced public expenditure • Maximise the potential of partnership working and integration to help achieve the above.
Next steps
• Discuss these challenges and the role of SSCB in meeting them as a group of Area sub-group chairs with the Independent Chair of SSCB

South East Area Group

Key Achievements in 1 April 2015 – 31 March 2016
• Case study work – each SE area SSCB meeting has focused on individual children's

situations in the safeguarding system. This has worked well in considering agency responsibility and accountability and has led to the Child Protection Team Manager in Children's Services producing a practice guide to terminology in care proceedings and child protection processes. This has now been circulated county wide

- Learning from Serious Case Reviews (SCR) – as a result of a series of workshops held in the SE area focused on barriers to learning from SCRs, a small working group developed a SSCB training session focused on Professional Challenge. This was developed and delivered by members of the SE Area Safeguarding Group and is now part of the wider SSCB training offer
- The area group has held 2 local partnership reviews, one of which resulted in the SCRG focusing on children who are home educated and the learning from this partnership was disseminated widely
- The SE area group in collaboration with the SSCB on line safety group, held a multi agency conference on 'on line safety' for over 100 delegates. Feedback has been very positive and learning identified.
- The SE area group is working closely with the voluntary sector to set up a children's reference group for the SE area group, so we can capture their views of the safeguarding system
- Domestic Abuse – this is a key area priority and the voluntary sector outreach service is a key contributor to the group. A number of activities have included presentations on Coercive Control and on male victims of DA
- Early Help – this is a key area priority and the SE area Early Help Pilot was a fixed agenda item for the duration of the pilot and the area group provided feedback and support to the pilot
- CSE – the area group has had regular updates on the work of the area MAECC and Triage Panels. The partnership has been very proactive in supporting this area of work
- The area group held a bespoke meeting to feedback on the draft thresholds / levels of need document

How have these achievements impacted upon Children in Surrey (positively and negatively)

- Joint supervision has developed good working relationships and has impacted on care planning for children which is more cohesive and joined up
- Local area multi agency workshops have identified learning and barriers to learning from SCRs. This shared learning has enhanced professional skill and knowledge and directly impacts on children where there are safeguarding concerns and an increase in professional discussions
- Learning from local partnership reviews has resulted in increased understanding of the role of agencies in the wider safeguarding system (eg. dentists). This increased awareness will improve appropriate referrals to safeguarding agencies
- Significantly increased understanding has been achieved as a result of the on line conference, directly supporting children who are vulnerable to exploitation via social media

- Having linked social workers allows for good communication and trust between agencies, leading to appropriate support being offered to children as a result
- The practice guide assists professionals in decision making in the child protection process and therefore is focused on best outcomes for children
- Raising professional awareness of domestic abuse has directly impacted on children receiving the right support at the right time, particularly earlier intervention
- Positive multi agency interventions have directly impacted on children at risk of CSE. There is a strong SE partnership approach to this issue
- Using a strengths based approach and focus will directly impact on the relationships with children and shifting culture from a deficit model to a strengths based model

How do you ensure that your work is informed by the voice of children?

- Children's direct experience of the safeguarding system is being used to inform partner agencies of the impact of their roles on children. This will lead to changes in practice and will be shared widely

Challenges for the Future

- Independent schools are difficult to engage locally
- Child exploitation in its wider sense needs to be tackled but not through CSE routes
- On line safety and its ever changing focus
- Implications of the MASH
- Implications of the refreshed Levels of Need document (pilot)

Next steps

- Development of further local partnership workshops
- Safeguarding training needs analysis required locally
- Multi agency audit of safeguarding case work to be reintroduced locally

South West Area Group

Key Achievements in 1 April 2015 – 31 March 2016

- All agencies were well represented at South West Area Group meetings which have provided a forum to discuss and progress the SSCB priorities and provide opportunity for multi-agency networking and sharing good practice.
- Updates on the MASH have been ongoing for the past several months.
- Feedback provided to all agencies from Serious Case and Partnership Learning Reviews and again how changes can be embedded in different agencies.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- Consistent feedback from serious case reviews and Partnership reviews encourages practitioners in partner agencies to embed learning from Serious Case Review feedback, which in turn ensures evidence based practice and a child focus outcome.
- Regular meetings are held to encourage reflection and assessment of whether strategy discussions are effective, to the point, children focused and reflective of Working Together to Safeguard Children aims and ethos.
- Health are not always present in strategy discussions as it can be difficult to get a health representative at the time required by police and social care if a strategy discussion is urgent and requires immediate assessment. This has impacted negatively on the assessment as police and children's services are making assessments without information from health.

