surrey safeguarding CHILDREN BOARD

Annual Report 1 April 2017 to 31 March 2018

Contents

Introduction

I am pleased to present the Annual Report of the Surrey Safeguarding Children Board (SSCB) 2017-2018. I have been the Interim SSCB Chair since December 2017 and therefore much of the time covered by this report was under the chairmanship of Elaine Coleridge Smith who I would like to thank for her contribution on behalf of the partnership.

This Annual Report provides a detailed description and analysis of the significant work that has been undertaken by the SSCB Partnership in Surrey during 2017-2018, identifying both the successes but also the challenges and areas for improvement.

Throughout this period the local authority children's services have been the subject of a Department of Education Improvement Notice, issued following the publication in 2015 of a report by Ofsted which judged the overall effectiveness of children's services to be inadequate. A re-inspection in March 2018 found that services remain inadequate.

This has, inevitably, been challenging to all the partners in Surrey and the safeguarding partnership has not been as strong as it has needed to be in driving, implementing and challenging improvement progress. It must, however, be recognised that all partners are committed and have worked hard to improve safeguarding in Surrey and this is reflected throughout this report. Following an external review by a Local Government Association (LGA) associate, followed by a development day in February 2017, changes have been made both to the structure and processes within the SSCB, with a focus on being able to evidence impact on the lives and experiences of children and young people in Surrey. This is still work in progress.

Looking forward, the partnership is preparing to move to local Safeguarding Partnership arrangements, under the Children and Social Work Act 2017. Working Together 2018 clearly sets out the new arrangements and duties for the Police, Health and the Local Authority, along with other relevant partners agreed locally, but with increased freedom as to how these arrangements will work. During this period of transition a Business Plan has been developed also identifying the SSCB priorities for 2018-2019, with the aim of keeping up the momentum for further development.

Finally, I cannot finish this introduction without recognising and thanking all the SSCB member agencies, the chairs and members of the sub-groups, our lay member and the very experienced and dedicated SSCB team for the commitment and work they do to improve safeguarding for children in Surrey. The SSCB as it currently exists, and as it moves into the new Safeguarding Partnership arrangements, has much to do but I feel confident that the partnership will continue to work together, with renewed focus, to improve safeguarding in Surrey with a collective commitment to improving outcomes for children.

Claire Burgess
Interim Independent SSCB Chair.

What is a Local Safeguarding Children Board?

The Local Safeguarding Children Board (LSCB) is an independent body as defined in Working Together 2015. It should not be subordinate to, nor subsumed within other local structures.

Through the Board structure the LSCB provides the strategic direction for safeguarding children and young people and through the operational structure carries out the continuous monitoring and challenge of performance across relevant agencies in Surrey. The Board produces a Business Plan which sets out the priority improvements required in the safeguarding partnership and produces an Annual Report, which is a retrospective look at the previous financial year.

In accordance with statutory guidance the Board funds an Independent LSCB Chair who provides leadership and challenge to the Board via effective chairing of meetings and representation of the LSCB in the public domain and at other relevant governance boards.

In Surrey the Surrey Safeguarding Children Board (SSCB) was established to carry out this statutory role.

Objectives

Section 14 of the Children's Act 2004 sets out the statutory objectives and functions of the LSCB's as being:

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

Our Vision

For the SSCB to work together as an open and transparent safeguarding partnership, where a co-ordinated approach to our strategic and operational work ensures that Children in Surrey are seen, safe and heard.

Our Behaviours

Partners agreed in February 2018 the most important behaviours of the SSCB moving forward to be:

- Every member will understand their role, responsibility and accountability within the SSCB and seek opportunities to combine resources to achieve priorities;
- The SSCB will ensure that there is a co-ordinated system wide approach to planning and implementation of change, with consideration being given to the impact of change across the partnership;
- Partners will be open and transparent about performance identifying areas for improvement as well as areas of good practice;
- Equity in membership to utilise the collective strengths of the partnership with a focus on listening to the contributions of the views of children and families.

Membership

The LSCB Partnership in 2017-2018 was made up of a number of key agencies that work in the Children's Sector. The agencies represented at the Board were as follows:

Surrey Children's Schools and Families
Surrey Police
Borough and District Councils
Kent and Sussex CRC Ltd
National Probation Service, South East and East Division
HM Prison Service
CAFCASS
Surrey Fire Service
NHS England
Guildford and Waverley Clinical Commissioning Group
First Community Health and Care
Central Surrey Health
Surrey and Borders Partnership
Public Health
Surrey Acute Hospitals
Army Welfare Service
Homestart Surrey
Education Phase Councils: Primary, Secondary and Special Schools
Further Education Sector
Independent Preparatory Sector
Adult Social Care
Surrey Youth Focus
Surrey County Council Schools and Learning
Lay Member
Also Invited:
SCC Cabinet Member for Children and Families Wellbeing
Surrey Safeguarding Adult Board
Senior Principal Lawyer Surrey County Council

What the membership said about the SSCB?

As part of the Chair's role Claire Burgess has met with all the members of the SSCB. The feedback from these meetings and partners' feedback, provided as part of the Peer Review, has been used to ensure that the SSCB going forward is structured appropriately and works effectively to achieve its key priorities. This development work to strengthen the partnership is reflected in the revised business plan, which brings together the existing improvement plans and defines the SSCB focus for the next year.

What is working well?

- Positive relationships and commitment to the work of the Board
- Improved communications/relationships
- Partnership working in some sub-groups
- Learning & development
- Section 11 process improved with greater challenge
- SSCB summary dashboard
- Support to the Board

What are we worried about?

- The voices and views of children and young people are not informing and shaping what we do;
- Sustainability and impact;
- Finding a practical solution to information sharing;
- Over emphasis on process and a lack of forensic focus/analysis;
- Responsive rather than proactive in forward thinking;
- Communications;
- Attendance at some sub-groups – too many meetings;
- Governance and accountability between Statutory Boards;
- Link between strategy and practice not always evident;

Things that we would like to change:

- Children and young people representation and contribution to the work of the Board and sub groups;
- Develop a closer working relationship with the Surrey Safeguarding Adults Board to avoid duplication and better manage resources;
- Review and improve the Board structure and sub groups;
- Work as a 'whole system'; not in silos;
- Greater accountability and assurance between partners, particularly following statutory inspections;
- Setting of core priorities with measures of success;
- Focus on performance of all agencies and achieve impactful outcomes for children and young people;
- Strengthen governance relationships with other strategic boards.

SSCB Governance Structure

The SSCB has a Business Plan, agreed by partners which is aimed at delivering the statutory requirements of the legislation governing the work of LSCB's and the needs of local children and young people. In order to achieve this, set direction and monitor progress, the SSCB has an established sub group structure and some short term task and finish working groups, which are accountable to the Board.

As part of the LGA Peer Review partners reported that the structure of the architecture of the SSCB Sub Groups and its relationship to other Boards required clarification and review. Partners reported finding it increasingly difficult to attend the numerous meetings due to resourcing issues in their individual agencies and in some sub groups partners felt that work was not progressed at an appropriate pace, with some actions being carried forward from one meeting to the next.

Chairs of individual sub groups and partners contributed to discussions and a proposed structure which was shared with the SSCB membership in February 2018. This is set out in the structure diagram below. The restructuring of the sub groups was agreed in principle in March 2018.
In the diagram below a number of sub groups are identified as being under review or have a specific timescale for future review.

Following further discussion with partners the following decisions were made:

- Area Groups were recognised as being the interface of the Board with practitioners and have historically had an important role in the taking forward the business priorities of the SSCB into operational practice; dissemination of learning from audits and case reviews; updates on policy and procedure changes and to provide a networking opportunity between the wider partners. Following the peer review each area group has been asked to review their roles and identify whether as a multi-agency partnership group they benefit from their association with the SSCB.
- Neglect Task and Finish Group: This group is proposed to continue as a sub group of the SSCB with a defined scope of work and its continuation will be reviewed in March 2019 following a review of progress against its work plan.
- Online Safety Group: This group is proposed to continue in its current format until discussions have been held with partners to agree the best approaches to take to develop this group into a forum led by young people. Initial contact has been made with partners to progress this work
- Learning and Development Group: The role and functions are to be reviewed and decisions made about its continuity.

The roles of Sexual Exploitation, Assault and Missing Management Board (SEAMMB), the Health Sub Group, Education Sub Group and Policies and Procedures Group are proposed to continue in their current format until local safeguarding partnership arrangements are agreed under the new Working Together to Safeguard Children 2018 Guidance and the role of the SSCB going forward is better understood. Transitional arrangements for the SSCB will be in place until local safeguarding partnership arrangements are implemented, by September 2019.

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Revised Roles and functions of the SSCB Groups

Working Together to Safeguard Children 2018 will provide further guidance on the development of local safeguarding partnership arrangements which will inform the future role of the SSCB and the governance and structure of sub groups

In the interim, as part of the re-focussing and re-defining of the partnerships role, the Board approved the following changes which will be implemented incrementally during 2018:

Executive:

In preparation for the new safeguarding partnership arrangements this new strategic group, with membership drawn from Children's Social Care, Police, Health and Education, will support the transitioning arrangements under the new Working Together statutory guidance 2018. It is anticipated that this group will meet in September 2018 to agree terms of reference and membership.

SSCB:

The main Board for the LSCB is constituted in accordance with statutory guidance (Working Together to Safeguard Children 2015). Revised statutory guidance, Working Together to Safeguard Children 2018, published in July 2018, will inform the future role and function of local safeguarding arrangements and provide the framework for discussion by the Executive Board. Until this guidance is published the SSCB Board has strategic accountability for performance monitoring and assurance to discharge its statutory responsibilities; receives analysis reports/exception reports from the Quality Assurance and Performance Group and will continue to provide a forum for challenge and problem solving; providing challenge and giving actions to sub groups.

Business Group:

In March 2018 the Business Group replaced the former Chairs' Executive Group in the previous structure. It will have revised terms of reference which will define the role, responsibility and accountability of this group to take forward the SSCB Business Plan Priorities, provide challenge and scrutiny to other sub groups of the Board and to report to the SSCB on progress against the 2018-2019 Business Plan.

The group will also be responsible for providing challenge to the SSCB on key matters arising from the day to day business of the Board.

The core membership consists of the Chairs of every sub group. The group is chaired by the SSCB Independent Chair and provides opportunity for the Chair to hold the sub groups to account on behalf of the SSCB Partnership.

Child Death Overview Panel (CDOP)

CDOP and SCRG will remain in the proposed structure as the Statutory Sub Groups of the Board fulfilling their roles and responsibilities as set out in statutory guidance.

The role of CDOP is to:-

- Receive and critically examine reports of all child and neo natal deaths in Surrey and ensure that significant cases are identified and referred to the Strategic Case Review Group for further consideration
- Publish an Annual Report
- Collate and oversee national returns
- Ensure full analysis of all Child Deaths in Surrey to ensure that learning from these cases is captured for professionals to inform future practice or safety campaigns

Strategic Case Review Group (SCRG)

The role of SCRG is to:-

- Examine individual cases referred to the SSCB and make a decision as to whether criteria for a Serious Case Review (SCR) to be commissioned are met or consider whether an alternative Learning Review should be undertaken to inform practice improvement within the partnership;
- Make recommendations to the Chair of the SSCB on the partnership response to the referral
- Commission and contribute to SCR's and other Learning Reviews
- Oversee Surrey contributions to SCR's and Learning Reviews commissioned by other LSCB's
- Oversee action plans arising from completed reviews
- Agree draft review reports with authors prior to presentation to the Board

Quality Assurance and Performance Group

Formerly known as the Quality Assurance and Evaluation Group.

This group is reviewing its terms of reference and membership and will have as a key function in the analysis of the SSCB Report Card; measuring progress against the Business Plan and the work of other sub groups; providing challenge to partners for assurance purposes. The group will receive responses to challenges for inclusion into the quarterly report to SSCB and also respond to challenges/questions from the SSCB Board and Improvement Board.

Neglect Sub Group

This former task and finish group will become a full sub group of the SSCB until a further review is undertaken in March 2019.

