

# Scrutiny Children & Young People Sub-Committee Agenda



To: Councillor Jan Buttinger (Chair)  
Councillor Sean Fitzsimons (Vice-Chair)  
Councillors Sue Bennett, Patricia Hay-Justice, Maddie Henson,  
Maria Gatland, Bernadette Khan, Andrew Rendle, Dave Harvey,  
Elaine Jones and Leo Morrell

Reserve Members: Simon Brew, Margaret Bird, Sherwan Chowdhury,  
Patsy Cummings, Humayun Kabir, Andy Stranack and David Wood

A meeting of the **Scrutiny Children & Young People Sub-Committee** which you are hereby summoned to attend, will be held on **Tuesday, 28 November 2017** at **6.30 pm** in **The Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

JACQUELINE HARRIS-BAKER  
Director of Law and Monitoring Officer  
London Borough of Croydon  
Bernard Weatherill House  
8 Mint Walk, Croydon CR0 1EA

Ilona Kytomaa  
02087266000 x62683  
ilona.kytomaa@croydon.gov.uk  
www.croydon.gov.uk/meetings  
Monday, 20 November 2017

Members of the public are welcome to attend this meeting.  
If you require any assistance, please contact the person detailed above, on the righthand side.

N.B This meeting will be paperless. The agenda can be accessed online at [www.croydon.gov.uk/meetings](http://www.croydon.gov.uk/meetings)



## **AGENDA – PART A**

**1. Apologies for absence**

To receive any apologies for absence from any members of the Committee.

**2. Minutes of the previous sub-committee meeting (Pages 5 - 10)**

To approve the minutes of the meeting held on 17 October 2017 as an accurate record.

**3. Disclosures of interest**

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Democratic Services representative at the start of the meeting. The Chair will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

**4. Urgent Business (if any)**

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

**5. The Annual Report of the Croydon Safeguarding Children Board (Pages 11 - 126)**

**6. Statistics on missing children (Pages 127 - 130)**

**7. Use of pre-birth assessment and legal planning to support early permanency decision making (Pages 131 - 154)**

**8. Work Programme Report (Pages 155 - 156)**

**9. Exclusion of the Press and Public**

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

“That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended.”

## MEETING OF THE

### CHILDREN AND YOUNG PEOPLE SCRUTINY SUB-COMMITTEE

Minutes of the meeting held on Tuesday 17 October 2017 at 6.30pm

#### WRITTEN MINUTES – PART A

**Present:** Councillor Jan Buttinger (Chairman)  
Councillors Sean Fitzsimons, Sue Bennett, Margaret Bird, Maddie Henson,  
Bernadette Khan and Andrew Rendle

**Also in attendance:**

Councillor Alisa Flemming, Cabinet Member for Children, Young People and Learning

Councillors Joy Prince and Andy Stranack

**A33/17      Apologies for absence (agenda item 1)**

Apologies were given for Councillor Maria Gatland (represented by Cllr Margaret Bird at this meeting), Councillor Patricia Hay-Justice, Dave Harvey, Elaine Jones and Leo Morrell.

**A34/17      Minutes of the meeting held on Tuesday 19 September 2017  
(Agenda item 2)**

The minutes were agreed.

**RESOLVED THAT:** the minutes of the meeting held on 19 September 2017 be signed as a correct record.

Updates were provided on the following:

- Further to the Scrutiny recommendation made at the 19 September meeting to organise learning and development visits on children's services, an undertaking has been made to organise monthly sessions to enable members to follow the journey of children at risk to a better life
- It has now been agreed to carry out satisfaction surveys with children services staff, the results of which will be shared with scrutiny members.

**A35/17      Disclosures of interest (agenda item 3)**

There were none.

**A36/17 Urgent business (agenda item 4)**

There was none.

**A37/17 Exempt Items (agenda item 5)**

There were none.

**A38/17 Children's Improvement – Deep Dive: Missing Children in Croydon (agenda item 6)**

The following officers were in attendance for this item:

- Barbara Peacock Executive Director (People)
- Philip Segurola, Interim Director, Early Help and Children's Social Care

A presentation was given on the recent Deep Dive on Missing Children, which covered the following areas:

- Strengths and areas requiring improvement
- An acknowledgement that front-line practice on missing children is under-developed
- Information on the work of the Improvement Board and planned Deep Dives
- Feedback on a recent programme of audits on current practice in addressing the needs and risks faced by missing children
- Planned improvements to services

Asked how many children were missing *at present*, officers replied that there were 24 looked after children currently missing, the majority of these unaccompanied asylum seeking children. They added that some had been missing for some time and that the council was working with its partners to find them. Officers stated that there were also 9 missing children who were not in care.

Officers explained that the police had two categories of absence:

- "Unauthorised absence": this covered children going missing for several hours
- "Missing children": this category covered children going missing for far longer periods

Members noted that the council accommodated looked after children from other boroughs. Officers were asked for the reasons why this was happening. They replied that this was due to issues of suitable accommodation in some boroughs or because the child might be housed with a relative who lived some distance away from his parents' home. They added that Croydon was popular with other boroughs because it provided good support to unaccompanied asylum seeking children.

Members were informed that the number of children in care was rising nationwide and that there had been a drop in adoptions. Many care leavers were also staying with their foster carers for longer under the "Staying Put" scheme. Overall, the borough does not have sufficient numbers of foster carers. Other boroughs housing looked after children in Croydon tend to use private fostering agencies, which charge about twice the cost of a person fostering Croydon's looked after children.

Officers highlighted the fact that gang culture was a key factor in children going missing.

Members asked whether social workers had the necessary skills to deal with the various challenges presented by missing children. Officers acknowledged that some social workers needed to improve their understanding of procedures relating to missing children and that there were issues with record keeping on Return Home Interviews (RHIs). It was explained that notes on such interviews were sometimes held as e-mails or in other formats, but not on the CRS system where they should be stored, and that some social workers thought that the NSPCC was in charge of carrying out all Return Home Interviews. Officers acknowledged that there was a clear need for greater consistency in record keeping.

Members asked whether new social workers were provided mentoring and support by their team. Officers acknowledged that induction and accountability both needed improving.

In answer to a question, Members were advised that it was particularly challenging to find and provide support to missing children who were not looked after by the council. They observed that missing children could be involved in "county lines", whereby a group establishes and operates a telephone line with a mobile phone in order to get young people to sell drugs to users at street level in rural areas some distance away from their home address, such as coastal or market towns.

Officers stated that professional curiosity was a mark of an effective social worker, who would take all measures necessary to find out where a missing child was and to establish contact with them to ascertain what risks they were facing. Members felt that there was a need for social workers to display more tenacity in addressing children's difficulties

Members were given assurances that foster carers were also interviewed where the situation of the child warranted it.

Members questioned officers about motivation levels in social work teams and efforts made by managers to improve them. The Executive Director for People explained that senior officers met regularly to discuss such issues and that the recommendations of the Ofsted inspection had led to more open discussions on underlying problems. She added that such discussions were now beginning to yield positive results.

Members asked how officers tested whether efforts to change the culture had had a positive impact. They were advised that this was done through "poll surveys" with staff. In addition, a "staff reference group" was due to start working with the Improvement Board created in the aftermath of the inspection.

Officers stressed that it could take a long time for children's services to progress from an "inadequate" rating to a "good" rating. In the case of Kent County Council, it had taken seven years.

Officers confirmed that only 23% of Return Home Interviews (RHIs) had been completed but that steps would be taken to improve the dashboard provided to members at the meeting. They acknowledged that the data provided on RHIs was

excessively complicated and that they had a duty to keep the whole population informed, including Looked After Children.

Cllr Andy Stranack, who is a member of the Corporate Parenting Panel, gave out Department for Education statistics regarding missing children to all in attendance. The Cabinet Member undertook to take it away for examination. The Executive Director for People offered to discuss these figures at a future meeting of the sub-committee and to provide more context for the statistics to be provided.

Members noted that paragraph 4.4 of the report (page 17) stated that none of the relevant children's files contained minutes of the Missing/High Risk Panel meeting where their cases had been discussed. They sought assurances that the department would henceforth make sure that all procedures were followed scrupulously and that notes of meetings were recorded in the right place. They suggested that key officers should take responsibility for ensuring that this happened.

Members enquired about the support provided to children and young people with special educational needs. Officers stated that they only held records for those who had a formal statement of special educational needs.

Officers were asked whether Skype was used to conduct Return Home Interviews as young people were comfortable with the use of I.T. Officers felt that the interview should be held face to face and be a thorough discussion of the circumstances that led the child or young person to go missing

Officers were asked how many children were currently missing education. They explained that new legislation which came into force in September 2016 (The Education (Pupil Registration) (England) (Amendment) Regulations 2016) required schools to inform their local authority whenever a child of compulsory school age left a school *before* completing the school's final year or joined the school *after* the start of the first year, and to inform it of the date when they are about to delete a pupil's name from the admission register, thus ensuring an uninterrupted record of a child's progress through school or revealing any gaps in provision. One member noted that she knew of children who had been out of education for five years and been missed by monitoring systems.

Members asked for the presentation to be e-mailed to the Sub-Committee.

Officers were thanked for their report and fulsome replies to Members' questions.

**RESOLVED:** to note the report.

#### **A39/17 Work Programme (Agenda item 7)**

Members discussed the work programme for the 28 November sub-committee meeting.

The Chair asked for the new Chair of the Safeguarding Children Board, Di Smith, to be invited to attend the meeting. The Executive Director (People) confirmed that this would be done. The Chair also requested that the



covering report for the Annual Report of the Safeguarding Board should give a description of her role as the Chair of the Board.

The Sub-Committee agreed to:

- Add an agenda item on statistics relating to missing children
- Postpone the item on youth employability to a later meeting – possibly in the following municipal year
- Have a briefing meeting on “Public Law Outline” and “Early Permanence” prior to the 28 November meeting and to request a written briefing on these two topics ahead of the briefing meeting, in order to gain a better understanding of these two items

The Sub-Committee also agreed that the Cabinet Member Question and Answer session for Cllr Alisa Flemming should be moved from the 6 February meeting to the 13 March meeting.