Challenges for the Future

- Explore how Health Colleagues can be part of telephone strategy discussions in SPIM meetings more consistently
- Proactively seeking the voice of the children in assessment for children at risk of CSE
- Continue to discuss/review all learning from SCRs / Partnership reviews and discuss whether they are being embedded into practice and share good practice where appropriate.

Next steps

- Learn lessons from CSE Peer review challenges and discuss how these are embedded into practice and share good practice.
- Learn from other area groups how they proceed with their agendas and share good practice.

Online Safety Group

Key Achievements in 1 April 2015 – 31 March 2016

- We held a multi agency conference "Protecting Children On and Offline" on 24th June 2015 which was attended by about 200 professionals from Surrey.
- The conference had keynote speakers who talked about the risk to children online and how we are implementing the 'Prevent' strategy to stop children becoming involved or supporting terrorism. Workshops were also held on subjects such as gang activity, children exhibiting sexualised behaviour, FGM, and the work of the NSPCC and Parent Zone. A play called "In the Net" was previewed which is aimed at years 3 and 4 in primary schools.
- The Online Safety Group work closely with Parent Zone who partner CEOP.
- We now have Surrey Police Prevent Coordinator on our group and have close links with the CSE group as a great number of children are groomed online.
- We have developed a training programme on CSE, Prevent and Online grooming which is now an SSCB established course.

How have these achievements impacted upon Children in Surrey (positively and negatively)
• Members of the group deliver training in schools which has been favourably received and help has been given in creating policies designed to protect children. • Members of the group work closely with children e.g. YSS and ACT.
How do you ensure that your work is informed by the voice of children?
• We are looking at ways of working more closely with children including having conferences for them. • A lot of school presentations are given to parents and pupils and online safety is now taught in schools.
Challenges for the Future
The Online arena is ever changing and difficult to stay ahead. Professionals receive training as do pupils but it is the parents who have the gap in knowledge.

Policies & Procedures Group

Key Achievements in 1 April 2015 – 31 March 2016
• Following findings outlined in the SSCB QA&E bruising audit, the group revised and published a new Multi-agency Protocol for the Management of Actual or Suspected bruising in Infants who are Not Independently Mobile. A multi-agency communication strategy was disseminated to all partners to coincide with the launch and publication of the protocol on the SSCB website. • The group revised and updated the procedures for Children with Disabilities which also includes a section on the management of actual or suspicious bruising. • The Child Protection Medical guidance was revised. • A PREVENT procedure was developed which includes the referral pathway and flow-chart • The group updated and the multi-agency domestic abuse procedure and supporting guidance • The group revised the multi-agency supervision principles • Review of Guidance on Working with Hostile, Non-compliant clients and disguised compliance was completed
How have these achievements impacted upon Children in Surrey (positively and negatively)
The group have responsibility for: • Ensuring local policies, procedures, protocols and guidance are up to date and compliant with the requirements of current legislation, statutory guidance and research

evidence

- Ensuring that all the SSCB policies, procedures and protocols are accessible to all staff within member agencies and independent practitioners in contact with children and their families
- Ensuring current safeguarding procedures are reviewed in light of any issues arising from local or national case reviews including Serious Case Reviews/Child Death Reviews

How do you ensure that your work is informed by the voice of children?

- The P&P group will work in close collaboration with other SSCB sub-groups to review the impact on outcomes of policies procedures guidance and protocol in safeguarding and promoting the welfare of children.
- The P&P group will communicate with representatives of other SSCB sub-groups to ensure effective information sharing and a co-ordinated approach to recurring themes.
- The P&P group will publish new guidance and relevant policy/procedure to all organisations that have a responsibility for safeguarding children
- The P&P group will ensure that all new procedures will be informed by what children need and want to feel safe
- The P&P group will co-ordinate effective communication and publicity in relation to new policies and procedures.