The early recognition of Neglect and the response to Neglect in Surrey is a concern of the SSCB and this is evidenced in the Serous Case Reviews commissioned by the Board, data shared by partners as part of the SSCB Report Card and through SSCB audits of Neglect. The continuing business priority of the Board to improve outcomes for children at risk of experiencing neglect remains a key priority.

To enable a greater focus on Neglect the terms of reference and membership of this sub group will be refreshed to ensure that:

- It can lead on the there being a shared understanding of 'Neglect' across the partnership
- Support the development and implementation of assessment tools to identify and respond to Neglect at an early stage
- Develop a shared way of working across the partnership, where good practice is shared and practice that requires improvement is challenged.

Early Help Task and Finish Group

This new, short term, task and finish group has been established to start to influence and progress the thinking around the development of the Early Help system in Surrey, including the Multi-Agency Safeguarding Hub (MASH) and to ensure that the Early Help pathway works to provide a co-ordinated and timely response to children and young people across the levels of need.

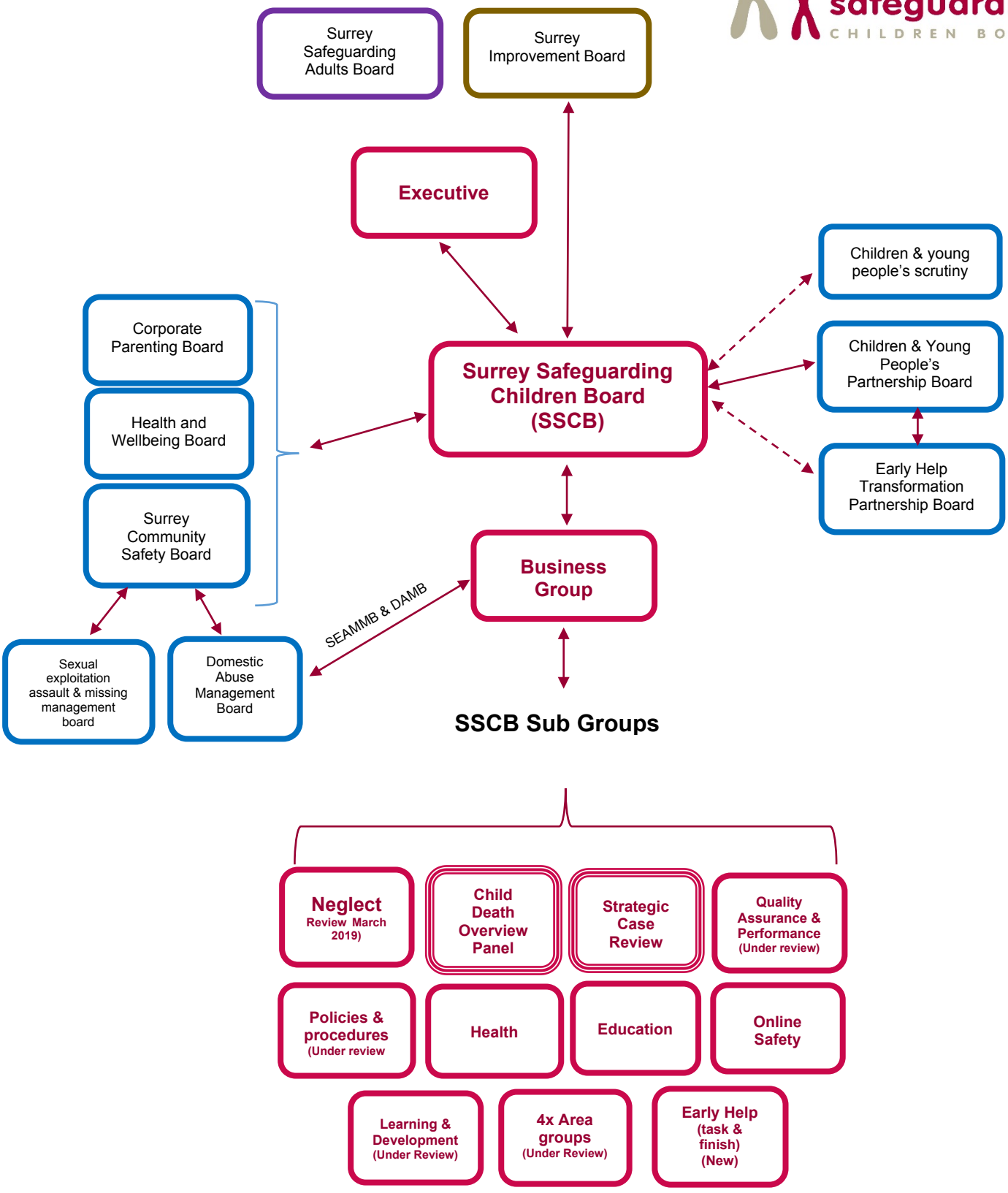
It was established following a discussion at the Surrey County Council Improvement Board which highlighted the SSCB's concerns around the current arrangements for Early Help intervention in Surrey and support for families when issues start to emerge. It is a short term group expected to conclude its work in September 2018, by which time it is anticipated that new arrangements will have been introduced in Surrey to address the concerns highlighted by both the SSCB in November 2017, following the audit of the MASH and Early Help Pathway, and by Ofsted in their February – March 2018 inspection.

This group will work closely with change leaders in Surrey and will influence the Surrey Level of Needs document which defines the thresholds for access to services across the Surrey system.

Surrey County Council Improvement Board

Over the last three months the Improvement Board's scrutiny relationship with the SSCB has been reset and their respective roles are now more clearly understood by partners. Going forward the strategic partnerships will be better aligned and the SSCB will be increasingly held to account for improvement activity across the partnership. The Improvement Board will task the SSCB to undertake key pieces of work to understand more about areas of concern or to enable the Improvement Board to be reassured of the impact of improvement work within the partnership. A current example of this work being an analysis of the attendance of schools at S47 strategy meetings following a challenge from schools that they are not invited and engaged in early discussions about children.

Proposed Surrey Safeguarding Children Board Structure 2018-2019



Key

Keep Informed

Reports to

Statutory Group

Business Planning Processes

The Business Plan 2016 to 2018 agreed four areas of focus relating to 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
- Current Child Protection process in protecting those children identified as in need of protection and who are looked after (LAC). To include consideration of Neglect.
- The response and impact of partners work to protect children and young people at risk of Child Sexual Exploitation (CSE)
- The impact of Domestic Abuse Services in reducing the incidences of Domestic Abuse and protecting children and young people from harm.

Progress against the 2016-2018 Business Plan Priorities

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.

What is Early Help for Children Young People and Families?

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

What is working well?

- The Multi Agency Safeguarding Hub (MASH) and Early Help Coordination Hubs are starting to embed into practice since their launch in October 2016; the MASH is overseen by the MASH Executive Board and the Early Help Transformation Board oversees the Early Help offer;
- Surrey Family Services launched as a new service in May 2017, bringing together a number of services under one Head of Service;
- Recruitment of Staff to the Early Help Coordination Hubs went well with the majority of roles been successfully recruited to by August 2017;
- Strategic leads within Surrey Family Services continued to build upon the Partnership Events held in 2016 to develop a local response to children and families with emerging needs;
- The SSCB audit of the MASH and Early Help Pathways was scoped and agreed to be carried out in October /November 2017, twelve months after the re-launch of services;
- Improved data collection across Early Help Services within Surrey Family Services is starting to enable a more informed analysis of impact.

What are we worried about?

- The lack of clarity of what the vision for Early Help 'going forward' looks like. At SSCB led focus groups for partners there was confusion about the 'referral pathway' into services and partners roles and responsibilities within the Early Help system;
- The sustainability of the MASH without further reform; the MASH received 62,310 contacts in 2017-2018, of which 20% were identified as requiring Early Help support and 20% were progressed to Children's Social Care; approaching 60% of referrals were for information advice and guidance;
- Data from the MASH shows an overwhelming number of contacts at Level 1 being made to the MASH, some 29,000 level 1 contacts were received over the reporting period;
- The application of the Level of Needs / Threshold Document by partners in some sectors is not well understood which is evidenced in some poor quality referrals into the MASH from the partnership;
- Unclear messages being disseminated throughout the partnership about how to make a referral and whether this should be to an Early Help Coordination Hub directly or through the single front door of the MASH;
- The use of additional threshold descriptors in Early Help that were not reflected in the published Level of Needs document leading to confusion in the partnership, particularly within Universal Services;
- The quality of contacts being made by partners to the MASH and their expectations of 'what happens next' was found in audit to be unrealistic in some cases;
- Backlogs of contacts in the MASH, particularly in referrals into the MASH from Police;
- The voice of children not being heard and responded to by practitioners, and the child's voice not sufficiently influencing practice within the partnership;
- In August 2017 Ofsted found that insufficient analysis of family history or over optimism about parents' capacity for change has led to families initially being offered Early Help when a social care assessment is needed.

The SSCB responded to these concerns through the testing of practice in audits carried out by the Quality Assurance and Performance Group; through challenge to partners; by convening meetings with partners and sharing findings from audits to challenge thinking; by listening and responding to concerns and by sharing learning from audits and SCR's with partners. The impact of this work is commented upon later in the report.

Priority 1 SSCB Data Set Information to 31 March 2018

Conversions of MASH contacts received between 1 April 2017 to 31 March 2018

Child in Need Pathway	Quarterly								Last 3 Months						Year to Date	
Front Door	Q1 2017/18		Q2 2017/18		Q3 2017/18		Q4 2017/18		January		February		March			
MASH Contacts Received	15,220		14,814		16,286		15,990		5,809		4,881		5,300		62,310	
of which:																
New Contacts	-	-	-	-	15,722	97%	15,659	98%	5,694	98%	4,776	98%	5,189	98%	-	-
Information on an exiting case	-	-	-	-	564	3%	331	2%	115	2%	105	2%	111	2%	-	-
Outcome of contact:																
Progress to Childrens Social Care	3,080	20%	2,804	19%	3,140	19%	3,364	21%	1,177	20%	984	20%	1,203	23%	12,388	20%
Information and Advice	8,837	58%	7,865	53%	9,591	59%	9,580	60%	3,722	64%	2,983	61%	2,875	54%	35,873	58%
Progress to Early Help	2,015	13%	2,380	16%	2,087	13%	1,659	10%	536	9%	543	11%	580	11%	8,141	13%
Continue with Early Help Episode	998	7%	1,418	10%	1,132	7%	918	6%	288	5%	290	6%	340	6%	4,466	7%
MASH Enquiry	276	2%	332	2%	325	2%	244	2%	84	1%	74	2%	86	2%	1,177	2%
Not Recorded	14	0%	15	0%	11	0%	225	1%	2	0%	7	0%	216	4%	265	0%

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**

What are the Statutory Responsibilities of Local Authorities and Partner Agencies?

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

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

Surrey County Council have responsibility as corporate parents to ensure the wellbeing of children in care, with the primary responsibility to ensure that those children who are growing up in care or who are care leavers, have the best possible opportunities and support available to them to achieve their full potential. Scrutiny of services provided to children in care is Surrey is overseen by the Social Care Services Board.

The SSCB receives the Annual Report of the Corporate Parenting Board, which is a retrospective report covering the previous reporting year. The report for 2017-2018 is due to be presented to the SSCB Full Board in July 2018. In order to receive assurances about the current reporting year the SSCB relies upon the analysis of data provided to the SSCB and the Surrey County Council Improvement Board, which is attended by the SSCB Independent Chair and provides the opportunity to challenge current data and seek assurances through Surrey County Council of areas of concern.

What is working well?

- The support provided to Care Leavers results in better outcomes in Surrey than other authorities, with increased numbers achieving employment or training/apprenticeships;
- There is a pro-active and effective Care Council which meets monthly and is a group of care experienced children aged 13-24;
- There are a range of ways that looked after children and care leavers can share their views and have an impact on changing practice and services;
- The number of children on Child Protection plans for over 18 months have reduced from 6.1% to 4.8% in the last twelve months, and those on plan for 2 or more years has reduced from 2.7% to 2.0% which is now below the regional average of 2.6%;
- 886 out of 944 (94%) of Looked after Children have up to date reviews;
- Between March 2017 and August 2017; 78.7% of children and families involved in Child Protection conferences completed a quality assurance form which will inform practice improvements;
- In April 2017 Ofsted reported that children live in safe and stable placements and have contact with their family particularly brothers and sisters and social workers know the children well.