RESOLVED to:

- (i) Add an agenda item on statistics relating to missing children
- (ii) Postpone the item on youth employability to a later meeting – possibly in the following municipal year
- (iii) Have a briefing meeting on “Public Law Outline” and “Early Permanence” prior to the 28 November meeting and to request a written briefing on these two topics ahead of the briefing meeting, in order to gain a better understanding of these two items
- (iv) move the Cabinet Member Question and Answer session for Cllr Alisa Flemming from the 6 February meeting to the 13 March meeting.

---

The meeting ended at 8.50pm

This page is intentionally left blank

For general release

<b>REPORT TO:</b>	<b>Children and Young People Scrutiny Sub- Committee 28 November 2017</b>
<b>SUBJECT:</b>	<b>Croydon Safeguarding Children Board Annual Report 2016/17</b>
<b>LEAD OFFICER:</b>	<b>Jo Negrini Chief Executive Officer</b>
<b>CABINET MEMBER:</b>	<b>Alisa Flemming Cabinet Member for Children, Young People and Learning</b>
<b>PERSON LEADING AT SCRUTINY COMMITTEE MEETING:</b>	<b>Di Smith Interim Independent Chair of Croydon Safeguarding Children Board</b>

<b>ORIGIN OF ITEM:</b>	This item is included in the work programme for this sub-committee.
<b>BRIEF FOR THE COMMITTEE:</b>	To examine the work of the Croydon Safeguarding Children Board (CSCB) including changes following the Ofsted inspection of children's services in June-July 2017

## 1. EXECUTIVE SUMMARY

- 1.1 This report presents the Annual Report of the Croydon Safeguarding Children Board 2016/17 together with an outline of recent changes arising from the findings of the Ofsted inspection of local authority services for children in need of early help and protection; children looked after and care leavers and the review of the Local Safeguarding Children Board.
- 1.2 The Annual Report of the Croydon Safeguarding Children Board (CSCB) is an evaluation of the progress made by partners against the CSCB Business Plan 2016/17 and sets out the priorities for 2017 onwards. The Annual Report was prepared in May of 2017.
- 1.3 On 4<sup>th</sup> September 2017, Ofsted published its report providing an overall judgment that Children's Services are inadequate. The Local Safeguarding Children Board was also judged as inadequate as inspectors found that it had not established effective arrangements to discharge its statutory functions. The Ofsted report also commented that the annual report and business plan are overly optimistic about progress, lack rigour and are not evidence based.

- 1.4 This evaluation by Ofsted calls into question the credibility of the Annual Report 2016/17 and therefore this report focusses mainly on the findings of Ofsted and the actions being taken to address key areas of weakness and secure improvement in the CSCB.
- 1.5 The actions to improve the CSCB are included in Croydon Children's Improvement Plan and progress is monitored through the Children's Improvement Board which meets monthly. The Interim Independent Chair of CSCB is a member of the Children's Improvement Board.
- 1.6 In addition to securing improvement the CSCB has begun to consider the implications of the Children and Social Work Act 2017 and the proposed revisions to 'Working Together' guidance.

## **2. OFSTED INSPECTION**

- 2.1 Ofsted's review of the effectiveness of Croydon's Safeguarding Children Board (CSCB) evaluated the extent to which CSCB complies with its statutory responsibilities in accordance with the Children Act 2004 and Working Together regulations. It considered evidence relating to its coordination of the work of statutory partners in helping, protecting and caring for children in the local area and the mechanisms in place to monitor the effectiveness of those local arrangements.
- 2.2 The overall judgement from Ofsted is that the CSCB is inadequate, as it has not fully established effective arrangements to discharge its statutory functions. In particular it does not understand the experiences of children and young people locally and has failed to sufficiently monitor and evaluate the effectiveness of frontline practice.
- 2.3 Several weaknesses were highlighted in the Ofsted report including the CSCB's lack of direction and purpose. The Annual Report 2016/17 was reviewed by Ofsted and judged to be overly optimistic and lacking in rigour. It was found not to be evidence based particularly since it does not accurately reflect the failures to safeguard children and young people in Croydon.
- 2.4 The main areas for improvement relating to the overall effectiveness of the CSCB identified in the recommendations of the Ofsted report include:
  - discharge of statutory functions and responsibilities;
  - understanding of the experiences of children and young people;
  - monitoring and evaluating frontline practice;
  - Early Help Strategy;
  - thresholds;
  - embedding learning from serious case reviews;
  - use of procedures around CSE and Missing among practitioners.

## **3. STATUTORY ROLE OF THE LSCB AND INDEPENDENT CHAIR**

- 3.1 The statutory roles, objectives and functions of LSCBs are set out in Section 14 of the Children Act 2004. An LSCB must be established for each local authority area. The LSCB has a range of roles and statutory functions including the

developing of local safeguarding policy and procedures and scrutinising local arrangements.

3.2 The statutory objectives of LSCBs are;

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

3.3 The functions are as follows:

- developing policies and procedures for safeguarding and promoting the welfare of children in the area of the local authority;
- communicating to persons and bodies in the area of the authority the need to safeguard and protect the welfare of children, raising awareness of how this can best be done and encouraging them to do so;
- monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and Board partners on lessons to be learned.

3.4 In order to provide effective scrutiny, the LSCB should be independent. It should not be subordinate to, or subsumed within, other local structures. Every LSCB should have an independent chair who can call all agencies to account.

3.5 It is the responsibility of the Chief Executive to appoint or remove the LSCB Chair with the agreement of partners. The LSCB Chair should work closely with all LSCB partners and particularly with the Director of Children's Services.

3.6 The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

#### **4. IMPROVING THE PERFORMANCE OF THE CSCB**

4.1 In September 2017, a new Interim Independent Chair of CSCB was appointed with a specific brief to secure improvement in all areas identified by Ofsted and to contribute to the development, monitoring and implementation of the Children's Improvement Plan. The Children's Improvement Plan is the single plan across the Council and partners to drive improvement.

4.2 One section of the plan relates to improving the effectiveness of the CSCB and strengthening partnership working. It outlines the key actions to be taken to address each of the main areas for improvement. The Independent Chair of the CSCB provides a report to each meeting of the Children's Improvement Board outlining progress made in improving the effectiveness of the CSCB.

4.3 Securing effective arrangements to ensure the discharge of statutory functions of the CSCB has been a priority over the last two months. A CSCB

Development Day on 4<sup>th</sup> October focused on the findings of the Ofsted inspection and the changes that would be required for the CSCB to become effective.

4.4 The Independent Chair has found it encouraging that partners within the CSCB acknowledge that the 'Inadequate' judgement relates to the whole partnership (CSCB) and not one agency. The Development Day was characterised by a genuine desire to improve and there was no evidence of defensiveness or denial.

4.5 Partners identified four main areas for improvement:

- effective challenge;
- scrutiny, monitoring and evaluating frontline practice;
- focus on outcomes and making a difference for children;
- and ensuring direction and purpose.

They also committed to improvements in board culture with priority to be given to the development of:

- challenge;
- focus;
- and prioritisation.

4.6 An executive group of the CSCB has been formed of the three strategic safeguarding partners (local authority, CCG and police).

The role of the executive group is to:

- oversee the implementation of the CSCB section of the Children's Improvement Plan;
- lead the review of the membership, remit and priorities of the board to ensure effective processes to monitor and evaluate actions for their impact on outcomes for children;
- review and rationalise the subgroups and clarify their remits to ensure alignment with CSCB priorities;

4.7 A significant area of challenge for the CSCB is the large number of Serious Case Reviews and Learning Reviews in Croydon as these place considerable time pressure on all partners and the board management team. An unintended consequence of the large volume of SCRs is that commissioning, management and monitoring of the SCR process can appear to take precedence over the learning.

4.8 The CSCB intends to identify opportunities to align learning from SCRs with the Croydon Children's Improvement Plan. The focus will be shifted to ensure that learning is disseminated more effectively across the partnership so that it promotes and supports improvement and becomes embedded in frontline practice. This proposal was discussed at a meeting with Ofsted inspectors earlier this month and they were supportive of this approach.

4.9 A composite log of learning across all SCRs and learning reviews is being developed and updated and will be used to analyse and respond proactively to emerging themes.

## **5. RESPONDING TO CHANGES IN LEGISLATION AND STATUTORY GUIDANCE**

- 5.1 The implementation of the Children and Social Work Act 2017 and the proposed revisions to Working Together will have implications for the safeguarding arrangements in all local areas. The executive group will lead on behalf of the CSCB in considering the implications of the Children and Social Work Act 2017 and the revised 'Working Together' guidance including:
- the replacement of Local Children Safeguarding Boards (LCSBs) with local safeguarding partners (local authority, CCG and police)
  - the establishment of a new national Child Safeguarding Practice Review Panel
  - the transfer of responsibility for child death reviews from Local Safeguarding Children Boards to new Child Death Review Partners
- 5.2 By February 2018 the executive group will have developed proposals about how the safeguarding partners will work together, and with other agencies, to safeguard and promote the welfare of children in Croydon in line with revised guidance 'Working Together – 2018'.

### **Appendices**

Croydon Safeguarding Children Board – Annual Report 2016/17

---

**CONTACT OFFICER:** Di Smith, Interim Independent Chair of Croydon Safeguarding Children Board

#### **BACKGROUND DOCUMENTS:**

Children Act 2004;

'Working together to safeguard children' – 2015, DfE statutory guidance;

Children and Social Work Act 2017;

'Working together to safeguard children' October 2017, DfE proposed revisions to statutory guidance.