Challenges for the Future

- Ensuring that changes to procedures and new procedures are widely communicated.
- Supporting partners effectively to ensure that procedures are widely communicated and implemented into practice.
- Evaluating the impact of procedures on practice.

Next steps

- For the group to develop an action tracker which gives assurance that procedures under review are on target for completion and provide a mechanism to hold members to account.
- For the group to develop a work plan for monitoring when procedures, guidance or protocols are requiring updating.
- For the group to develop a more effective interface between adults and children's safeguarding groups by bringing together the two groups to discuss common agenda items
- Developing a system for practitioners in partner agencies to provide feedback on new policies and procedures

Quality Assurance and Evaluation Group

Key Achievements in 1 April 2015 – 31 March 2016

- The major focus of the last year for the SSCB QA&E group has been on Targeted Priority 3, namely to ensure that, professionals and the child protection processes effectively respond to those children in need of protection.
- The group has focused on a number of key areas:
- -the Neglect Strategy and Action Plan ;
- -the effectiveness of the Core Group process, and
- -the engagement of partners through the Section 11 audit review.
- In conjunction with the Policy and Procedures Group we developed a comprehensive Neglect Assessment Tool which has been successfully piloted and has now been rolled out across the partnership.
- There have been regular audits of the Core Group process throughout the year in order to gauge the effectiveness of partners working together and to monitor for change and improvement. This has led to an improvements in the regularity of Core Groups taking place (over 90% each quarter), combined with a closer focus on the impact of child protection plans.
- There has been a major focus on widening the engagement of partners in the Section 11 process. Workshops with the Borough and District Councils have achieved considerable improvement in both the completion of these audits and the quality of the responses.
- We have also successfully rolled out the process to all schools in Surrey with high take up by Local Authority and Academy Schools, although limited response from the Independent sector
- The second area of focus has been seeking to improve the quality of the SSCB's data set, particularly in support of the development of our CSE Profile.
- We now have an agreed framework with the Borough and Districts on data that can identify those children in unsuitable housing, or part of homeless families.
- We have also agreed across the partnership a CSE data set which has already enabled us to compile our first Problem Profile.
- We have also been able to use partnership agencies data to cross-reference children and identify children who may be vulnerable to CSE and require an early intervention service.

How have these achievements impacted upon Children in Surrey (positively and negatively)

- There have been a series of positive changes for Surrey in the last year which may in part be linked to the QA&E Group's work on the effectiveness of the Core Group process.
- The numbers of children on Child Protection Plans for lengthy periods of time has decreased significantly in the past year.
- The number of children subject to CP Plans for more than 16 months has dropped from

155 at the start of the year to 98 at the end of the year and

- The number subject to CP Plans for more than 24 months has decreased from 59 to 29 during the same period.
- The cross referencing exercise that takes place termly on children who go missing and are absent from school has helped to identify children who are vulnerable to CSE, but not currently identified as at risk. This has enabled early intervention to be put in place to prevent these children becoming victims. On each occasion we were able to identify approximately 20 children currently not deemed as at risk of CSE, but were going missing and persistently absent from school and make referrals for early help.

How do you ensure that your work is informed by the voice of children?

- During the period the QA&E Group has been developing its participation strategy so that the voice of the child is prominent in the work and the recommendations we make.
- Specifically in the past year, the group has conducted a focus group session with children at risk of CSE in order to inform future commissioning of services that children say they find most effective; w
- e conducted an online survey with children on social media and digital awareness so that we can target the Board's Online Safety Strategy and Action Plan and
- A major consultation exercise has been carried out with children looking at the communication and guidance we provide on our Child Protection.

Challenges for the Future

- There continue to be areas for improvement in the development of our data set specifically, the quality of this in enabling us to effectively commission future services. The corollary to this is that when gaps are identified the continued squeeze on public sector finances will limit the commissioning options.
- There remain a high number of children subject to CP Plans under the category of neglect, which is a key area of focus for the partnership and the QA&E Group. 62.6% of all children subject to a CP Plan in Surrey were so under the category of neglect (561 of a total of 896).
- The effectiveness of the Neglect Strategy and supporting action plan developed by the QA&E group will be a vital area of work to monitor and track if we are to achieve improved outcomes for children.