What are we worried about?

- The number of children who are looked after has increased from 869 in March 2017 to 944 at 31 March 2018, representing an 8.6% increase;
- 242 (26%) Looked After Children in Surrey are placed out of area and live more than 20 miles outside of the County. This is significantly greater than the national average of 14%;
- Initial Health Assessments (IHAs) are worrying low with only 63% being completed and of these only 13% were completed within timescales. 131 children at March 2018 have therefore not received their Initial Health Assessment and this has been challenged by partners in both the Quality Assurance and Performance Group and the Surrey County Council Improvement Board to understand why these assessments are not taking place;
- Adoption teams are very effective in placing complex children and achieving permanency;
- Learning from serious case reviews shows that the step up and step down processes to / from Child Protection Plans is not sufficiently robust leading to re-referrals;
- 26% of children in Surrey are subject to repeat Child Protection Plans which has increased from 23.25% in the previous year;
- Professionals being over optimistic about a families capacity to sustain change;
- The high number of referrals to the Strategic Case Review Group (SCRG) where Neglect is a concern;
- 69% of children on Child Protection Plans in Surrey are under the category of Neglect compared with 66% in 2016-2017
- Ofsted in April 2017 highlighted concerns that management oversight and scrutiny of Independent Reviewing Officers (IRO's) was inconsistent and 'not driving children's plans';
- Permanency plans are insufficiently robust;

- Too many children experience drift and delay and spend extensive periods of time at the pre-proceedings stage.

Priority 2 SSCB Data Set Information to 31 March 2018

In the 12 months to 31 March 2018 5844 Strategy Discussions took place of which 4247 (73%) led to Section 47 enquiries being undertaken; 1443 (33.9) of which led to an Initial Child Protection Conference (ICPC) being convened.

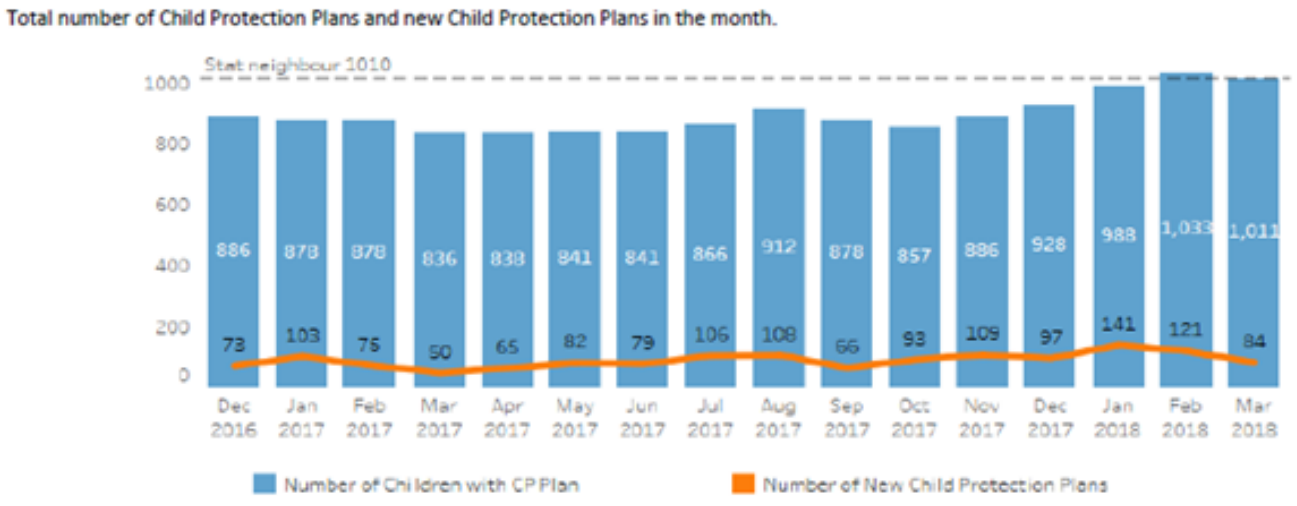
Outcomes from ICPC show that 1,139 of cases led to a Child Protection Plan and a further 264 received services to support the family. 40 (3%) required no further action.

This data demonstrates that only 24% of the original number of strategy meetings held, resulted in the child being put on a Child Protection plan or receiving services.

The SSCB Quality Assurance and Performance Group are undertaking audits on a sample of Strategy Meetings as there is concern that a significant proportion of Strategy Meetings held do not include key partners in Education and Health. The findings from this work will be presented to the Surrey County Council Improvement Board.

At 31 March 2018 1011 children were on a Child Protection Plan in Surrey, compared to 836 in March 2017. This represents a 20.9% increase over the past twelve months.

The best hypothesis for this increase, as there is no notable change in demographics in Surrey, is that there is either more effective risk evaluation in the system, which has led to an increase in the number of children going to conference; representing a 're-setting of the system' or that the system has become more risk averse; or a combination of both.



	Surrey in Context				
	Surrey 2016/17	Surrey Latest	Stat Nbr 2016/17	Region 2016/17	National 2016/17
Rate of CP Per 10,000 Pop	32.5	39.0	39.0	41.3	43.3

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Children's Involvement in Conferences

Children's participation at conferences has been highlighted as an area for improvement within the service. In the first six months of the reporting period, 313 children received invitations to attend conference of which 125 attended.

A plan to address children's participation was completed in December 2017 with a review to measure the impact of this work six months after full implementation. The SSCB Business Plan for the next 12 months has reflected the need for partners to ensure that the voices and lived experiences of children are taken into account by services and are integral to the work undertaken with families. The SSCB will conduct a mapping exercise and analysis of children's engagement with partners to understand the systems currently in place, their impact and effectiveness and to support the partnership to make improvements.

Ofsted noted in April 2017 that "Children are actively encouraged to participate in their reviews…. and in some cases children are supported to chair their own meetings".

	2016				2017									2018		
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of Looked After Children (LAC)	898	894	876	869	864	860	867	874	883	892	928	938	944	951	946	944
- Of whom aged 18	0	0	0	1	0	1	1	1	1	2	2	5	8	21	15	14
Rate of Looked After Children per 10,000 pop	34.7	34.5	33.8	33.6	33.4	33.2	33.5	33.7	34.1	34.4	35.8	36.2	36.4	36.7	35.9	35.9
Number of UASC supported	153	159	157	145	144	142	133	130	121	122	129	128	127	113	111	106
Number of Care Leavers supported	479	488	491	498	510	507	510	515	524	517	517	518	502	509	516	534
Number of Care Leavers that are UASC					196	196	195	200	210	206	205	205	209	211	215	226

Surrey in Context					
	Surrey 2016/17	Surrey Latest	Stat Nbr 2016/17	Region 2016/17	National 2016/17
LAC Per 10,000 Pop	34.0	36.4	41.5	51.0	62.0
Care Leavers per 10,000 pop	19.2	20.6	Not Available		

As already stated by 31 March 2018, 944 children were Looked After Children compared to 869 in March 2017. This represents an 8.6% increase over the past twelve months. Despite this increase Surrey rates per 10,000 of the population remains statistically lower than statistical neighbours and significantly lower than the national average.

The number of LAC with a completed Initial Health Assessment is 63%, significantly below the target of 80%. The trend line for IHA shows an improvement in performance between December 2017 and February 2018 but in the last three months there has been no significant change in the completion of IHAs.

Review Health Assessments for LAC in care for 1 year or over is 87%. Data has shown an improvement between December 2017 and March 2018. Performance data on Dental checks for LAC in care for over 1 year shows that the figure remains consistent at 83% but this figure reduces to only 63% for children who are in care for less than a year. The SSCB and Improvement Board are continuing to monitor these trends in 2018 to understand why improvements in the spring of 2018 have not been sustained

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.

What is working well?

- Sexual Exploitation, Assault and Missing Management Board (SEAMMB) is an effective and well attended multi agency meeting that has strategic oversight of Child Exploitation in Surrey;
- The new Return Home Interview Service, delivered by Surrey Family Services, is beginning to embed into practice and there has been a positive impact evidenced in an increase in the uptake of interviews by children and young people who go missing;
- Risk Management Meetings, which meet weekly, were introduced in July 2017, ensuring that conversations are more timely around missing and at risk children;
- The role of Child Exploitation, Missing and Hidden Crimes Coordinator role has been recruited to and will lead to a more flexible resource being available within the partnership;
- The Office of Police and Crime Commissioner (OPCC) have continued to provide 50% of the funding for the Partnership role to support work involving Child Exploitation;
- SEAMMB receives update reports from the OPCC office which allows the voice of victims to be heard;
- Sexual Assault referral Centre (SARC) supports children who have been the victims of sexual assault or abuse
- A Child Independent Sexual Violence Advisor (ISVA) provides emotional and practical support for children; working in partnership with families and agencies, to ensure that Children's needs are met;
- Direct 1 to 1 or group therapeutic support is provided by the Sexual Assault Recovery Service (STARS) to children affected by sexual abuse.
- Partnership procedures, when managing allegations of Harmful Sexual Behaviour, have been reviewed and updated to reflect current good practice, as a direct response to a complaint raised by a family with Police and new systems are in place and proving to be effective;

- There is evidence, supported by Ofsted, of an improved partnership response to children experiencing or at risk of Child Sexual Exploitation in Surrey;
- Surrey Police is relaunching and increasing awareness of the Partnership Intelligence Form; a means for partners to quickly and efficiently share information with Police; the impact of this initiative is an increase in reports from 10 a month to between 40 and 50 per month.
- Engagement with children has been scoped against the 'See me, hear me' framework, which will inform practice and lead to improved engagement with children and young people;
- The missing children performance data set has been refreshed to look at the most at risk children and links to other factors such as crime, exploitation and domestic abuse. This provides a broader picture of the child but is not yet fully effective and will be developed further in 2018.

What are we worried about?

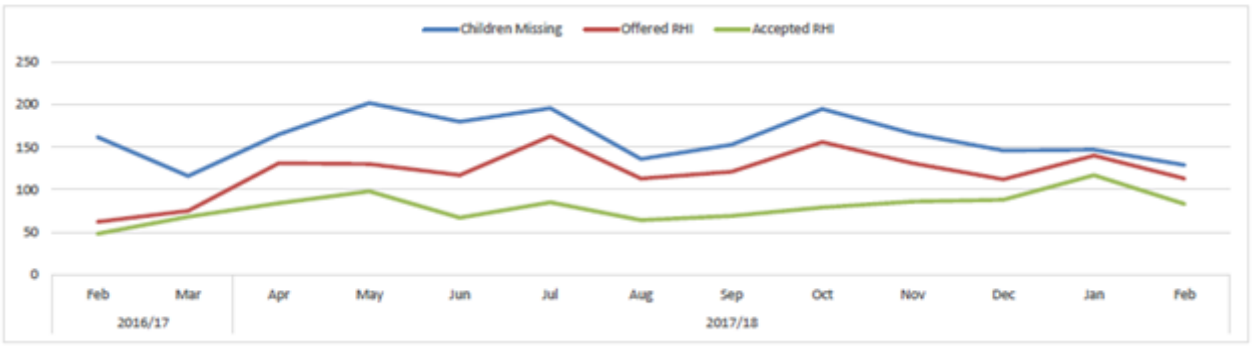
- Information sharing between agencies in Surrey still requires improvement and barriers to information sharing need to be addressed;
- The local Problem Profile of Child Exploitation in Surrey is not sufficiently developed;
- The powers of Community Safety Partnerships have not been sufficiently utilised to disrupt perpetrators in the local community and stronger links are required between the SSCB/SEAMMB and the Community Safety Partnership Board to enable this work to progress;
- There are low numbers of referrals of perpetrators to Community Harm and Risk Management Meetings (CHARMMS);
- Children involved in sexual abuse cases are not being referred to the Sexual Assault Referral Centre (SARC) particularly the under 13's;
- SARC are not routinely invited to attend or contribute to Strategy Meetings;
- Not enough is known about criminally exploited children in Surrey and there is currently a gap in this intelligence;
- The wider partnership are insufficiently aware of the links between criminal exploitation, missing episodes and Child Sexual Exploitation and there is a training / awareness raising need;
- There is no specific measurement of progress which demonstrate the impact of the considerable work that the partnership has undertaken and in 2018-2019, key performance indicators need to be agreed to track progress and measure impact;
- The impact of Gangs and County Lines in Surrey is not fully understood by the partnership and awareness raising is at an early stage;
- Improved processes are in place to engage children who go missing in return home interviews however they are not yet being used effectively to assess risk and keep children safe.