This page is intentionally left blank





Page 17

# Croydon Safeguarding Children Board Annual Report 2016/17



**cscb**

Croydon Safeguarding  
Children Board



# Safeguarding is everybody's responsibility

Page 18

This report gives an overview of the work of the CSCB from April 2016 to March 2017; showing what our plans were, what we achieved and what further work needs to be done to strengthen safeguarding arrangements and promote the welfare of Croydon children.

You can read more about the Croydon Safeguarding Children Board and the business unit at our website: [www.croydonlcsb.org.uk](http://www.croydonlcsb.org.uk)

If you have any questions, comments or feedback about the content, please contact any of the following:

---

Telephone: 020 8604 7275

Email: [safeguardingchildrenboard@croydon.gov.uk](mailto:safeguardingchildrenboard@croydon.gov.uk)

---

Sarah Baker, Independent Chair

Email: [sarah.baker@croydon.gov.uk](mailto:sarah.baker@croydon.gov.uk)

---

Maureen Floyd, Board Manager

Email: [maureen.floyd@croydon.gov.uk](mailto:maureen.floyd@croydon.gov.uk)

---

Aleisha McKenzie, Child Death Single Point of Contact

Email: [aleisha.mckenzie@croydon.gov.uk](mailto:aleisha.mckenzie@croydon.gov.uk)

---

# Contents

<b>Foreword</b>	<b>4</b>	<b>CSCB duties and responsibilities</b>	<b>43</b>	Housing	80
<b>Introduction</b>	<b>6</b>	Child Death Overview Panel	45	Education	81
<b>Welcome to Croydon</b>	<b>7</b>	Audit	48	Children with Disabilities	82
Croydon Children – Numbers	12	Serious Case Reviews & Learning Reviews	54	Young Carers	83
Voice of the Child	13	Section 11	57	Missing Children	84
<b>About the Board</b>	<b>16</b>	Private Fostering	59	Other Local Authority Children	87
Lay members report	18	LADO	61	Child Sexual Exploitation	88
Board Structure	19	<b>Safeguarding themes</b>	<b>62</b>	Gangs and County Lines	93
Membership and attendance	20	MASH	64	Serious Youth Violence	93
Budget	22	Child Protection	65	Young People involved in County Lines	94
<b>Business plans 2016/17</b>	<b>23</b>	Looked After Children	68	Female Genital Mutilation	95
<b>Inspection and Review</b>	<b>40</b>	Unaccompanied Asylum Seeking Children	69	Modern Day Slavery	97
JTAI Inspection	41	Independent Reviewing Officers	71	MAPPA	98
CSCB Review	42	Early Help	72	Preventing Radicalisation	99
		Best Start	73	<b>Learning and development</b>	<b>100</b>
		Children in Need	74	<b>Priorities for 2017 onwards</b>	<b>106</b>
		Mental Health	75	<b>Glossary</b>	<b>108</b>
		Domestic Abuse & Sexual Violence	78		



# Foreword by the Independent Chair

## Welcome to the 2016/17 Annual Report of the Croydon Safeguarding Children Board (CSCB)



I have been the Independent Chair of CSCB since March 2016. This is a statutory post as set out in Working Together 2015. My job is to hold agencies to account for the effective coordination of the commissioning and provision of services for children to ensure that children are safeguarded and the welfare of children in the area is promoted. I provide independent challenge so each Board Agency partner and their representatives are held to account.

My strategic role is to hold partners to account for the safeguarding arrangements for children in Croydon, the priorities of which are set out in the CSCB business plan. To achieve this I have monthly Governance meetings with the Leader of the Council, the Lead member for Children, the Chief Executive of Croydon Council and the Executive Director of People. I also have one to one meetings with the Strategic Lead officers for the statutory partner organisations on a regular basis. These meetings are effective in influencing the CSCB agendas for successful delivery of the CSCB business plan. Meetings are well attended by partners and the lead member for Children attends the CSCB as a participant observer so that she is informed and can provide effective challenge to the Council officers.

My evaluation of the CSCB business plan is that partners have successfully completed 8 of the 10 priorities set out in the business plan and made good progress against the remaining two priorities. At the same time the CSCB has been proactive in responding to emerging issues including a Joint Area Targeted Inspection of the Front door and the partners service response to CSE and Missing (May 2016).

Partners give vulnerable children and their families the highest priority.

I am also the Independent Chair of the Croydon Safeguarding Adults Board, a statutory position under the Care Act 2014. I use my knowledge from both Boards to make links and find solutions for children and families. I am working with strategic leaders to ensure safeguarding is an integral part and embedded within the Local Strategic partnership.

There were a number of Strategic leadership changes which coincided with my appointment. To benchmark the current position of the CSCB the Executive Director of People and myself commissioned an independent review of the CSCB. This was reported in January 2017. The review highlighted some significant areas for the CSCB to address to ensure the CSCB partners are meeting their statutory responsibilities. I am impressed by partners' commitment to acknowledging and addressing the issues raised in the review. There are ten priorities of which 7 have been achieved. The other 3 are being successfully progressed.

I am proud that the partners have worked together in some significant areas that have impacted on the lives of children such as findings from SCR, County Lines and FGM where Croydon is a fore runner and has achieved national and international recognition.

A significant achievement has been the Triple C Partnership between the London Borough of Croydon, both Croydon Safeguarding Boards and Crystal Palace Football Club & Foundation.



Croydon partners are recognised for the excellent work they do in supporting Unaccompanied Asylum Seeking Children (UASC). I have heard directly from UASC at the Corporate Parenting Panel and the difference Croydon's partners are making to their lives.

However challenges remain in strengthening the partners response to meeting the needs of children experiencing Neglect. To improve the oversight of the CSCB of Children with Disabilities I have asked the All Age Disability service to report to the CSCB. Children experiencing Neglect and Children with Disabilities are priorities for the CSCB next year.

Partners can tackle these difficult issues as demonstrated through the progress made in the MASH against the recommendations made in the JTAI report May 2016.

The Executive Director of People commissioned a review of Early Help services. In order to ensure the CSCB has effective oversight of the implementation of the recommendations of the early help review a dedicated sub group has been set up to actively monitor progress.

The CSCB is a multiagency partnership and is much more than the sum of its parts. Managers and front line practitioners across the partnership all work extremely hard under significant resource pressures with some of the most vulnerable children in Croydon. CSCB partners have demonstrated they give the highest priority to safeguarding children demonstrated through their commitment and attendance at CSCB meetings, engagement in multiagency audit of practice, serious case reviews and CSCB multiagency training.

Our work together over the last year demonstrates effective partnership working which provides a sound basis to tackle the challenges ahead. The CSCB Annual report identifies a number of risks. These will form the CSCB risk Register which the board will monitor.

- Changing demographics with associated deprivation, an increasing child population and associated demand on health services to support and identify vulnerable children.
- Affordable and suitable housing.
- Looked after Children health assessments.

I would like to thank partners for their continued commitment to safeguarding children across Croydon and look forward to working with you next year.

I commend the report to the Children and Families of Croydon as a measure of progress made and commitment to continuing to ensuring effective systems and processes are in place to ensure children are safeguarded.



**Independent Chair**  
Croydon Safeguarding Children Board





# Introduction

The CSCB Independent Chair is required to produce an Annual Report which evaluates the partner progress against the Business Plan and to demonstrate that the statutory requirements of the Board have been met

The report has been structured to give priority to the voice of the child and to understand their perspective. This is underpinned by Progress against the Business Plan and other activities undertaken by the Board throughout the year. It celebrates our achievements, identifies what we need to do and sets our priorities for the coming year.

Page 22



**Pages 13-15.** Children leading the report is an active decision by the Board to give a greater priority to gaining children's views, and to understand how their views are captured across the partnership and how they shape services.

**Pages 16-22** provide details of how the Board is structured to make sure that the legal duties and requirements are carried out effectively.

**Pages 23-39** give examples of what has been achieved by the Board in 2016/17 including progress on the Business Plans.

**Pages 40-42** summarise the findings of Joint Targeted Area Inspection conducted in May 2016 and the CSCB review in November 2016.

**Pages 43-61** provide details of the work completed in respect of the Board duties and responsibilities to understand how effective the partnership is at safeguarding in order to learn and improve the outcome for children.

**Pages 62-99** provide a snapshot of the range of safeguarding issues affecting Croydon Children and what is being done to address them.

**Pages 100-105** gives account of the Learning and Development programme completed to improve the skills of the children's workforce.

**Pages 106-107** shows the plans for the future direction and intentions of the Board.



# Welcome to Croydon



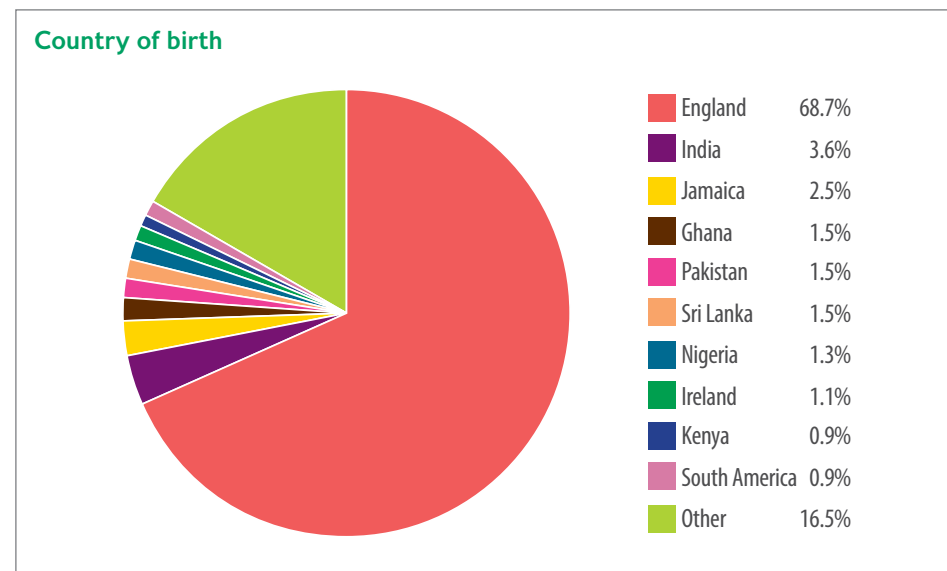
# Welcome to Croydon

The London Borough of Croydon, is one of 32 London boroughs and in 2015 there were 93,194 children aged 0-17 making Croydon the second most populated borough in London

The CSCB partnership is concerned about the impact of population growth on the safeguarding needs of children. Children and young people under 16 make up 22% of the population and Black and Minority Ethnic children account for 44.9% of the child population.