Next steps

Four major audits are being commissioned, each linked to the SSCB's Business Plan priorities:

- Effectiveness of assessment of neglect and how that impacts on the partnership intervention with children suffering from neglect
- The quality of Independent Return Interviews for children who go missing from home, or care and its impact upon the reducing the number who go missing and the number who go missing more than once
- The effectiveness of the MARAC process and programmes working with perpetrators of

Domestic Abuse

- The quality of assessment for early help and the impact of subsequent intervention, including consideration of the effectiveness of the MASH

Priorities for next year and beyond

Targeted priority 1

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

Our application of thresholds is not always consistent, emphasising the need to address this through the MASH & Early Help and the new SSCB threshold guidance

Targeted Priority 2

To ensure professionals and the current **Child Protection processes** effectively protect those children identified as in need of protection and who are looked after (LAC). To ensure that the voice of the child is heard

Targeted Priority 3

To challenge and scrutinise the effectiveness of the response and impact of partners work to protect children at risk of **Child Sexual Exploitation (CSE).** To ensure that the voice of the child is heard

Targeted priority 4

To monitor and challenge the effectiveness and impact of the **Domestic Abuse Services** in reducing the incidences of Domestic Abuse and protecting children from harm. To ensure that the voice of the child is heard

What you need to know

SSCB Independent Chair

Elaine Coleridge-Smith

SSCB Partnership Board Manager

Janice Morgans

Participant Observers

Linda Kemeny, Cabinet Member for Schools, Skills and Educational Achievement

SSCB Membership (as at 31 March 2016)

Atkinson	Helen	Surrey County Council	Director of Public Health
Baker	Sarah	Central Surrey Health	Director of Quality (Nursing)
Bayley	Wendy	HMP & YOI Bronzefield	Head of Reducing Reoffending
Boodhoo	Amanda	Guildford and Waverley CCG	Designated Nurse for Safeguarding
Brocklesby	Kate	Guildford and Waverley CCG	Designated Doctor
Cassam	Carol	NHS England	
Ely	Kathleen	Virgin Care	Executive Nurse and Head of Children Services
Findlater	Donald	Lucy Faithfull Foundation	Research & Development Director
Fisher	Julie	Surrey County Council	Deputy Chief Executive, and Director of Children's Services

Frost	Val	First Community Health and Care	Clinical Operations Director
Furnell	Paul	Surrey Police	T/Detective Chief Superintendent
Gordon-Walker	Julian	Surrey County Council	Head of Safeguarding
Hall	Pam		Lay member
Jeffries	Victoria	National Probation Service, South East & East Division	Assistant Director
McCarthy	Mary Ellen	Lumen Learning Trust	Executive Principal
Monk	David	Pond Meadow School	Head teacher
Morgans	Janice	SSCB	Interim Partnership Manager
Newbould	Sam	Kent, Surrey & Sussex CRC Ltd	Head of Service for Resettlement
Newnes-Smith	Cate	Surrey Youth Focus	Chief Executive officer
Nosal	Vernon	SSAB	Interim Head of Quality Assurance and Adults Strategic Safeguarding
Oddoye	Mayvis	SABP	Consultant Nurse – Safeguarding
Osborne	Phil	Surrey County Council	Head of Early Years and Childcare Service
Peers	Kevin	Surrey County Council	Interim Assistant Director, Children's Services
Polley	Janet	Surrey County Council	Principal Lawyer
Rafferty	Sean	Surrey County Council	Head of Family Services
Randle	Kerry	SCC Schools and Learning	Area Education Officer – NE
Rankin	Suzanne	Ashford & St Peter's Hospital Trust	Chief Nurse
Round	Louise	Tandridge District Council	Chief Executive
Satchell	Sue	CAFCASS	Service Manager
Searle	Ron	Warwick School	Head teacher

Stobbart	Vicky	NHS Guildford and Waverley Clinical Commissioning Group	Executive Director of Nursing, Quality and Safeguarding
Symonds	Garath	Surrey County Council	Assistant Director Commissioning & Prevention

Contributors

With thanks to the following who contributed information for the Annual Report 2015 – 2016:

- SSCB Support Team
- SSCB Independent Chair
- SSCB Partnership Board Manager
- Surrey County Council Head of Safeguarding
- SSCB Quality Assurance and Evaluation Officer
- Designated Nurse Safeguarding Children
- Chairs of SSCB Sub Groups
- Surrey Police Public Protection Unit
- SSCB Training and Development Officer
- Surrey County Council Elective Home Education
- SSCB Area SEND Programme Leader
- Surrey County Council Fostering Team
- Director of Public Health
- Lay Member
- Surrey County Council Assistant Director Commissioning & Prevention
    - MASH
    - Early Help
    - Family Support Programme
- Surrey Police Detective Superintendant
- SSCB CSE Partnership Manager
- HOPE Service
- Carers Strategy & Development Manager
- Surrey County Council Care services Team, Residential
- Surrey County Council Head of Countywide Services
- Surrey County Council Community Safety Manger
- Surrey County Council Local Authority Designated Officer
- Surrey County Council Performance and Systems Development Team
- Surrey County Council Carers Strategy and Development Manager
- CSF Strategy and Policy Development

Recipients of Annual Report

In line with statutory requirements the SSCB Annual Report has been sent to the following people:

- Surrey County Council, Chief Executive
- Surrey County Council, Cabinet Member for Schools, Skills and Educational Achievement
- Surrey Police and Crime Commissioner
- The Council's Cabinet
- Chair of Health and Wellbeing Board
- Chair of Surrey Community Safety Partnership

- Chair of Children and Young People Partnership
- Chair of Surrey Safeguarding Adult Board
- Local Family Justice Board

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

Overarching priority:

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

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

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

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

SSCB aims to provide the leadership and support required to enable children to feel safe and protected within their communities. In addition to the delivery of its core business SSCB has agreed four additional areas of improvement which require greater scrutiny based on audit, partner's reports to the board, evolving statutory guidance and inspection outcomes.
The Learning and Improvement Framework published by the SSCB contains more detailed information of how partners' improvement activities inform future priorities and is a statutory responsibility in WT 2015. SSCB Strategic Documents

Summary of the SSCB key areas of scrutiny 2016 – 17				
The effectiveness of Early Help for children and families who do not meet the thresholds for statutory intervention and support by Children's Social Care.				
The effectiveness of the current **child protection processes** in protecting those children identified as in need of protection and who are looked after (LAC). To include consideration of **'neglect'**				
The effectiveness of the response and impact of partners work to protect children at risk of **Child Sexual Exploitation (CSE).**				
The effectiveness and impact of the **Domestic Abuse** Services in reducing the incidences of Domestic Abuse and protecting children from harm.				
SSCB will focus on				
Strengthening accountability across partners Scrutinising how well partner agencies' safeguarding arrangements demonstrate improved processes and cultural change Ensuring that the SSCB's responsibility for strategic oversight of child protection arrangements is shared and understood by local agencies, across local partnerships and within Surrey's communities	**Training with impact and testing if learning is embedded** Reviewing safeguarding training to ensure that it is well co-ordinated across the partnership and has an impact on practitioners in the safeguarding system Testing how well learning is embedded in front line practice across Surrey Testing how well learning from case reviews is embedded in to practice across Surrey	**Auditing, scrutinising and challenging** **Maximising the use of performance data** Reviewing SSCB Quality Assurance processes to ensure that it is well co-ordinated across the partnership and has an impact on practitioners. Testing how well learning from audit is embedded in front line practice in Surrey	**Listening to children and families** Ensuring that children's views are reflected within the partnership	**Engaging with local communities** Supporting the development of a co-ordinated and multi-agency response to • CSE • Early Help • Neglect • Domestic Abuse Ensure that local communities are better engaged in the work of the Board and within the partnership

Detailed Work plans 2016 – 17

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

OUTCOME		Q1	Q2	Q3	Q4	Narrative
The Early Help workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate Early Help services for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care	**Early Help sub group** **Supported by** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **MASH & Early Help program board** • **Surrey Children & Young People partnership**					
The Early Help workforce is effective in **sharing relevant information** at a strategic and delivery level						
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across the Early Help sector.						
Agreed multi agency **plans, policies and procedures** relating to Early Help are delivered effectively, and the impact on C&YP is positive.						
The Early Help workforce is effective in **delivering excellent services** for children, young people and families who do not meet the thresholds for statutory intervention and support by Children's Social Care						
Children and Young people receiving Early Help Services **actively contribute to decisions affecting them**. When appropriate, advocates ensure that the child's voice is heard.						