Priority 3 SSCB Data Set Information to 31 March 2018

Missing Children
Children with a missing episode and Return Home Interviews in the month

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Children starting a missing episode	162	116	165	202	180	196	136	153	195	166	146	147	129
Children offered a return home interview	62	75	131	130	117	163	113	121	156	131	112	140	113
% offered a return home interview	38%	65%	79%	64%	65%	83%	83%	79%	80%	79%	77%	95%	88%
Children accepting a return home interview	48	68	84	98	67	85	64	69	79	86	88	117	83
% offered that accept a return home interview	77%	91%	64%	75%	57%	52%	57%	57%	51%	66%	79%	84%	73%

Missing Children
Children with a missing episode and Return Home Interviews in the month



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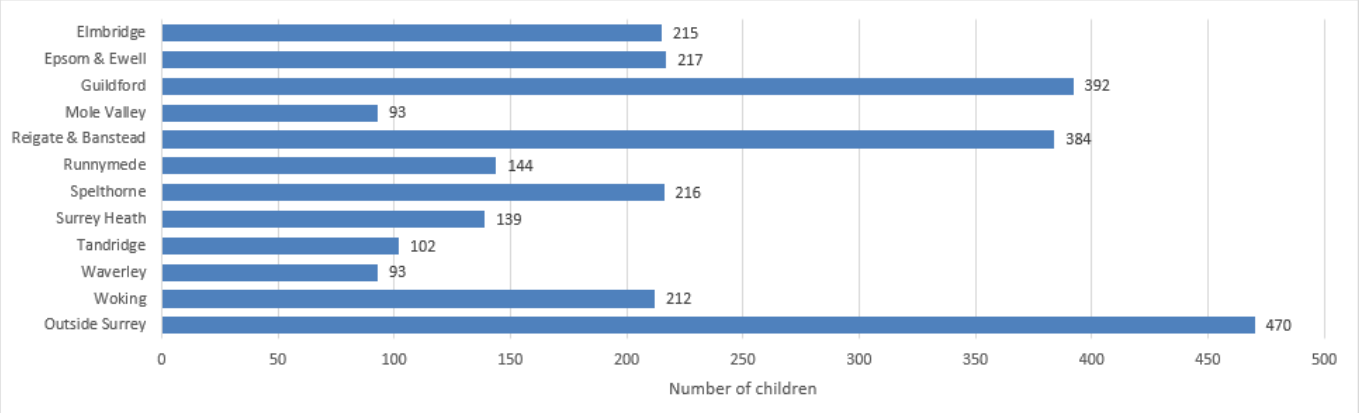
% offered that accept a return home interview	77%	91%	64%	75%	57%	52%	57%	57%	51%	66%	79%	84%	73%

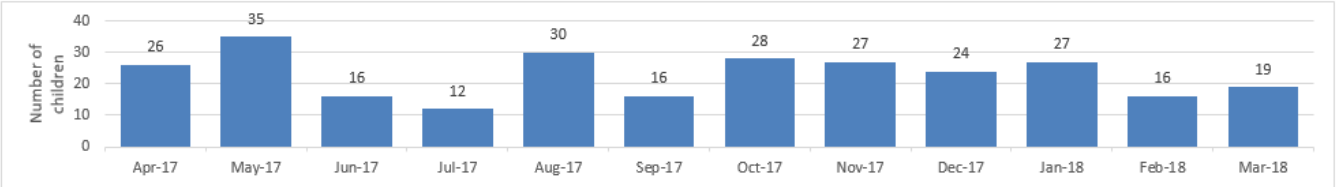
Children missing from home, care or education are not automatically at risk of child or sexual exploitation, however, there is insufficient analysis in Surrey of the 'push pull factors' and risks associated with missing episodes.

In Surrey the Exploited and Missing Children Delivery Group is co-chaired by Police and the SSCB. A key priority for 2018-2019 is to develop the Missing Children Dashboard to include Education Data.

Current work mapping the Borough and Districts where children go missing from is beginning to improve understanding and local intelligence but greater improvement is required. Data is also presented in the table below which shows 470 missing episodes relating to children living outside of Surrey.

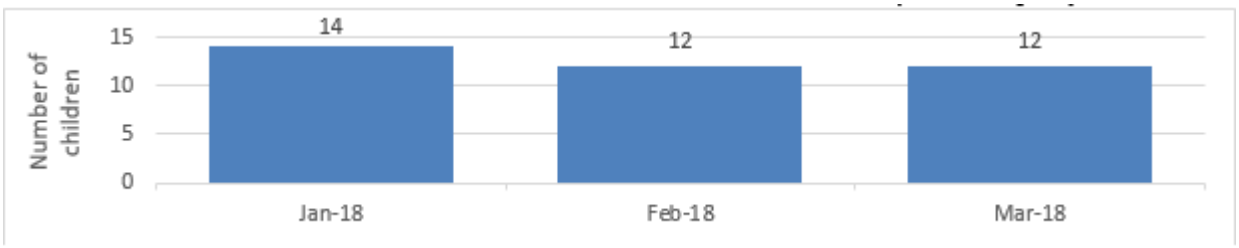


Missing children at risk of Child Sexual Exploitation (CSE)



This chart shows the number of children who have had missing episodes in the month and who are also on the Children's Service CSE list and are reviewed at the Area Risk Management Meetings.

Missing children at risk of criminal exploitation (data only reported from January 2018)



Unaccompanied Asylum Seeking Children (UASC)

There are 67 open referrals to UAS Children in Surrey; 57 are aged under 18 and 10 are aged 18 plus. 3 are female and the remaining children and young people are male. The children are from 12 regions of the world, the majority are Eritrean (17), Sudanese (12) Afghan (10) Iranian (8) Iraqi (4). 9 of the over 18's are care leavers.

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

What is working well?

- Surrey County Council on behalf of funders of domestic abuse services in the County including the Police, the Office of the Police & Crime Commissioner, Surrey County Council and District and Borough councils, have commissioned 'Safe Lives' (a national domestic abuse charity) to support the development of a joint commissioning strategy;
- Women's Aid Change That Lasts (CTL) pilots are running in east Surrey to pilot the 'Trusted Professionals' initiative and develop family hubs to support children and victims of domestic abuse;
- Operation Encompass is embedding into practice and improving information sharing with schools, to enable children to be better supported;
- Surrey is recognised as being innovative and committed to taking a needs led, strengths-based and trauma informed approach with domestic abuse;
- In January 2018 a countywide conference was held to bring together professionals who have a role in reducing domestic abuse and those supporting victims / survivors and their children;
- Improved information sharing in the partnership;
- There are 50 Specialist Domestic Abuse Champions across Children's Social Care, and the 11 Borough and District Councils in Surrey;
- Surrey was awarded White Ribbon Status in 2018;
- The conviction rate for offences (rolling year data) is 78.6% and continues to improve month on month. This represents an improvement of 5% compared to the same period in 2016-2017;
- A new strategy against domestic abuse in Surrey for 2018-23 has been approved, with a vision for every adult and child experiencing domestic abuse to be seen, safe and heard and free from the harm caused by perpetrator behaviour and will be effective from April 2018.

What are we worried about?

- Domestic abuse is the highest reported violent crime in Surrey and yet numbers show that domestic abuse is still a 'hidden' crime;
- The most vulnerable children and adults at risk of harm from domestic abuse, neglect and abuse are not identified early enough in the current system;
- The need for a 'Domestic Abuse Referral Pathway' through the MASH to enable better recognition and decision-making has not been developed;
- The national charity Safe Lives estimates there are 35,400 victims of domestic abuse in Surrey, with approximately, 3,300 children living in households where their parent is at a high or medium risk of serious harm or homicide;.
- 60% of child protection concerns relate to domestic abuse and 20% of all referrals from the MASH to Early Help Coordination Hubs are for domestic abuse;

- 7 out of the last 10 published Serious Case Reviews and Partnership Reviews in Surrey included domestic abuse – two of which were linked to serious financial difficulties within the family;
- There have been two jointly commissioned Domestic Homicide Reviews and Serious Case Reviews commissioned in Surrey involving children where domestic abuse was a significant factor;
- 90% of users of Surrey Domestic Abuse Services are also in contact with other agencies, most notably Surrey Police, GPs, mental health services, courts and children's services;
- Surrey Police have recorded a 9.7% increase in the volume of domestic abuse recorded incidents compared to the same period in the previous year (+100 offences)
- Since January 2018, Surrey has experienced month on month increases in Repeat Offender / Repeat Victims, over 1/3 of recorded offences being a repeat offence;
- MARAC referrals where children are in the household increased from 53 in March 2017 to 59 in March 2018, affecting 115 and 112 children respectively;
- The total number of children recorded by Surrey Police as being involved in domestic abuse incidents was 740 at March 2018 (850 March 2017);
- Learning from SCRs in Surrey shows that professionals do not use professional curiosity to explore concerns around domestic abuse more fully;
- Safe Lives (2017) estimate that the full cost of providing domestic abuse services in Surrey based on visible need would cost approximately £5,970,000. Current funding is £I,543,000 across the partnership;
- DHRs and SCRs in Surrey show that risks associated with domestic abuse are not fully recognised and understood and escalating risk is not thoroughly explored by professionals;
- Coercive control and violent resistance are not well understood.

Governance and SSCB Engagement in Domestic Abuse Priorities

In Surrey the governance of the Domestic Abuse Strategy (2013-18) sits with the Community Safety Board (CSB).

The Surrey Domestic Abuse Management Board (DAMB) leads the Surrey Against Domestic Abuse Strategy, with delivery managed through the Surrey Domestic Abuse Delivery Group. These are multi-agency boards that work to prevent domestic abuse occurring; to ensure agencies intervene and provide support at the earliest opportunity.

There is an updated Inter-Board Protocol (2017) which sets out the proposed working arrangements between the Surrey Health and Wellbeing Board (HWB), the Surrey Safeguarding Adults Board (SSAB), the Surrey Safeguarding Children Board (SSCB), the Surrey Children Young People's Partnership (CYPP). the Surrey Community Safety Board (CSB) and the Surrey and Sussex Criminal Justice Partnership Board. The Protocol recognises that domestic abuse is a whole community issue and that Board priorities need to be aligned and clearly articulated to ensure that work is effective, impactful and not duplicated.

Financial Support for the SSCB

The SSCB is well supported by partners in terms of financial and non-financial support. The operational budget for 2017-2018, after accruals, showed a £1000 overspend over the 12 months to 31 March 2018, resulting in a partner carry forward to 2018-2019 of £136,960. Training revenue for the year was £103,890. Training costs have been well managed with venue costs for the year being £7,000 compared to £21,000 in 2016-2017. The costs of private trainers remains at approximately £25,000.

Costs associated with SCRs were lower than forecast due to delays in commissioning which has led to a significantly higher budget allocation for SCRs in the 2018-2019 financial year.