Croydon is a major economic centre in London with 81.8% of the population economically active. The borough is at the heart of a range of investments among them the £1.4bn regeneration of the Whitgift shopping centre, further bolstered by the arrival of Westfield, and the recently opened Boxpark pop-up mall all delivering 5,000 new jobs as well as acting as a catalyst for the wider regeneration of Croydon.

Year	0-17 projected population (Croydon)
2016	94,753
2017	95,778
2018	96,856
2019	98,024
2020	99,278
2021	100,513
2022	101,643
2023	102,562
2024	103,315
2025	103,769







Location of the borough of Croydon





# What do the changes mean for Croydon Children?

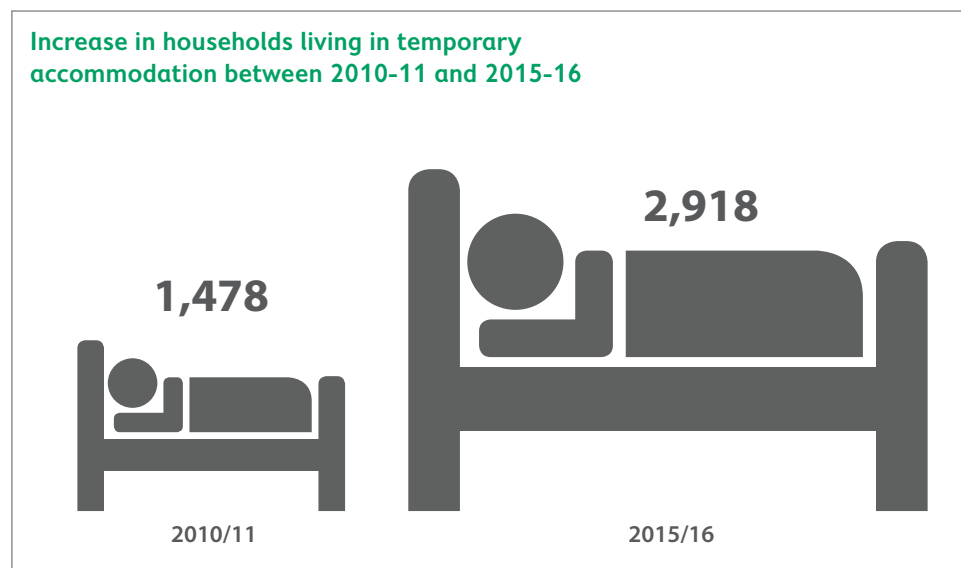
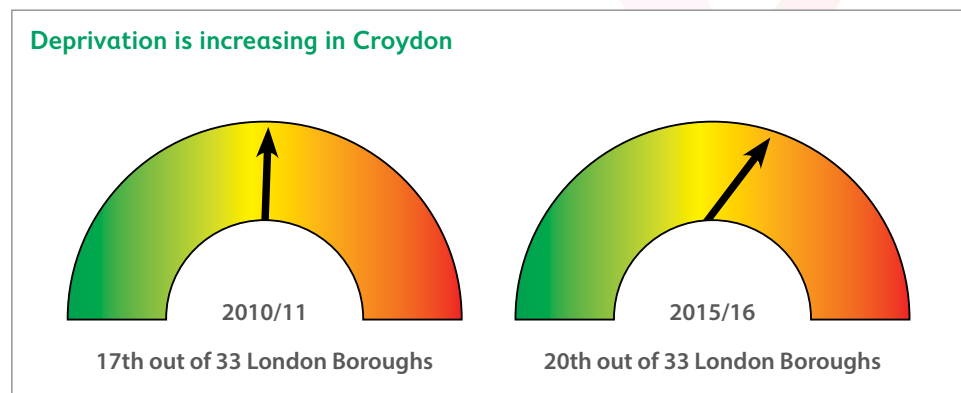
There is significant investment and growth opportunities which will have substantial benefits for children, families and communities in the borough many of who demonstrate significant levels of need. The present reality is one of stretched resources meeting increased need.

Croydon children need these economic developments which will directly and indirectly impact on them in the coming years. For example: Croydon Council is continuing to deliver school places to meet need across the borough and its latest commitments include provision for an additional 1,500 primary and 4,000 secondary spaces with the intention of a further 750 for children with special educational needs.

## Deprivation is increasing in Croydon

21% of Croydon children are living in poverty (18,000 children).

30% of Croydon children live in working families who receive tax credits.





# Joint Strategic Needs Analysis

Published September 2016

## Croydon is performing well in relation to children:

- Hospital admissions for children caused by injuries.
- 16-18 year olds not in education, employment or training.
- Emotional well-being of looked after children.
- Children eligible for free school meals achieving a good level of development at age 5.
- Use of e-cigarettes at age 15.

## Areas identified as challenges for Croydon in relation to children are:

- First-time entrants to the youth justice system.
- Police recorded adult domestic abuse incidents.
- Households in temporary accommodation.
- DtaP/IPV booster vaccination at 1 year and 5 years.
- Hib/MenC booster vaccination and PCV booster vaccination coverage in children aged 2.
- MMR vaccination coverage in children aged 2 (1 dose) and aged 5 (2 doses).
- Excess weight in 10-11 year olds.
- HPV vaccination coverage for one dose in girls aged 12-13.
- Under 16 conceptions.
- Antenatal risk assessments before 13 weeks | Low birth weight of term babies.
- Attainment at key stage 2.
- Children travelling to school by public transport, cycling or walking.



# Croydon Children

## The numbers

### During 2016/17

<b>2</b>	arrests for suspected FGM
<b>17</b>	children had been involved in County Lines
<b>22 to 33</b>	children at MASE panel each month
<b>453</b>	troubled families outcome achieved
<b>443</b>	children missing education in 16/17
<b>572</b>	contacts at the Family Justice Centre
<b>574</b>	children were missing
<b>578</b>	cases heard at MARAC
<b>1,178</b>	child protection investigations
<b>1,757</b>	CYP referred to Specialist CAMHS
<b>2,672</b>	missing episodes involving children
<b>2,886</b>	adults completed online safeguarding children training
<b>10,393</b>	children received free school meals
<b>21,161</b>	contacts into MASH
<b>94,743</b>	children in Croydon (projected)

### On 31 March 2017 there were:

<b>209</b>	elective home educated children
<b>368</b>	children with a child protection plan
<b>793</b>	looked after children
<b>438</b>	CYP supported by CWD social care service

### Percentages in 2016/17

<b>9.3%</b>	decrease in drug trafficking offences
<b>28.9%</b>	schools rated as outstanding
<b>37.6%</b>	increase in SYV offences on 15/16
<b>50%</b>	secondary schools had gangs training
<b>53.3%</b>	schools rated as good





# Voice of the Child

Ensure that the Voice of the Child is a priority in all that we do

## Business Plan Priority 1

The CSCB is leading a cultural change in proactively seeking children's views in order to inform and influence the way agencies work. The Board gives the highest priority to listening and learning from the voice of the child and has doubled its efforts to make sure all the different ways the voice of the child is used is captured so the impact of this work is demonstrated more effectively. We have given examples of the voice of the child below and there are other examples throughout the report where the voice of the child illustrates the impact.

Page 29

This Priority has two strands, one in capturing the voice of the child and two, how that has influenced the work, the 'so what' factor.

Board partners were required to demonstrate both of these elements in January at the QAPP sub-group meeting. Examples were provided from each Agency using a specifically designed template. A similar exercise took place at the Board Development Day, whereby Board members were able to give examples of where the voice of the child had influenced work to date and also in discussing how future work could benefit.

To ensure that the Voice of the Child is integral throughout all of the Board's future work the CSCB Report Template now has a specific Section: The voice of the child, the child's experiences, parent and carers' views.

One seemingly small example has had a significant impact. The engagement with just ten young people as detailed below has resulted in a 10 point guide that has been circulated across the partnership, to thousands of staff, which underpins frontline practice and has been adopted by the partnership.

## Examples of Voice of the Child – 'What I Need From My Professional'

In November 2016, the Young People's Specialist Engagement Team from the Early Intervention and Support Services at Croydon Council consulted a group of 10 young people to gather their views about how they would like professionals (such as social workers and key workers) to best work with them and support them. The young people were chosen as a representative sample of the range of ages, cultures, ethnicities and areas of the borough who come into direct contact with Council staff. The children included young carers, looked after children, young people with special educational needs and disabilities, young people with mental health support needs, young people from emergency accommodation and young people who have a range of levels of professional intervention

**The group concluded the event by agreeing their 'top ten rules' for professionals which has since been adopted by the Board.**





Top ten rules for professionals

## WHAT WE NEED FROM PROFESSIONALS

1. Ask about how I am and my week before going straight into the bad stuff.
2. I want you to listen to me and understand.
3. Please keep me more informed about what is going on and why.
4. Think about my ambitions and support me to be able to try new experiences.
5. A social worker is meant to make things better, please don't make me feel inferior.
6. Please don't ask so many questions that aren't relevant.
7. Be honest and sensitive with me.
8. Talk to me about what I'd like concerning my life.
9. Don't make any decisions without my opinion.
10. Be a stable person in my life

### Voice of the Child – Youth Council Survey

Each year the Youth Council carries out **a survey to find out the concerns of young people** living and studying in the borough. The results are used to set the Youth Council's priorities and campaigns for the following year.