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

OUTCOME		Q1	Q2	Q3	Q4	Narrative
The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and who are looked after.	**Neglect sub group** **Supported by** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **SSCB SCR** • **Surrey Children & Young People partnership**					
The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level						
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's' services.						
Agreed multi agency **plans, policies and procedures** relating to children in need of protection and who are looked after are delivered effectively, and the impact on C&YP is positive.						
The Children's workforce is effective in **delivering excellent services** for children, young people and families who are identified as in need of protection and who are looked after.						
Children and Young people identified as in need of protection and who are looked after **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.						

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

OUTCOME		Q1	Q2	Q3	Q4	Narrative
The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and who are looked after.	**CSE sub group** **Supported by** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **SSCB SCR** • **Surrey Children & Young People partnership**					
The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level						
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's' services.						
Agreed multi agency **plans, policies and procedures** required to protect children and young people at risk of Child Sexual Exploitation are delivered effectively, and the impact on C&YP is positive.						
The Children's workforce is effective in **delivering excellent services** required to protect children and young people at risk of Child Sexual Exploitation.						
Children and Young people **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.						

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

OUTCOME		Q1	Q2	Q3	Q4	Narrative
The Children's workforce is competent in **identifying vulnerability** based on ability to assess, plan, deliver and evaluate services for children, young people **i**dentified as in need of protection and vulnerable due to incidences of Domestic Abuse	**Domestic Abuse sub group** **Supported by** • **SAB** • **SSCB QA** • **SSCB L&D** • **SSCB P&P** • **SSCB SCR** • **Surrey Children & Young People partnership**					
The Children's workforce is effective in **sharing relevant information** at a strategic and delivery level						
Workforce planning effectively **manages risk** associated with financial constraints and recruitment issues across all Children's' services.						
Agreed multi agency **plans, policies and procedures** required to protect children and young people at risk from Domestic Abuse are delivered effectively, and the impact on C&YP is positive.						
The Children's workforce is effective in **delivering excellent services** required to protect children and young people at risk from Domestic Abuse.						
Children and Young people **actively contribute** to decisions affecting them. When appropriate, advocates ensure that the child's voice is heard.						

Glossary of Terms

ACT	Assessment, Consultation Therapy
AEHEP	Association of Elective Home Education Professionals
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
C GAS	Children's Global Assessment Scales
CPP	Child Protection Plan
CSE	Child Sexual Exploitation
C&F	Child and Family Assessment
C&YP	Children and Young People
DA	Domestic Abuse
DCU	Diversity Crimes Unit
DfE	Department for Education
DHR	Domestic Homicide Review
DSL	Designated Safeguarding Lead
EHE	Elective Home Education
FGM	Female Genital Mutilation
FGMPOs	Female Genital Mutilation Protection Orders

FMU	Forced Marriage Unit
FMPOs	Forced Marriage Protection Orders
FSP	Family Support Programme
GP	General Practitioner
GRT	Gypsy, Roma, Traveller
HONOSCA	Health of the Nation Outcome Scales
HTP	Harmful Traditional Practices
ICPC	Initial Child Protection Plan Conference
IRIS	Identification and Referral to Improve Safety programme
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Child
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAECC	Missing and Exploited Children Conference
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
NEET	Not in Education, Employment or Training
PCC	Police Crime Commissioner
NSPCC	National Society for the Prevention of Cruelty to Children

OFSTED	Office for Standards in Education, Children's Services and Skills
PEP	Personal Education Plan
PPU	Public Protection Unit
RAIS	Referral, Assessment and Intervention Service
SABP	Surrey and Borders Partnership
SCR	Serious Case Review
SENCO	Special Education Needs Coordinator
SEND	Special Educational Needs and Disability
SGO	Special Guardianship Order
SPOC	Single Point of Contact
SPIM	
SSAB	Surrey Safeguarding Adult Board
SSCB	Surrey Safeguarding Children Board
UASC	Unaccompanied Asylum Seeking Children
YSS	Youth Support Services

Surrey Safeguarding Children Board

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