Organisation	Contribution
CCGs	£134,490.00
Surrey County Council	£164,100.00
Surrey Police	£28,320.00
NHS trusts	£15,300.00
District and boroughs	£11,220.00
Probation	£6,405.00
Cafcass	£550.00
Total Contributions	£360,385.00
Training contributions	£16,888.00
TOTAL Contributions	**£377,273.00**

14

Surrey County Council Re-inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers

During February / March 2018 Ofsted re-inspected the Local Authority services for children in need of help and protection, children looked after and care leavers. The OFSTED report was not published within the timeframe of this report but is now accessible at Ofsted Report Published May 2018

Ofsted judged Children's Services as inadequate with the following grade profile:

1.Children in Need of Help and Protection		Inadequate
2.Children looked after and achieving permanence		Requires Improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires Improvement
3.Leadership, Management and Governance		Inadequate

Ofsted made a total of 18 recommendations:

RECOMMENDATIONS

1. Leaders should urgently review the alignment of strategic and operational plans with improvement board objectives to ensure that these are streamlined and complementary. These efforts should aim to quicken the pace of providing consistently safe and effective services for the most vulnerable children.

2. The local authority should put children's voices at the centre of its improvement work and further embed the recently developed systemic quality assurance framework to prioritise improvements in frontline practice. The feedback provided by children, such as their dislike of the frequent changes of social workers and living in foster placements too far from their family homes, should attract concrete responses, as well as acknowledgements.

3. Leaders should urgently renew efforts to engage universal partner services, such as schools and health, to undertake lead professional roles and to form teams around children and families when difficulties emerge. These measures should aim to reduce the number of children requiring local authority targeted Early Help and the high volume of inappropriate low-level referrals to the MASH.

4. Improve the quality of management oversight across all services, and specifically assure that the family history, the impact of previous interventions and any delays are always considered and addressed. Frontline managers should only step down or close cases when there is substantial evidence that children's circumstances and outcomes have improved and that these improvements are likely to last.

5. Improved management decision-making should include more visible responses to alerts and escalations by child protection conference chairs, independent reviewing officers (IROs) and actions arising from multi-agency risk assessment conferences (MARAC) and multi-agency public protection meetings (MAPPA).

6. Senior managers and leaders should scrutinise and measure performance more effectively and ensure that compliance with important statutory requirements is met. These requirements include ensuring that information from all agencies involved with children is considered at strategy meetings, that initial child protection conferences are held promptly and that children who come into care have their health assessed within the first month.

7. Senior leaders and managers must improve the understanding and application of internal thresholds and transfers of cases across the service. These measures should include stopping inappropriate transfers for assessments from the MASH which are subsequently cancelled or discontinued. When safeguarding issues are identified for children with disabilities, they should receive skilled and well-informed risk assessments from social workers who know them.

8. The timeliness and oversight of work for children in the PLO pre-care proceedings phase should be quickly strengthened to reduce a long-established pattern of delay for many of the most vulnerable children.

9. The local authority should ensure rigorous adherence with Surrey Police to the joint Surrey protocol for the provision of local authority accommodation when children are charged and denied bail in custody, in accordance with the provisions of the Police and Criminal Evidence Act 1984.

10. The quality of assessments and plans for children should be improved. Assessments should analyse the already helpful collation of risks and needs with greater coherence and clarity to inform well-defined and measurable child protection and child in need plans.

11. All staff should receive training on the assessment of neglect, and use specific tools in their direct work with children experiencing neglect. Child in need, child protection reviews and core group meetings should evaluate children's progress more concisely, in addition to sharing and updating information.

12. The local authority should strengthen early planning for children who may need permanent care, with a sharper focus on all options, including foster to adopt.

13. The local authority should urgently improve the quality of personal education planning for children in care and closely analyse the impact of the pupil premium in improving children's educational progress.

14. Managers should improve the knowledge and confidence of social workers regarding the suitability and application of statutory guidance concerning connected person's assessments. Decisions concerning the prompt temporary approval of family and friends carers should be strengthened.

15. Children and young people who are on child protection plans or in care should understand the role of independent advocates and have easy access to them if they choose to seek their help.

16. Young people in care who are aged 16 and 17 should be offered better support by personal advisers to prepare pathway plans for their arrangements when they turn 18 years of age.

17. The care leavers' service should provide all young people with clearer information on their entitlements and their health histories. Personal advisers should routinely check that young people are aware of their detailed entitlements when important changes are in process, such as moving into independent accommodation and starting a further or higher education course.

18. The workload of personal advisers in the leaving care service, and social workers in some parts of the children's service, should be reduced. Caseloads should be manageable and allow time for frontline workers to regularly meet with children and young people and complete all the necessary work.

Learning from Reviews

The SSCB has a robust and well defined case review process in order to support a culture of continuous learning.

Not all of the case referrals to the Strategic Case Review Group (SCRG) were completed within the required timescales, due to significant delays in the decision making processes during the autumn of 2017. It was the first priority of the Interim Independent Chair in January 2018 to consider SCRG's recommendations for the commissioning of reviews; these were agreed and the outcomes shared with the National Panel of Independent Experts on SCR's.

The SSCB Learning and Improvement Framework details the various mechanisms used by the SSCB to share the learning from case reviews and audits.

Serious Case Reviews

There is a statutory requirement for LSCBs to undertake reviews of serious cases in specified circumstances.

The criteria for case reviews are set out in Working Together to Safeguard Children 2015 as follows:

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In Surrey the Strategic Case Review Group (SCRG) is responsible for reviewing all referrals from partner agencies and making recommendations to the Independent Chair as to whether the above criteria are met.

Statistical Data in Surrey

In the reporting period SCRG received 10 new referrals, one re-referral for consideration and one notification from another LSCB of a review being undertaken, which related to a child who formerly lived in Surrey. SSCB were not required to contribute to this out of area review.

The recommendations of SCRG were as follows:

- One of the referrals was an escalation of a concern about the handling of a referral and professional decision making which should have been progressed through the SSCB Escalation Procedure.

- One resulted in the commissioning of a single agency review within Health
- One combined DHR/SCR was commissioned and three Serious Case Reviews.
- Of the remaining referrals there were two Partnership Reviews commissioned, each for two cases with similar issues to be explored. One of these referrals was considered in March 2017 by SCRG and was then re-referred, and it therefore does not form part of the current year dataset.
- The final referral was commissioned as a Partnership Review.

The SSCB concluded the following reviews during 2017-2018:

Child CC: Jointly commissioned DHR/SCR: Published in November 2017
Child FF: Was exempted from publication by the National Panel
Child GG: Published in October 2017
Child MM: Partnership Review: Published April 2017

Child CC's Story:

The SSCB jointly commissioned a Serious Case Review/ Domestic Homicide Review in relation to a 14 year old child known, for the purposes of the review, as Child CC.

Child CC's father collected the child from school and later that evening emailed the school to inform that due to a family tragedy Child CC would be absent from school until 29 June. In the early hours of 18 June the father travelled to France, where, on 27 June, he disclosed to a friend the deaths of his wife and daughter. On 28 June, the father took his own life in France. On 29 June the friend contacted Surrey Police to advise of father's suicide and register concerns about the wellbeing of mother and Child CC. On the same day the school contacted Surrey Police to report concerns about Child CC as she had not returned to school. Police attended the home address and found the mother and Child CC deceased inside the family home. In November 2015 the Coroner returned verdicts of unlawful killing in respect of the mother and Child CC.

Good Practice

- School contacted Police when Child CC did not return to school on the expected date;
- Surrey Police deployed an officer to visit the home when the mother called to report domestic abuse and hung up.

Summary of Key Recommendations

- Partnership responses to domestic abuse require review and better co-ordination;
- Domestic Abuse, Stalking and Harassment (DASH) risk assessment tools should be routinely completed;
- Improved referral pathways where there are concerns about domestic abuse;
- Improved signposting of victims to locally available specialist domestic abuse support services;

- Independent Schools should include domestic abuse awareness into their training and to integrate the Spiralling Toolkit into PHSE lessons;
- SSCB to challenge NHS England to resolve the issue of private health providers not sharing health records to support SCR / DHR's which may threaten the safety of children and adults at risk of domestic abuse;
- Debt advisory services to develop a system whereby individuals with County Court Judgements relating to debt are provided with information about domestic abuse services.

Child GG's Story:

The SSCB commissioned a Serious Case Review in relation to a 16 year old child known, for the purposes of the review, as Child GG.

Child GG was placed in police protection and was subsequently voluntarily accommodated, i.e. became looked after with parent's agreement, due to concerns that the child was being sexually exploited by adults. Child GG's parents had been raising concerns about vulnerability however services that were provided had an emphasis on mental health support and substance misuse.

Concerns that Child GG was being sexually exploited were discussed at 6 multi-agency meetings prior to Child GG being taken into Police protection. There were issues around threshold for access to service and a lack of co-ordinated response to Child GG's and the family's needs. There was evidence of relationship based practice providing consistent, clear and structured relationships however not all professionals fully understood the impact of AHDH and ASD on behaviour. The review highlighted a lack of management oversight, drift and delays in assessments being completed. However assessments that were completed were of good quality.

Good Practice

- Professionals had an understanding of Child GG's vulnerabilities and risks of CSE;
- Although frequently excluded, schools kept Child GG on roll and when permanently excluded, arrangements for alternative provision were made taking into consideration the family's wishes to avoid use of online provision to minimise risks to the child;
- There was evidence of relationship-based practice by the Family Support Services (at the time Youth Support Service), Surrey Police (SPOC) and Catch-22;
- When assessments were completed, they were of good quality;
- Evidence of improvement in disrupting perpetrators.

Summary of Key Recommendations

- SSCB partnership needs to assess the current knowledge and practice around CSE and work with partners to improve understanding of adolescent behaviour, ADHD, ASD;
- Relationship based practice should be encouraged, particularly with hard to engage children
- SSCB to audit the extent to which effective, reflective supervision and management oversight is implemented across agencies;
- Partners to address the use of blaming language and improve record keeping to reflect this;

- Improve and embed MAECC and triaging processes (now known as risk management meetings);
- Raise awareness of CSE with taxi drivers, hotels, after school clubs, youth groups, park wardens and sports clubs;
- Mapping the range of specialist and voluntary services that are provided and commissioned to assist children and sharing this information with professionals working with young people;
- Partnership to ensure that assessments are completed within timescales and are of good quality.

Learning Leaflets and the published reports are available at: Learning from Local Reviews

Child MM's Story:

Child MM is a child in Surrey's care and was 13 years old at the time of the review. Child MM had escalating emotional and behavioural difficulties to the extent that no community provision could be identified to keep them safe, no secure care was available. Child MM experienced emotional and physical harm and was accommodated in 2009 following periods on Child in Need and Child Protection Plans. Child MM suffered severe neglect and has acute attachment issues.

Professionals worked tirelessly as Child MM's needs escalated, but suitable placement options became fewer over time until, at the end of 2015 it was more of a case of who was willing to accept Child MM rather than finding a carefully matched placement. In November 2015 no one would accept Child MM and Surrey Children's Services were left managing a child in crisis, with no available placement. A range of emergency measures were put in place to accommodate Child MM with at times up to six social care and police staff managing behaviours, which required frequent restraint. Staff felt impotent to meet Child MM's needs and the care Child MM received in response to their needs was inappropriate and very distressing.

Good Practice

- Staff worked in extremely challenging and risky circumstances to try to find a suitable placement, despite some experiencing severe injury;
- Professionals in Social Care and Police kept Child MM's wellbeing and safety central to their work;
- In recognising the risk that Child MM posed to herself and others a secure welfare order under s25, Children's Act 1989 was successfully applied for through the family court; although this also had the impact of dis-barring non secure placements.

Summary of Key Recommendations

- There were significant failings in a system that rather than protecting Child MM, having secured a S25 order, failed to recognise the needs of the most complex and vulnerable children by ensuring that a secure placement is available. The Department for Education need to review and commission appropriate placements where a s25 order has been made;

- That NHS England, CCG's and Local Authorities develop joint commissioning arrangements responsive to local need; that integrates tier 3 and 4 CAMHS provision; improves access to mental health secure provision;
- That an integrated response to complex and vulnerable children in crisis is developed which, recognising the common experiences of Children in crisis, brings together services and care pathways;
- Local authority and CCG's together with local health providers develop provision for emergency care for children unable to access secure mental health or welfare settings;
- Police, Health and Local Authority chief officers should agree an inter-agency children's escalation protocol where they, or officers directly authorised on their behalf, should be informed and make decisions in relation to the most serious cases.
- SSCB and partners should identify multi agency training and development opportunities to support the need for professionals to maintain a focus on the needs of the child at times of crisis when inter-agency relationships are most tested.