- In 2016, 852 young people completed a survey using face to face interviews with members of the youth council across the three youth council forums in Croydon. Crime and safety, things to do and unemployment were the main concerns.
- These are now priorities for the partnership through the Community Safety Partnership and the Croydon Congress which will be led by young people.
- The CSCB Independent Chair is working with the Chairs of the other strategic partnerships to ensure that these priorities are being progressed.
- As a result of the survey young people:
  - met with police officers to discuss fear of crime
  - created and planned a workshop that they delivered to peers in school
  - created a film about fear of crime in the town centre.



# Voice of the Child – Return Home Interviews

When children go missing, they are encouraged to take part in a Return Home Interview (RHI)

There is a dedicated RHI commissioned service from the NSPCC, in addition the work is supported by visits from allocated local authority social workers and safe return visits completed by Police Officers .

Although the example below represents comments from only a small proportion of the 574 children who went missing in the year, their feedback in response to the RHI remains valuable. The NSPCC presented a report on their intervention to the Board in November 2016, reporting on the outcomes of their work for the year until August 2016. In their findings the impact of the RHIs was recorded as:

- Some children have stopped going missing.
- Others have reduced their number of missing episodes.
- Advice and support to parents and carers.
- Feedback can be offered to parents and carers.
- Partnerships between agencies are key to success.

See page 84 for more on Missing Children.





# About the Board





# About the Board

## Statutory duties and responsibilities

The functions undertaken by the Croydon LSCB are set out in Chapter 3 of the revised Working Together to Safeguard Children issued in March 2015. Regulation 5 of the LSCB Regulations 2006 sets out in detail the functions of an LSCB. [Link to Working Together 2015](#)

### The core objectives of Local Safeguarding Children Boards (LSCB)

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- To ensure the effectiveness of what is done by each such person or body for that purpose. [Link to 2006 Regulations.](#)

Page 33



### What is the Croydon Safeguarding Children Board?

The Board is made up of representatives from local statutory and voluntary sector agencies that work with children and their parents or carers and two long-standing Lay Members.

The Board is led by an Independent Chairperson whose role is to hold agencies to account. It is the responsibility of the Local Authority Chief Executive to appoint the Independent Chairperson (with the agreement of a panel including LSCB partners and Lay Members) and to hold the Chairperson to account for the effective working of the LSCB.

In order to provide effective scrutiny, an LSCB should not be subordinate to, nor subsumed within, other local structures.

The Board agrees a Business Plan each year which ensures its functions are fully carried out and improvements can be progressed which arise from local and national learning.

The main Board meets every 2 months during the year. The Board's terms of reference were reviewed in early 2017 and a new CSCB Governance Arrangements was published in February 2017 with an accompanying Compact Agreement setting out the commitments expected of each partner Agency.

## Lay Members

The two Lay Members represent the local community on the CSCB and operate as full members on the Board.

In addition to their Board attendance, one attends the Quality Assurance, Practice & Performance (QAPP) Subgroup and the other attends the Section 11 Panel. They are both fully committed to safeguarding in the community and are able to bring a richness and insight to the work of the Board.

Both lay members have been with the Board since 2012 and have agreed to help with the transition for new Lay members to settle into the position.

## The main role for Lay Members on LSCBs is in:

- supporting stronger public engagement in local child safety issues and contributing to an improved understanding of the CSCB's child protection work in the wider community;
- challenging the CSCB on the accessibility by the public and children and young people of its plans and procedures; and
- helping to make links between the CSCB and community groups.

Note comments from their Annual Feedback report below.

**My input has helped in communication and resolving safeguarding issues within my Muslim community. I have helped the department to understand complex culture issues within my community. I have recommended follow up on safeguarding checks within our mosques and community centres.**

Lay member 1

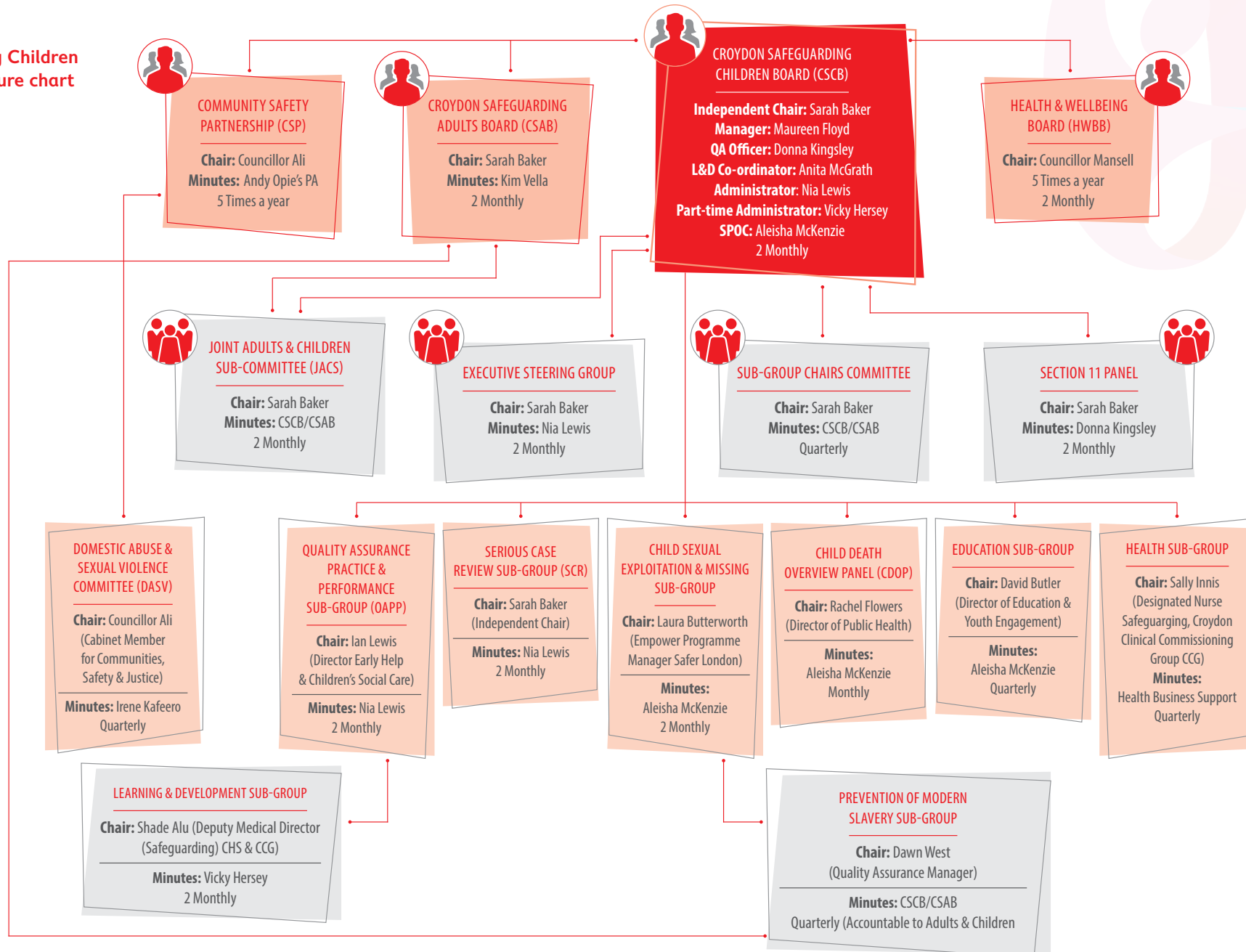
**I have been among the voices that have helped the Board to challenge its effectiveness, for example, through participation in the recent independent review of the Board.**

**I have always tried to give the perspective of the ordinary person in the street when asking questions or commenting on papers presented to the Board, but with the benefit of knowledge and experience of a wide range of regulatory and performance frameworks.**

Lay member 2



Croydon Safeguarding Children Board structure chart





# CSCB structure – the role of sub-groups

A significant amount of the LSCB's work is undertaken by the Executive and Subgroups. These groups help to progress many of the detailed actions in the CSCB Business Plan

The Executive and the Subgroups are accountable to the Board and this is reflected in the terms of reference of each group. The subgroup Chairpersons are all Board members and report routinely at the main Board and Executive in addition to coming together in a quarterly Chairs meeting.

## CSCB Connections

The Structure Chart above shows the connections the CSCB has with other strategic Boards. Those formal arrangements with local partnerships are currently the subject of a review led by the London Borough of Croydon Chief Executive in order to maximise collaboration for safeguarding through agreed priority work streams and to avoid duplication.

A memorandum of understanding is being developed to ensure the CSCB Chairperson can be fully briefed and provide influence on safeguarding issues for vulnerable children and adults across the partnership.

## Membership and attendance

A list of the statutory and non-statutory Board members as at 31 March 2017 and their attendance is shown below. We are confident the Board is represented by the right local statutory and voluntary agencies who are engaged appropriately in the subgroups.

A challenge has been made by the Independent Chairperson to the London Community Rehabilitation Company (CRC) as a representative has not attended any Board meeting during the year. To date a satisfactory conclusion has not been reached, although the Chair has participated in a discussion about this at the London LSCB Chairs meeting as this is an unresolved London-wide issue.

NHS E(London) have stated to all London LSCB's that they cannot attend boards as a routine but will attend where there are issues they can contribute to. London LSCB Chairs have challenged this decision.



**Statutory and non-statutory Board members as at 31 March 2017 and their attendance**

<b>CSCB Board</b>	<b>Attendance %</b>
Independent Chair	100%
Strategic Director People (DCS)	75%
Lead Member	62.5
Lay Member (1)	37.50%
Lay member (2)	87.50%
People, QA & CSC and Early Intervention	100%
Youth Offending Team	50%
CAFCASS	25%
Schools	50%
Croydon Health Services	75%
Director of Quality & Governance, CCG + Designated Professionals	100%
South London and Maudsley NHS Foundation Trust	50%
NHS England	0%
National Probation Service	75%
Community Rehabilitation Co.	0%
Metropolitan Police	100%
Head of School Standards	75%
Director of Safety, LA	50%
Director of Housing, LA	12.50%
Director of Adult Social Care	37.50%
Director of Public Health	62.50%
UKVI	25%
London Ambulance Service	37.50%
Voluntary Sector	100%

**JACS (Joint Adults and Children Sub-Committee)**

The first meeting of the new quarterly Joint Adults and Children Safeguarding Committee (JACS) took place in March 2016. This new approach has helped to ensure that strategic priorities are jointly agreed with a focus on the cross cutting agendas that impact on the commissioning and provision of services for vulnerable adults and children.

Bringing strategic leads of both Boards together has maximised the opportunities to work together, which has already enabled collaboration in agreeing joint safeguarding priorities of Domestic Abuse and Sexual Violence and Prevent and Radicalisation.

**Future themes on the agenda for 2017/18 will be:**

- Mental Health
- Alcohol and Substance Misuse
- Female Genital Mutilation
- Modern Slavery and Human Trafficking.

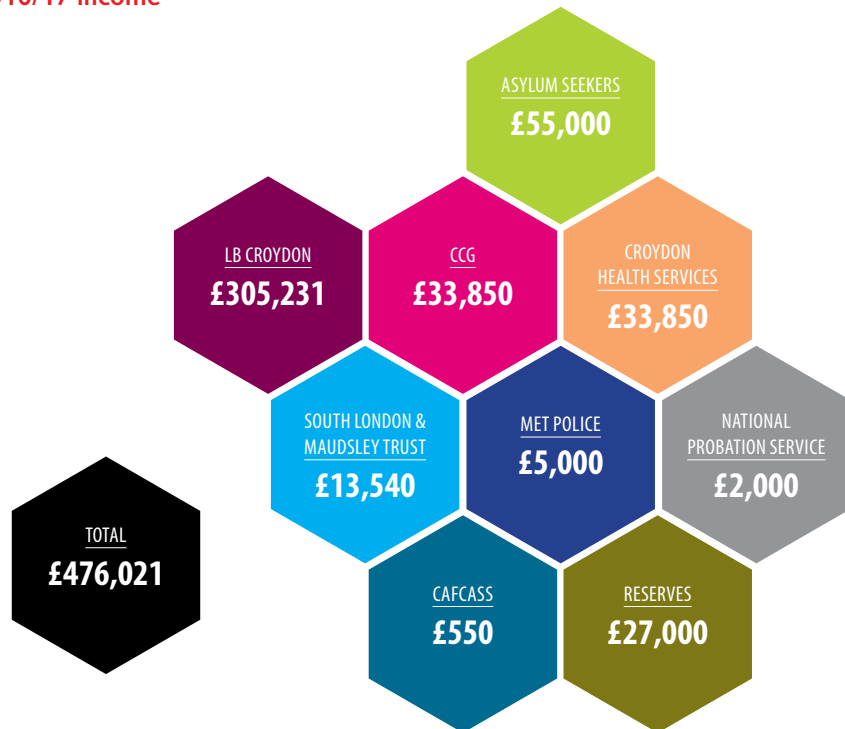


# CSCB Budget

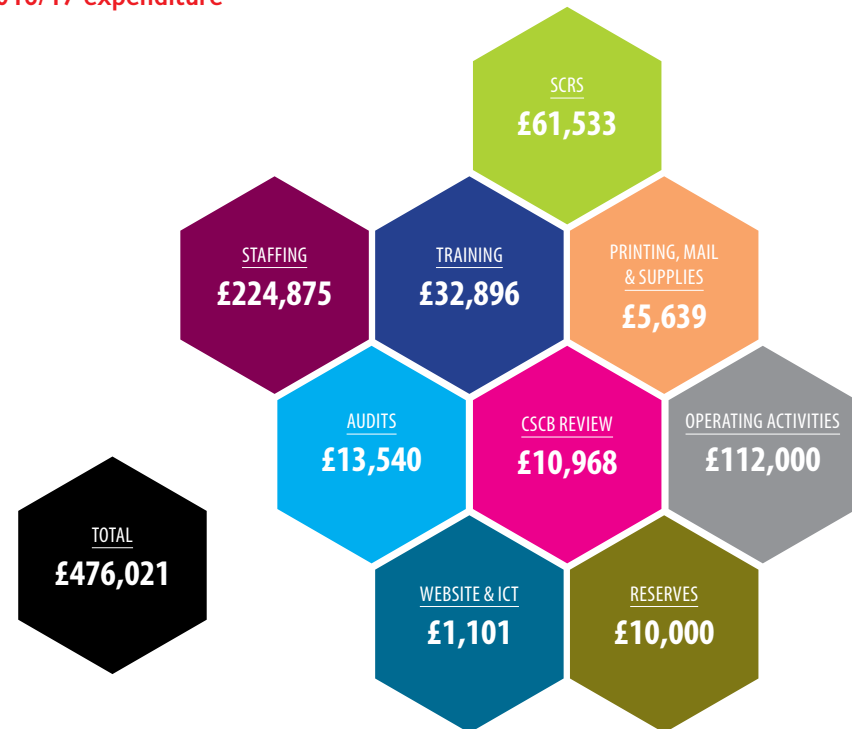
The Safeguarding Board is jointly financed by contributions from partner agencies, with the largest proportion coming from the local authority. The Board has again successfully managed a balanced budget, despite there being no change in member contributions for 4 years.

All LSCB member organisations have an obligation to provide resources (finance and in kind) to enable the LSCB to be strong and effective.

## 2016/17 income



## 2016/17 expenditure





# Business Plan 2016/17



# Business Plan 2016/17

In the CSCB Annual Report 2015/16, we concluded that based on our assessment of that year and known emerging themes the Business Plan was drawn up with issues identified as of the greatest priority to the Board (see list below)

This list has not remained static, further priorities emerged over the year, following the JTAI Inspection, the MASH and Early Help Reviews and the Review of the CSCB. Each of these have added further issues to be addressed by the Board and its partners. Examples of the progress achieved with the 2016/17 Business Plan Priorities are detailed here:

Page 40

## Business Plan Priority 1

BP 1 was reported on pages 13-15 of this report.

## Business Plan Priority 2

Improve the quality of the information and analysis to the Board to demonstrate the difference the Board is making to the lives of children and young people, also to inform its main areas of focus going forward.

It is vital that the Board have a comprehensive overview of the data relating to children in order to make informed judgements about the safeguarding and welfare of children in Croydon. Previous iterations had proved challenging and unnecessarily complicated. Following a well-attended Board workshop in February 2016 a new dataset was agreed using a new methodology.

CSCB Business Plan Priorities		
BP1	Ensure that the Voice of the Child is a priority in all that we do	
BP2	Improve the quality of the information and analysis to the Board	
BP3	Improve ways to communicate with children and young people, and families	
BP4	Develop joint working across the CSCB partnership on assessments, plans and interventions	
BP5	Develop its approach to Commissioning Serious Case Reviews and Learning Reviews to further develop local learning and practice development	
BP6	Review the changes that have taken place as a result of recent audits and the impact these changes have had	
BP7	Hold a CSCB Conference and focus on Neglect	
BP8	A co-ordinated and comprehensive safeguarding focus within schools	
BP9	Improve the way we engage with children and their families in their own communities	
BP10	Respond to Wood Review and the Children and Social Work Bill	





# Business Plan Priority 2

## Information and analysis

### Achievements

- CSCB dataset redesigned, following workshop, agreed more relevant and concise.
- The quality of the data and analysis significantly developed and improved and is now well embedded.
- Quarterly submission of data with commentary produced by agencies across the CSCB.
- Use of the Huddle portal which enables collective scrutiny, mutual challenge and support.
- Oversight at Quality Assurance, Performance & Practice (QAPP) Subgroup when each quarterly report is considered, and exceptions reported to the CSCB.

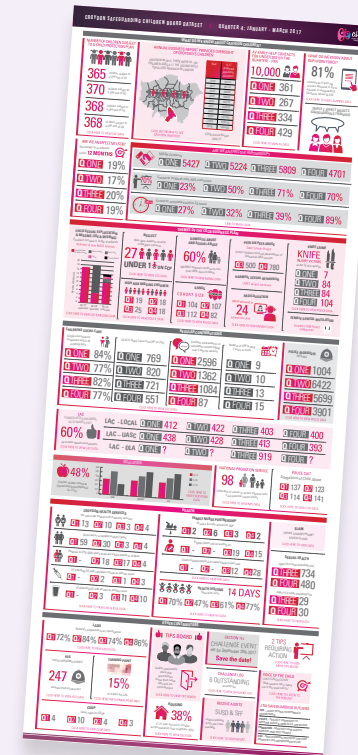
### Impact

- Better able to monitor trends, identify best practice and highlight risks in the system.
- Gaps identified, Challenge log maintained in Huddle.
- Improved understanding of Performance issues has led to challenge and improvements on a number of issues – for example the level of referrals from GPs that were not taken up by CAMHS and the level of contacts to the MASH that do not become a referral.

### Areas for development

- The Data Set and its usage continues to require additional work in some areas.
- QAPP to further embed its role in challenge and oversight.

**The CSCB Data Set**  
Please note: the data shown is not current and is for illustration purposes only





# Business Plan Priority 3

Gain a better appreciation of the experience and expectations of children and young people in Croydon; and improve ways to communicate with children and young people, and families, about safeguarding and promoting welfare

The approach to this priority has been on multiple levels: from the Board itself seeking to engage with public to introduce them to the work of the Board, increased website communications, engaging with other organisations who have face to face contact with the public, linking with other strategies, such as with Trading Standards and Croydon-Drop-in. This is in addition to the strategies of Board partners.