Parsons Green Incident:

On 15 September 2017 an Unaccompanied Asylum Seeking Child (UASC) in the care of Surrey Children's Services, detonated an explosive device on the London Underground at Parsons Green. A review of the background and events leading to this incident was commissioned by Surrey Police, Surrey County Council and the National Counter-Terrorism Police HQ.

The review identified a number of learning points and recommendations which have been taken forward by the commissioning agencies and the Home Office. The detailed recommendations and responses can be accessed at: Home Office letter, June 2018.

The SSCB will seek assurances from the Prevent Executive Board on the progress of the action plan in Surrey.

Key themes in Serious Case Reviews and Domestic Homicides in Surrey 2016-2018

A summary of learning from Case reviews and audits shows that key themes are:

- In 10 out of 12 cases professionals had not sufficiently considered historical information;
- In 8 out of 12 cases domestic abuse was either not recognised or was not considered to be a risk factor, but was evident in the family;
- In 9 of the cases reviewed there was a lack of dynamic risk assessment, where a significant change of family circumstances did not lead to professionals revisiting earlier assessments;
- Emerging themes include the impact of family debt on the safety of children within the family and was the most significant factor in two recently concluded Domestic Homicide Reviews;
- Over time case reviews showed that the role of male carers and understanding of the context of male carers within families improved; however, in 5 of 8 reviews concluded between 2016-18, and some currently commissioned reviews, it is the impact of changes in

partners and short term relationships, introducing males into the household, that is becoming more significant.

Child Deaths in Surrey

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and others who were involved in caring for the child. Families experiencing such a tragedy need to be met and supported with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child, and want to know that people will learn from what happened. The process of systematically and expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.' Child Death Review, Statutory Guidance 2017.

Child and Neo Natal deaths in Surrey are reviewed by a multi -agency panel; the Child Death Overview Panel. The role of this panel is set out in Working Together 2015.

Statistical Data in Surrey

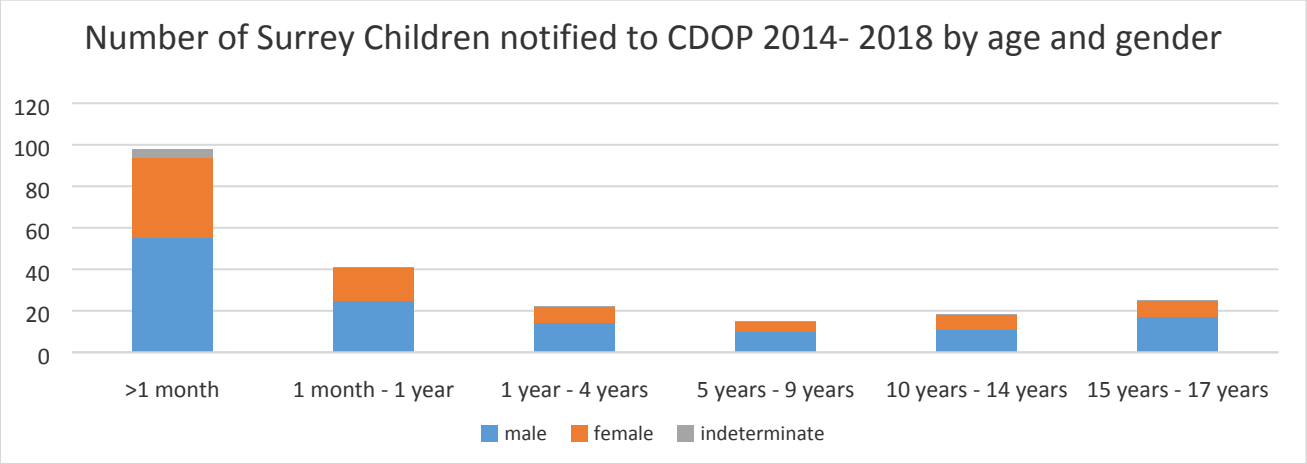
Between 1st April 2014 and 31st March 2018, Surrey CDOP was notified of 299 deaths of which 219 were children who were resident in Surrey.

From the available data of the 219 Surrey child deaths notified to CDOP between 1st April 2014 and 31st March 2018:

- 135 were male and 83 were female, 1 was indeterminable (Neo-natal);
- There were 98 neonatal deaths (infants who die before reaching 28 days of age);
- A further 41 were aged between one month and one year of age.

The infant mortality rate in Surrey (which is the rate of deaths in infants aged under 1 year) is 2.5 per 1000, compared to an England average of 3.9 per 1000, these figures mean that Surrey is performing statistically significantly better than the national average.

In the reporting period Surrey CDOP were notified of 91 child deaths, of which 33 were children who lived outside of Surrey.



Learning from Child Deaths

Themes identified by CDOP which were shared widely within the SSCB Partnership include:

- Early recognition of Sepsis;
- Sudden Unexpected Death in Infancy and the associated known risk factors (alcohol, drugs, smoking, co-sleeping, sleeping position and use of duvets;
- Assessments of the home environment need to include fire safety;
- Use of petrol generators in enclosed spaces – need for ventilation;
- Water safety awareness in schools/community: swimming in dangerous rivers.

All professionals and families in Surrey have access to CDOP information via the SSCB website or through the CDOP information leaflet which is widely circulated to the acute hospitals, community providers, GP surgeries, Children's services, Police and the Coronial Service.

In Surrey a Specialist Nurse proactively contacts families affected by a child death and offers them support and the opportunity to contribute to the Child Death Review Process to enable the families voice to be heard.

When a child dies from potentially modifiable factors, Surrey CDOP researches public health data and evidence of best practice around reducing these child deaths. This evidence is then used to inform practice across the County.

Quality Assurance and Performance

The SSCB delivers a robust Quality and Assurance programme to assure itself of the quality of safeguarding practice in Surrey. The Quality Assurance and Performance Sub group develop an annual audit plan which focusses on the SSCB Business Plan priorities. This has been identified as an area for further development in 2018 – 2019.

Non-statutory Section 11 Audit

What is a Section 11 Audit?

Section 11 of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children.

Working Together to Safeguard Children 2015 states the following as Section 11 standards:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;

- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services. Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- A designated professional lead (or, for health provider organisations, named professionals) for safeguarding;
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training;
- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children;

Section11 Safeguarding Audits of Statutory Partners are conducted on a biennial cycle in Surrey, with the year between audits being used to receive updates from Statutory Partners on their progress against their respective action plans.

In 2017-2018 the SSCB undertook an additional Section 11 Safeguarding Audit of Third Sector Organisations, Early Years Providers in the Private Sector, Sports Clubs and Faith Organisations. These are important partners in Surrey, providing a wide range of services to children and young people. Whilst Section 11 does not place statutory obligations on these organisations, it represents a standard of good practice and will help organisations improve their arrangements in keeping children and young people safe.

88 organisations across Surrey completed the on-line survey including faith organisations, early year's providers, leisure centres, sports clubs, various other clubs, information centres, support services for families and vulnerable children, mediation service, home start, outreach providers and many more.

Summary Findings

- 91 % of organisations had a designated safeguarding lead or staff trained in safeguarding with supporting procedures in place;
- 94% of respondents have either their own safeguarding policies or use the SSCB policy;
- The majority of organisations hold DBS checks for their staff and volunteers and offer staff training and were confident that their staff follow safeguarding procedures;
- Organisations would contact either the Local Authority Designated Officer (LADO) or escalate to a related body / organisation any concerns about unsuitable practice or behaviours by staff / volunteers. If organisations are worried that a child is being harmed outside the organisation, they are most likely to phone Surrey's Multi-Agency Safeguarding Hub (MASH). Organisations also stated that they would like to receive timely updates and feedback once referrals have been made;
- 78% of organisations who completed the survey are fully confident that all staff / volunteers who work directly with children would know where to escalate a safeguarding issue;

- 77% of organisations stated that they are 'confident' and 17% stated that they are 'somewhat confident' that staff / volunteers who work directly with children know how to share information securely and in a timely manner;
- Generally, children were not involved in creating safeguarding policies and procedures as 53% of the organisations stated "No" and 25% stated "Don't know". Organisations who involved children stated that their safeguarding policies help staff to develop positive relationships with children;
- Overall, staff/volunteers who work directly with children recognise the signs of Child Sexual Exploitation (CSE) and are aware of the process if they suspect a child is at risk or a victim of CSE. Seven organisations, mainly sports clubs, stated that they are not confident about the recognition and reporting of CSE.
- Organisations who completed the survey are generally able to identify opportunities to discuss concerns with their safeguarding lead / or anyone else. They stated that their staff / volunteers can identify safeguarding strengths and improvement in safeguarding practices.

The following activities were carried out during 2017 – 2018 as part of the SSCB's quality assurance functions:

From April 2018 - Follow up work from the Family Support Programme (FSP) audit carried out in February 2017

The SSCB conducted a case study audit of the Family Support Programme (FSP) in February 2017 to explore its impact and effectiveness as part of the Surrey Early Help system.

The main findings and areas for improvement were around the:

- Lack of a central data recording system;
- Lack of available information to explore the impact of the FSP work on families;
- Lack of knowledge of whether progress achieved during intensive support is sustained six months after the initial intervention?
- Lack of clarity around the services offered by FSP;
- Issues around interagency communication and engagement of other services;
- Effectiveness of the work of FSP on families with more complex needs (i.e. Children in Need).

In 2017/18, an action plan based on the findings from this audit has been developed by the FSP teams based in Boroughs and Districts. The plan addressed each of the recommendations with specific actions and outcomes. The SSCB QA&P group regularly monitor the progress of the action plan and the countywide FSP lead reports the progress to the QA&P group.

Some of the outcomes in the action plan cover:

- Improved information sharing;
- More accurate evidence of progress made and sustainability;
- Reduction in family support referrals;

- Improved and sustained progress against Department for Communities and Local Government (DCLG) outcomes;
- Wider awareness of services and scope of FSP to partner agencies and general public;
- Increased appropriate and more timely referrals to FSP to support families;
- Improved regularity, attendance by agencies and quality at TAF meetings and reports to TAF are effective and timely in return;
- Families feel supported to provide stable, consistent and appropriate care for themselves (measured by family feedback);

Some of the actions have now been completed and the SSCB QA&P group is working with Surrey Family Services (SFS) to support and challenge outstanding actions.

From April 2018 - **Follow up work from the SSCB Audit of Children on a Child Protection (CP) plans** under the category of neglect carried out in March 2017 will be undertaken.

The SSCB carried out a case file audit on CP plans under the category of neglect in March 2017 and the main recommendations from the audit included:

- A clear and consistent neglect risk assessment tool is required, to be rolled out across the partner agencies and support earlier recognition and assessment;
- Reduction in the significant delays in getting specialist assessments completed in the PLO process;
- The CP step down process requires special consideration to ensure that the improvement achieved while a child is on a CP plan is sustained;
- The SSCB training team and partner agencies need to continue to emphasise the importance of the voice of child and continue to provide training on disguised compliance;
- SSCB to undertake a review of Core Groups;
- Explore how to engage families who are not able to see the benefits of some of the services, especially with parents who may have mental health issues or are experiencing domestic abuse.
- Develop a dataset to understand the prevalence of neglect in Surrey as well as to measure the impact of some of the work being carried out.

An action plan has been developed by the SSCB Neglect Group based on the findings from this audit. The actions are monitored by the SSCB Neglect Group as part of Neglect Strategy and action plan. Neglect Group reports to the SSCB Business Group on progress.

Progress made to date:

- Work has continued on developing a dashboard that will form part of the SSCB report card to understand why Surrey has a high proportion of children on a CP Plan under the category of Neglect;
- A guidance document to accompany the SSCB Neglect Risk Assessment Tool has been developed, ratified and published;

- The Surrey Neglect strategy is being reviewed in order to reflect the Signs of Safety model with an increased focus on early help. The outcome measures are being revisited as part of this work;
- The Neglect Group has been considering the various neglect assessment tools in use across Surrey. Recent discussion included an update on the Graded Care Profile tool that has been used by a small group of social worker practitioners under guidance. Overall it was felt that we should initially embed Signs of Safety within the organisations, raise awareness of the current toolkit that has been ratified;
- Work has started with the L&D Group to develop a training pathway for neglect that incorporates Signs of Safety;
- Work has started on a proposal for getting feedback from young people about their experience of neglect, led by Children's services;
- Work is underway within Early Help to identify and explore services available to children and families to address neglect within Surrey;
- Following this audit, the Children's Services Quality Assurance team also reviewed the cases selected for the audit by working with social workers in order to address issues around those cases.

May 2017: Core Group Focus Groups

Multi-agency audits of Core Groups were carried out by the SSCB every year from 2012 to 2015 to identify any practice issues and to make recommendations for practice improvements over time. Although some improvements were identified, most of the findings were similar without any significant improvement being recorded.

Due to the remaining concerns that identified improvements were not embedding into practice the SSCB took a different approach to reviewing Core Groups in 2017; hosting a series of practitioner focus groups to explore the first-hand experiences of practitioners involved in Core Groups and understand more about current practice and barriers to practice improvements within the partnership.

Main recommendations from the practitioners' events include a need for:

- More administrative support;
- Better understanding of professionals' roles and responsibilities;
- Consistent guidance, contingency plans and standard template/structure;
- A standard template for submitting reports for professionals who are not able to attend a Core Group meeting;
- Times and venues of meetings need to be better considered and relate to each families circumstances;
- Social workers to meet and communicate with the family before the first Core Group meeting;
- Changes of professionals to be minimised to ensure consistency where possible;
- Everyone to take responsibility to share the voice of the child with the Core Group members;
- Professionals to take responsibility in making notes of their actions and delivering them;

- Actions from Core Group meetings to be clear and achievable. Child Protection Plans also need to be clear and achievable in order for Core Groups to progress that plan;
- The right professionals to be involved throughout.

The Core Group audit was presented to the full board meeting in July 2017. The board members agreed that Children's Services are in the best position to act as a lead agency and to work with partners to take the recommendations forward.

The procedure, guidance and templates of the Core Group meetings have now been revised and updated based upon the recommendations from this audit. This also includes a standard template for submitting reports for professionals who are not able to attend and clarifications on Core Group members' roles and responsibilities.

The findings have also been shared with the SSCB Learning and Development group and were incorporated into the SSCB foundation module training.

The general issues around administrative support have been acknowledged by the Assistant Director Children's Services in the Mighty Meeting on 16 January 2018. Children's Services are currently exploring how they can support the staff better to address issues around administrative support. However, there are still some issues highlighted by professionals that have not been addressed and remain unresolved.

There is a plan to undertake a piece of work in 2018 to gather the views of families and children to find out their experiences of Core Groups and how they support the family throughout the Child Protection process.

October/ November 2017 - MASH and Levels of Need Focus Groups

In October 2017 SSCB undertook a planned review of the MASH, 12 months after its launch. The review focused on the effectiveness of the interface between the MASH, Early Help and the SSCB Threshold Document. Four focus groups were facilitated - one with the practitioners who work within the MASH and three with practitioners who refer into the MASH. Practitioners' feedback was gathered on their experiences of the referral process, MASH processes and the SSCB Levels of Needs document.

The main recommendations by the practitioners included:

- Clarity to the partnership regarding the pathways ;single front door and one contact number for all routes into Early Help and Children's Social Care;
- Better communication and feedback processes from referral through to outcome;
- Summary page for Levels of Need document: Structure of Level of Needs document;
- Clear guidance on Escalation process;
- Accessibility to Multi Agency Referral Form (MARF) and online electronic MARF;
- Education around when to contact the MASH should it continue to be rolled out;
- Positive reviews to share with professionals; case reviews when processes worked well;
- Streamline process (stop changing process);
- Respect amongst professionals.

The findings were shared with all those who participated in the focus groups in a feedback session on 15th November 2017. A response was invited from Assistant Director Children's Services, the Head of MASH and the Head of Early Help & Family Services during the feedback session.

The SSCB partnership manager, the Head of MASH and the Head of Early Help worked together to address the issues highlighted by the practitioners and an update on the progress has been presented at the SSCB board meeting in January 2018. This includes:

- MASH and Family Services (Early Help) have integrated processes making them more efficient and decision-making more consistent. They have also split the MASH email addresses (one for children and young people and one for adults) so they can update on referrals as quickly as possible;
- Based on feedback from practitioners, single front door approach has been taken into account and one contact number for any safeguarding concern has been finalised;
- Based on feedback, the SSCB will be redesigning the levels of need document to make sure it is clearer on risk and harm, and to better identify the types of early help available in Autumn 2018;
- MARF (multi-agency referral form) will be reviewed by a multi-agency task and finish group overseen by the SSCB Policy & Procedure group;

Learning and Improvement – including Multi Agency Training

The SSCB offers a wide range of training programmes to partners and operates a commissioning and delivery model. The Training commissioners design course materials and plan the bi-annual training programme around the SSCB priorities, audit findings, learning from reviews, including SCR's and learning from child deaths. The training commissioners also work closely with partners to develop specialised programmes to support the SSCB priorities around Child Exploitation and Domestic Abuse. Since January 2018 the SSCB has jointly delivered with the Local Authority Signs of Safety Briefings to support the roll out of the strengths based practice model in Surrey.

What is working well?

- 34 different course programmes have been delivered to the multi-agency partnership;
- 201 training sessions have been delivered in the last twelve months;
- 2969 delegates attended the SSCB Training programmes and Learning Events;
- 495 delegates attended the SSCB Annual Conference;
- 45 delegates attended the CDOP Professional Development Day;
- Surrey CC, Education and Health engagement in the SSCB training programmes;

What are we worried about?

- 630 cancellations / no shows for training in the last twelve months;
- High numbers of no shows on courses offered free of charge;
- Early Help training courses were cancelled at short notice and the training offer in Early Help put on hold;
- Delegates being pulled off training at short notice due to operation priorities;
- 37 trainers cancelled at short notice; SSCB kept course cancellations to 5 by reallocating team resources to enable SSCB Training Commissioners to cover these cancellations;
- Insufficient capacity within the SSCB support team to meet partnership demand; the trainers pool is 19 internal trainers (from within Surrey County Council) and 4 external trainers.

Statistical Data

- Foundation Module 1 and Foundation Modules 2 were delivered on 47 and 46 occasions, respectively, during 2017-2018 ; 2056 delegates were trained;
- Learning from Serious Case Reviews and Audits was delivered on 9 occasions to 106 delegates;
- Introduction to Signs of Safety was offered 17 times from January 2018 to March 2018 and was attended by 149 delegates;
- Child Exploitation, Missing and Hidden Crimes training was attended by 153 delegates;
- Early Help Training was delivered to 238 delegates in the period September 2017 to January 2018, when the programme was put on hold by Surrey County Council;
- 521 delegates completed Domestic Abuse E-Learning;
- 788 delegates completed Working Together to Safeguard Children;
- 311 delegates completed CSE Level 1 E-Learning.

SSCB Conference 'Under the Radar; Young Minds – Safeguarding their Future'

The conference held on 22 November 2017 was well attended by 495 professionals from 36 agencies. The focus of the day was adolescent mental health and wellbeing. Three key note speakers explored the themes of adolescent brain development, co-ordination of mental health and wellbeing support in schools and prevention of radicalisation of young people.

A theatre production company presented a play 'Tough Love' which explored the theme of Peer on Peer abuse.

Workshops included; the experiences of children who are looked after (Total Respect); modern slavery and trafficking; peer on peer abuse; CAMHS services with a focus on self-harm; YMCA Heads Together .

Impact of Training:

In 2016 the SSCB adopted the Kirkpatrick four stage model of evaluation to measure the impact of training.

In 2017-2018, a full year of training data was available; from this a sample of fourteen courses, delivered between January 2017 and July 2017 were analysed.

507 delegates were invited to contribute to the analysis: 73 responded, a return ratio of 14.39%

Of this number we asked how many delegates would be happy for the SSCB to contact them to discuss the training further: 42 said yes (57.5%) 31 said no (42.5%).

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In the context of the sample size of 507, which represents 17% of the total delegates trained by the SSCB, this low response rate of 8% of respondents who were happy to be consulted further is problematic and does not adequately inform the SSCB whether training is meeting the needs of professionals and in ensuring that the training content is relevant to professionals in the multi-agency partnership.

Feedback from the sample suggests that SSCB training is highly regarded and of the original 73 respondents 95.89% said that they would recommend this training to others; 73% said that they had shared the learning with other colleagues or managers and 90% said that they had made changes to their practice as a result of the training that they had received.

86% of professionals who took part in the survey reported that their knowledge and skills in working with children and families had increased, which correlates with an analysis of 2016-2017 data, (89%).

The SSCB training team will continue to develop the evaluation process and an external review of the SSCB training offer is due to report in July 2018.

SSCB Business Plan April to September 2019

The SSCB priorities for the next eighteen months are included in the plan below. This plan will be managed and monitored through the SSCB Business Group

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
	Priority 1: Ensure that the child's voice and lived experience is integral to all the work that the SSCB and its partners undertake and that partner agencies proactively respond to direct feedback from children to improve their experiences					
2	Children and young people's views and wishes are heard by professionals using practice models that can be widely shared; monitored for impact and improved over time	SSCB QA & P All partner agencies	1.1	To undertake a mapping and analysis across the partnership to understand the systems in place for ensuring that the child's voice is heard? How their views are taken into account and actioned and what impact on practice can be evidenced?	By 30 September 2018	**Amber**
			1.1a	Independent Chair to meet with third sector representative and convene a meeting to discuss taking key engagement work forward	By 30 September 2018	**Amber**
			1.1b	Single and Multi-agency audit shows evidence that children's views have	By 31 December 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				informed positive practice change		
10, 20, 25,27	The lived experience and views of C&YP are clearly evidenced when events/circumstances have put them at risk and where there is learning for all the people supporting them about what they could have done differently.	SSCB Strategic Case Review Group (SCRG)	1.2	Referrals to SCRG to include the child's views and wishes if these have been sought and the child's voice to form part of any review subsequently commissioned.	By 30 September 2018	**Amber**
			1.2a	Terms of reference for SCR's/partnerships reviews focus on professional curiosity and past family history when reviewing the child's lived experience	With immediate effect	**Green: Completed**
106	Services will be assured by young people from their perspective with recommendations on how they can be improved within the partnership.	SSCB QA & P Group	1.3	Scope a Young Inspectors programme to provide assurance from a young person's perspective of the effectiveness and impact of services.	By 31 December 2018	
2, 27	Strengths based practice is leading to increasing evidence that children's views are informing safety plans and helping them to build resilience.	SSCB QA & P Group	1.4 links to 2.10	Audit of initial Child in Need Plans; Child Protection plans and review of plans at conferences/ core groups, including feedback from participants in	By 31 December 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				conferences and sub groups shows that the child's voice and wishes are heard and inform safety planning.		
	The voice of children and young people will inform and advise on safeguarding developments in Surrey	All partners; Surrey Youth Focus and partners Education sub group	1.5	Scope a reference group of children and young people to inform and consult on strategies, practice developments and inform the work of the sub-groups as appropriate.	By 31 December 2018	
	Priority 2: Hold partners to account for the development of an Early Help system which supports children with emerging needs through to the provision of statutory support and intervention					
3, 20, 21, 93	Professionals within Universal services provide support to children and families with emerging support needs	SSCB Business Group	2.1	SSCB will lead on partnership focussed actions to support senior leaders in empowering partners in universal services to undertake lead professional roles and form teams around families in	Draft scoping by 30 September 2018	**Amber On Track**