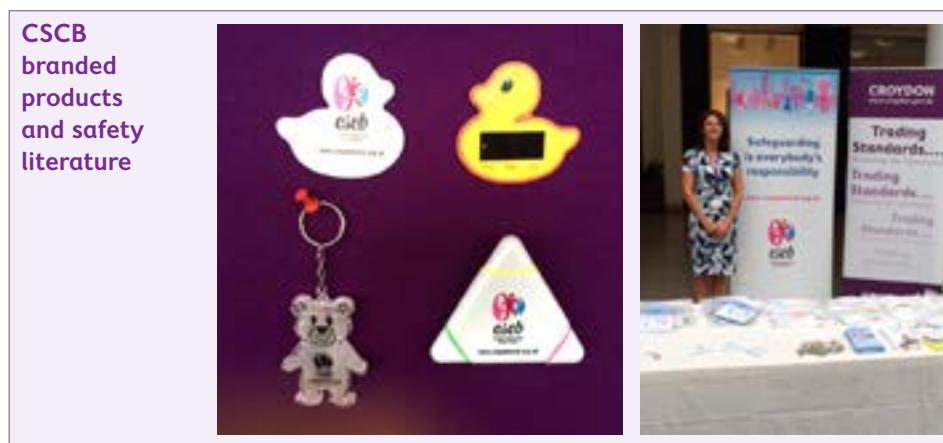
Page 42

## Achievements

Communications Strategy introduced in January 2016; the Board has increased opportunities to listen to children and young people, engage with the public and use their experiences and ideas to make improvements.

On 1 April 2016 there were 17 events planned for the year, by 31 March 2017 the Board had taken part in a programme of 66 activities including some new approaches.

- Triple C Event.
- Consulting with service users on the website.
- Attending Locality Meetings to meet with other Safeguarding stakeholders.
- Participating in community roadshows and awareness raising activities.
- Developing branded and safety products and advisory leaflets.



## Impact

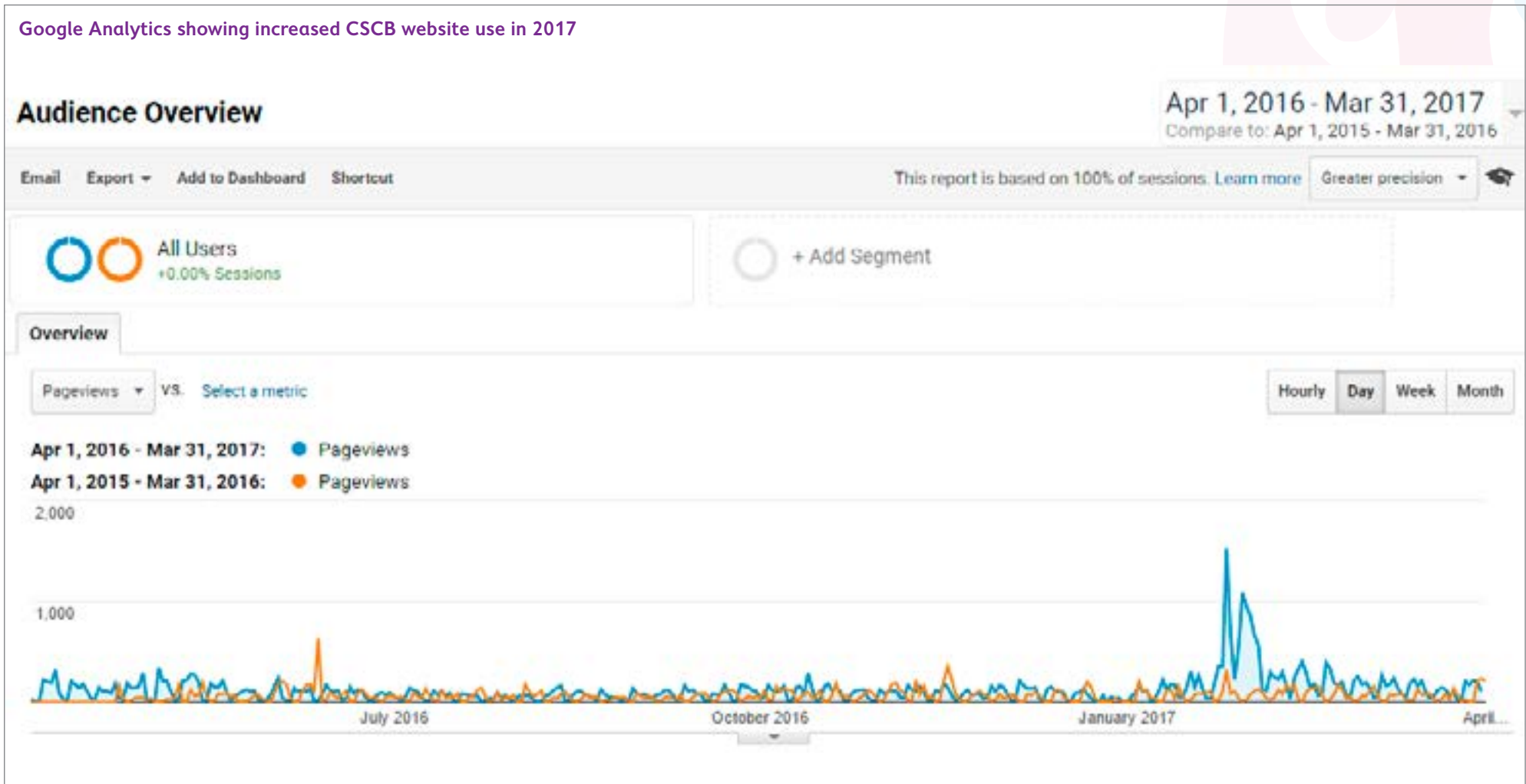
- Increased website use.
- Use of the CSCB Contact Us facility by families.
- Safety literature and goods shared.

## Areas for development

- Increased awareness of the remit of the CSCB.
- Young people analysis of website.
- Launch of the Twitter account.



Google Analytics showing increased CSCB website use in 2017



# Business Plan Priority 3

## Triple C safeguarding awareness

Crystal Palace Football Club (CPFC) has access to thousands of children and young people through its Community Foundation. CPFC have agreed to commence a safeguarding children training schedule with all their staff, to date over 160 staff have engaged in the on line training with many reporting that it has been beneficial in their day to day dealings with children. CPFC are represented on the Board as a community group and have been highly supportive in promoting safeguarding children issues. They are actively engaging in the Return Home Interview process to see how their involvement with young people can influence this ongoing area of work

Before any of the recent historic allegations in Football were disclosed, the Croydon Safeguarding Adults & Children Boards, Croydon Council and CPFC agreed to hold a **Triple C Safeguarding Awareness** training event, for business leaders in Croydon. Designed to promote the importance of incorporating safeguarding into their business strategy, including the use of the CSCB training material accessed via the CSCB website.

Representatives from approximately 100 businesses are due to attend the Triple C event in July 2017.





# Business Plan Priority 4

Develop joint working across the CSCB partnership on assessments, plans and interventions:

- Improving how well practitioners undertake assessments and manage cases together to improve safeguarding outcomes.
- Support Practitioners to enable them to have confidence and emotional intelligence in their practice.

Page 45

## Example 1

In December 2016, the CSCB and the Croydon Safeguarding Adults Board jointly published the Pre-Birth Assessment Multiagency Guidance.

In January 2017, the CSCB published Joint Working Practice on 'Safeguarding children and young people whose parents/carers' parenting capacity is impacted by mental health, substance misuse, learning disability and domestic abuse'.

These documents were both implemented following Task & Finish Groups which led on the findings from SCRs, the learning from sudden infant deaths and audits which were set to measure the degree to which there had been any changes in practice.

### Impact

- Pre-birth child protection conferences are more timely enabling earlier planning

## Example 2

Significant work has been undertaken by the Education sub group of the CSCB to identify and support those schools with low take up of the Croydon Early Help offer. 7 schools were identified and supported by Learning Access and Early Help Services.

The schools were identified by an analysis of Learning Access data relating to attendance, exclusions and Fair Access Panel referrals combined with data on the number of Early Help Assessments undertaken.

The Learning Access Service has developed a 'Team Around the School' approach to support further schools in 2017. This approach will provide a wraparound support package on a multiagency basis.

### Impact

- Increased take up of the Early Help Offer.
- 27.5% increase in Early Help Assessments.



# Business Plan Priority 5

In line with the Wood Review the CSCB will develop its approach to Commissioning Serious Case Reviews and Learning Reviews to further develop local learning and practice development [link to Wood Review](#)

## Serious Case Review methodologies and practitioner engagement

In accordance with our Learning and Improvement Framework we have utilised a range of different methodologies when commissioning our Serious Case Reviews (SCRs) and Learning Reviews (LRs), whilst ensuring practitioner engagement and learning events as a consistent feature with each Review.