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				response to emerging support needs		
22, 93	Improved quality of information sharing and decision making between agencies, at the earliest opportunity, when notification of possible harm to a child is received which then leads to a co-ordinated plan for assessment and intervention.	SSCB Business Group	2.2	SSCB will lead on Partnership focussed actions to establish and be assured of the role and function of the MASH going forward.	Review by 30 September 2018	**Amber: Under review as part of transformation plan**
24	Risk to Children is fully understood by engaging with all partners working with the family to ensure that they contribute/attend Strategy Meetings	SSCB QA Officer	2.3	SSCB will undertake an analysis of CSC data re invitations and attendees to S47 meetings between Nov 17 and Feb 18 for reporting to the IB May 2018	By 30 April 2018	**Green: Completed**
			2.3a	Audit of a sample of 20 cases identified from the above data set, where no representative from Health and/or Schools is recorded as attending to explore reasons for non-attendance and whether contributions were received in any other format	By 9 July 2018	**Amber:**

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
3,7,10,11, 20,22,25,26 31,	Children are kept safe by Practitioners with a clear understanding of : • the role and function of the MASH • their individual professional roles & responsibilities within Early Help and Statutory Services including their role as lead professionals • thresholds • of how to ensure that concerns/worries about a child are appropriately referred/stepped up	SSCB Business Group	2.4	• Clarify the pathway through the Early Help system and the role and contributions of the locality support arrangements in assessing need and managing risk. • Define and communicate across the Early Help system the pathway and step up /step down procedures across the levels of need. • Define and communicate within the Surrey partnership the role and function of the MASH	Progress review by 30 September 2018	**Amber: On going work within Children Social Care /JB change Director**
4,10,11, 20,25	Children are kept safe by a confident workforce who can make decisions about the right level of support to meet needs and manage risk.	SSCB Business Group and Learning and Development Group All partner agencies	2.5	Identify the workforce development needs and develop multi-agency training programmes to support practitioners in universal services to enable them to access appropriate tools to assess	Progress review by 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				emerging needs and develop an Early Help Plan.		
			2.5a	Partner agencies use effective triage when making a contact/submitting a Multi-agency referral form (MARF) to the MASH to ensure that an appropriate threshold decision has been made by practitioners	Progress review by 30 September 2018	**Amber: On-going development work in Children's Social Care**
3,10,20,22	Children receive support across a continuum of need that ensures that their emerging needs are recognised at the earliest opportunity and appropriate support is available to them in a timely manner	SSCB / Business Group	2.6	Develop a revised partnership Threshold Document /Level of Needs covering the whole of the Children's System	By 30 September 2018	**Amber: On track**
	Good information sharing protects children at risk of harm by removing the barriers that prevent informed decision making and robust safety planning	SSCB Business Group SSCB QA&P Group	2.7	Commissioning of a review of the Multi Agency Information Sharing arrangements to: • Identify barriers to be overcome and work with partners to address	By 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				these through protocols and systems • Test the impact of learning from Multi-agency case audits, SCR's and Learning Reviews in changing practice		
23	Level of Needs Document/ Threshold guidance for professionals is clear on when consent is required /where confidentiality is a consideration or the need is overruled by the level of risk	SSCB Business Group	2.8	Clear guidance to be developed on when consent is required from parents; children and young people, who should gain this consent and how it should be recorded; Clear articulation of when risk outweighs the need for consent and confidentiality of records.	By 30 September 2018	**Amber: On track**
3, 22, 97	Reduction in the number of inappropriate/ incomplete referrals to MASH ensures that children are kept safe by timely and appropriate intervention.	SSCB Learning & Development sub-group	2.9	Professionals are supported through training and awareness raising to use appropriate tools to identify an escalating risk and make complete and appropriate referrals into MASH/ statutory services	By 31 December 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
106	Children are seen their wishes heard and are kept safe in an effective countywide Early Help System.	QA & P Group	2.10 links to 1.4	Audit of Early Help 'contacts/referrals' across Surrey evaluates the impact and effectiveness of the Early help System from Universal Services to Statutory interventions and practice shows that in Early Help Assessments and through the monitoring of outcomes there is evidence that children have been seen and heard.	By 30 September 2018	
3,4,5,7,10,11, 20,22,23,25, 29,31	Practitioners are equipped through robust Multi agency training to support high quality decision making that keeps children safe from harm and holds risk at the right level in the children's system.	SSCB Learning and Development Group / SSCB Training commissioners/ QA & P group	2.11 & 3.2	Multi-agency training ensures that professionals are trained in: • Using Thresholds/Levels of Need to support decision making;	By 30 September 2018	
				• Use of single agency triage/management oversight to discuss concerns and support decision making;	By 30 September 2018	
				• Professionals understand their roles and	By 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				responsibilities in the Early help System;		
				• Referrals to the Multi Agency Safeguarding Hub (MASH) using the Multi Agency referral Form (MARF) are of consistently high quality and detail to ensure that Triage in the MASH is effective and timely;	By 30 September 2018	
				• Role of professionals in S47 enquiries, strategy meetings, conferences	By 30 September 2018	
				• Quality of assessment including the inclusion of family history and lived experience of the child	By 30 September 2018	
				• Supervision/ management oversight/ Escalation procedures are used routinely to challenge decision making when appropriate.	By 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
4, 20,22,24,25 30	C&YP are being supported in the right part of the children's system to meet the level of risk and needs that they are experiencing.	QA & P Group Partnership data teams	2.12	Data, and quality assurance activity evidences the timeliness of response to C&YPs needs, identification of risk and evidence of decision-making and management oversight to ensure that their needs are being met at the right level.	By 31 December 2018	
	Priority 3: Reduce harm to children and young people in vulnerable groups at risk of exploitation					
26,	Children at risk of exploitation are supported by well trained professionals skilled in identifying exploitation and in understanding and managing risk to vulnerable children	SSCB Strategic Case Review group / Neglect group/ SEAMMB / DAMB	3.1	Review learning from audits, inspections ,case reviews and JTAI reports to identify where additional support to professionals is required in: recognising risks and in identifying children at risk of exploitation	By 31 July 2018	**Amber: On track**
		SSCB Learning and development Group	2.11 & 3.2	Review and update training materials to reflect the findings of 2.1 & 2.2, and OFSTED findings and ensure that practical exercises within training sessions support	By 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				professionals in conducting dynamic risk assessments and using thresholds to support professional judgements when identifying next steps.		
10, 11,	Children's needs are assessed using evidence based tools which use a strengths based approach to provide consistent practice and good outcomes for families across Surrey.	SSCB Neglect Group/ Policy and Procedures QA & P Learning and Development	3.3	Agree within the partnership which evidence based tools will be used, when and by whom and to support practitioners in the assessment of risk at all levels of the children's system.	By 31 December 2018	
4,7,10,20,24,35	Assurance that within the partnership children are kept safe and that interventions to support escalating risks for children & families are effectively managed.	SSCB Business Group	3.4	To oversee a focussed piece of work on Risk: including 'holding of risk within the Children's system'; conducting dynamic risk assessments; management supervision in response to changes in risk.	By 31 March 2019	
102	Evidence of good information sharing across key partner agencies that enables an	SEAMMB	3.5	Develop a profile of children considered at RM meetings that enables the risk to children across multi	By 31 December 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
	effective and informed response to children at risk of exploitation.			vulnerabilities to be mapped, analysed and shared with Police, CSC and Health to inform statutory interventions		
	A comprehensive problem profile identifies children at risk, hotspots and informs disruption activities and enables targeted intervention to keep children safe from exploitation.	SEAMMB	3.6	Analysis of the integrated missing data identifies the push/pull factors affecting individual children and allows problem profiling to be more comprehensively developed.	By 14 December 2018	
		SEAMMB	3.7	Develop Understanding within the partnership of exploitation in Surrey, where it occurs by locality, gender, ethnicity/group, type of harm and frequency.	By 30 September 2018	
	SSCB Dataset and audits shows the impact of improved management of risk; better analysis and interpretation of RHI data and compliance with statutory guidance improves outcome for children known to be at risk of exploitation.	QA & P Group Exploitation & Missing Delivery Group	3.8	Development of the SSCB Scorecard and audit programme to provide assurance and challenge to the system on how well vulnerable children and young people are being protected and the	By 30 December 2018	Amber: On track

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
				interdependencies between risk factors are recognised and responded to appropriately in a timely way.		
	Priority 4: Ensure that all partners working with Children and Young People in Surrey recognise and respond to the needs of children and young people living with domestic abuse, substance misuse, neglect and mental health concerns to improve their outcomes and keep them safe.					
	A strategy that supports professionals to deliver Change that Lasts and the development of sustainable and cost effective Domestic Abuse service across the County that improves outcomes for families and keeps children safe	Domestic Abuse Management Board / Learning & Development Group	4.1	Refresh of Domestic Abuse Strategy reflects the findings of the Safe Lives review, legislative changes, the OPCC cost benefit analysis and learning from survivors / case reviews	By 30 September 2018	**Green: Completed**
	Professionals demonstrate understanding of the impact of coercive control and Domestic Abuse, and support survivors and their families to engage with services and get the 'right help' at the 'right time'	Domestic Abuse Management Board	4.2	Raise awareness with professionals and families of the impact of domestic abuse & coercive control on outcomes for children.	By 31 December 2018	
10 & 11	Assurance that children's wellbeing is central to risk assessments and safety	QA&P, Neglect Group, Health Group,	4.3	Multi-agency audits and case tracking/reviews show professionals are confident	By 31 March 2019	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
	planning.	Education Group		in assessing the risks and impact on a child's wellbeing of mental health, substance abuse, DA,		
10& 11			4.4	Family Resilience and strength based practice enables professionals to raise awareness of risk, build resilience and keep children safe.	By 31 March 2019	
	Assurance that the Domestic Abuse Strategy is achieving its objectives and that children in Surrey are seen safe and heard.	Domestic Abuse Management Board	4.5	Regular updates on progress against Surrey's response to JTAI are provided with supporting data to the QA & P Group.	By 30 September 2018 and 31 December 2018	**Amber On track**
10	Neglect Strategy and guidance supports professional practice to recognise and respond to emerging concerns of Neglect at the earliest opportunity.	Neglect sub Group	4.6	Launching and embedding the strategy and guidance and ensuring that neglect assessment tools are used consistently to identify risk and inform plans for intervention.	By 30 December 2018	**Amber On track**
10, 11,24,26,31	Children at risk of neglect or serious harm are kept safe by practitioners who understand and can consistently implement	SSCB Learning and Development Group / Quality	4.7	Evaluate, review and revise the Multi agency training provided to practitioners to ensure that it is fit for	By 30 September 2018	

Key OFSTED Rec.	What difference will this make to children in Surrey?	Lead Subgroup/ Agency	Action No.	Action	Timescale	Status RAG
	threshold guidance, and who use appropriate SSCB Tools & Guidance to identify, prevent and reduce neglect	Assurance and Performance (QA&P)		purpose and includes use of EH Tools/ supervision & management oversight and supports early identification of Neglect and/or significant harm.		
29,	Risks associated with neglect, children living with DA, parental substance misuse and the mental ill health of parents are kept safe within an early help system that identifies, assesses risk and provides the right support at the right time, at the right level	SSCB / Business Group, (QA&P) Neglect Group / P & P Group	4.8	The SSCB is assured that the whole of the Children's System supports the identification and holding of risk for vulnerable children & young people in the right part of the system and ensures timely of risk and need when circumstances change.	By 31 March 2019	

Appendix A

Recommendations from the LGA Peer Review

- Review the functions and membership of the SSCB Full Board in readiness for the changes in Working Together to Safeguard Children 2018-2019, including the frequency of meetings;
- Review with a view to reducing the number of sub groups including the alignment with other partnership boards;
- Establish a Strategic Executive of the three main partners, Surrey County Council, Clinical Commissioning Group and Surrey Police;
- Clarify the roles of CDOP and Strategic Case Review Group (SCRG) including the referral process to SCRG;
- Integration of SSCB Plans;
- Board members look at undertaking joint or individual visits to partner organisations;
- Develop a culture of continuous improvement based on confident and respectful challenge;
- Use performance information to better inform priorities and measure impact along the child's journey.