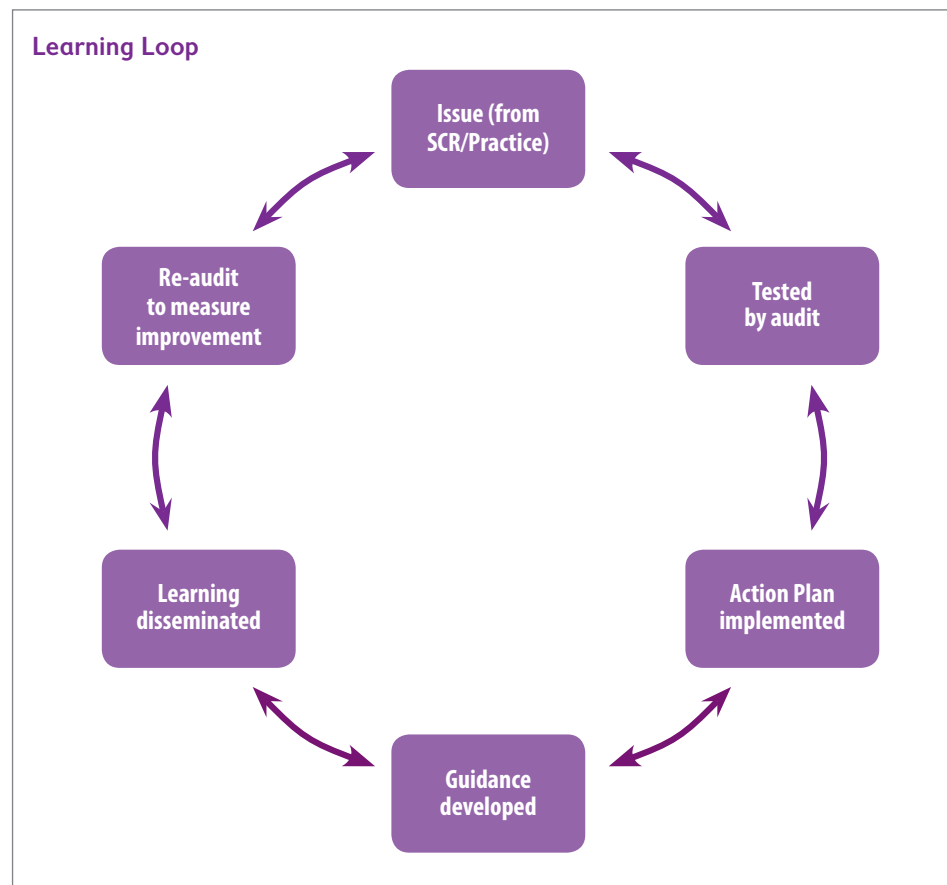
Feedback shows that practitioners and managers value these opportunities to reflect on the circumstances that existed at the time of the incident as well as explore in detail what happened leading up to the serious incident.

We have developed a cycle of learning from our reviews, for example, pre-birth assessments:

- we have undertaken an audit of the topic
- established if it is a wider issue than the one case being examined
- developed and progressed Action Plans to make improvements
- developed and published guidance, and
- tested those improvements with further audit to ensure than positive change has been embedded.

Learning is disseminated throughout all of these processes.

[Link to Learning & Improvement Framework](#)





# Business Plan Priority 5

## Develop local learning and practice development

All of our SCRs and LRs include practitioner learning, this is a summary of the Feedback and Learning Themes from practitioner events in 2016/17.

### What was of value from the SCR practitioner events?

- Opportunity to discuss and reflect on case practice and incidents.
- Provided guided discussion on the complexities of serious case review cases.
- Gave understanding of different perspectives from different roles, and a greater understanding of different roles and services.

### What did practitioners recognise that they could do differently?

- Use supervision more effectively.
- Alert health, social care and housing staff of transfers (in/out).
- Speak to child or parent alone.
- Improve use of Early Help Assessments.
- Improve communication and information sharing.
- Greater use of professional challenge and escalation.
- Maintain vigilance and professional curiosity.

The CSCB will test if these practice areas have been embedded during the next year.

### Learning themes

- Parental Mental Health.
- Parental Substance Misuse.
- Avoidant families and disguised compliance.
- Role of men and wider family.
- Pre-verbal attachment and communication.
- Understanding of Fabricated and Induced Illness particularly in educational settings.
- Working on cross-borough cases.
- Assessment of neglect.

These learning themes will be reflected in the CSCB Learning and Development programme 2017/18.





## Business Plan Priority 6

Review the changes that have taken place as a result of recent audits and the impact these changes have had

Audits planned by the CSCB invariably form part of a Learning Loop. For example an SCR identified issues of working with men, pre-birth and the impact of alcohol and mental health issues; all of these were subsequently followed up by audit, guidance, learning and further re-audit to determine if there had been any impact. The Audit cycle includes multiagency audits, independently-led audits, and single Agency audits.

Successive SCRs identified that significant men in children's lives were not forming part of the assessment or intervention, so action was taken to ensure that assessments could not be signed off in Children's Social Care without reference to the efforts that had been taken to engage, assess and include those men.

CSC have designed a specific methodology to record whether fathers' details are recorded on case files and whether fathers are included in assessments and attending CIN reviews, CP Conferences and LAC reviews. This 'experimental' reporting goes live in June 2017. Recording of fathers' attendance at CP conferences over the last year has seen evidence that more men are attending or are involved.

As a direct consequence of these findings and in order to address this gap, a project was initiated to:

- Engage with Young Fathers whose children are subject to proceedings.
- Identify and support those fathers with multiple disadvantage whose children are not yet on the radar in an early intervention capacity.

In April 2016, the Board endorsed a project proposal to employ a worker 2 days a week for 16 months within our family support and early intervention services. Working with Men is a national charity who manage and staff the project. The aim was to build capacity and confidence in men to better care for and participate in their children's lives.

- Male worker with a caseload of 10-15 fathers aged under 25 years, with Children in Need or on Child Protection Plan.
- 1:1 gender specific support.
- Aim to develop the men as Fatherhood Champions who in turn will be able to provide support within their own family and community.
- User feedback is a key part of learning what works and enables men to be more engaged with their families.

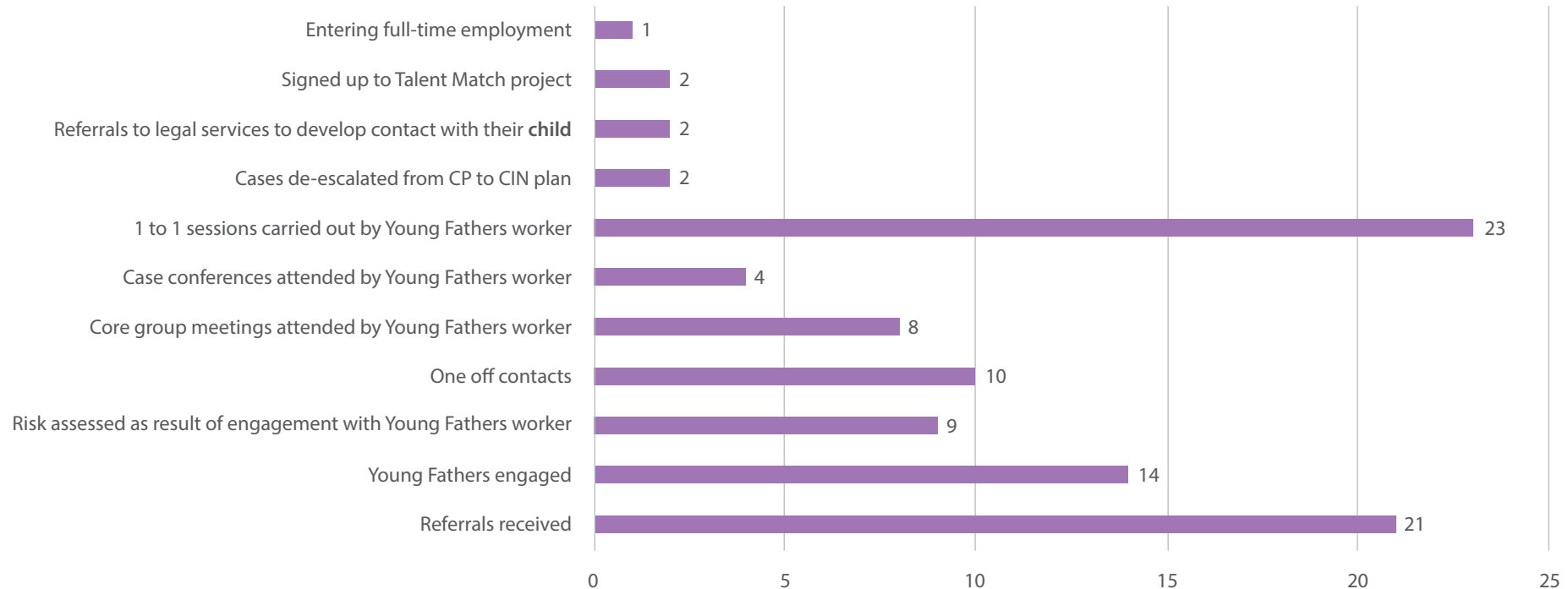




# Business Plan Priority 6

Example of impact of changes following audit  
Engagement of fathers – impact

Croydon Young Fathers Project – highlights





# Business Plan Priority 6

Example of impact of changes following audit  
Engagement of fathers – feedback

**Doing the consultations was the best thing you could have done to reach us.**

Father, age 19

**It is good to have someone to talk to, to help. The roads are not easy out here.**

Father, age 23

**The law is not on the fathers' side at all. With housing we have to claim we are homeless! But if we do that how can we be seen to look after our kids. It's crazy!**

Father, age 20

**It is really good you are doing this. If we had this when we were younger we may not have made the choices we did and got caught up in the madness.**

Father, age 21

**Thank you so much for all your help. I really appreciate it. There used to be services that helped but now there is none.**

Father, age 25



# Business Plan Priority 7

## Hold a CSCB Conference and focus on Neglect

The CSCB Neglect Conference is taking place in June 2017, speakers include the NSPCC and Research in Practice. The Conference will help drive forward a CSCB Neglect Strategy and develop assessment tools.

We know that there are a large number of children experiencing Neglect and the Board recognises that a Neglect Strategy would support the effectiveness and coordination of response by partners.

Page 51

**NSPCC**

**research  
in practice**





## Business Plan Priority 8

A co-ordinated and comprehensive safeguarding focus within schools across Croydon in order to identify children at risk and ensure a comprehensive safeguarding response

### Achieved

A new area on the Croydon Safeguarding Children Board website has been established to provide a single site “toolkit” for schools to use, providing model policies, guidance and resources. This is now being populated and will continue to be developed over the coming year.

Over the past year we have worked, alongside a range of external partners, including Safer London, MsUnderstood, the University of Bedfordshire, NHS and the NSPCC, to deliver a range of training for staff, focus groups of students, programmes, resources and guidance based on data and local intelligence to protect those most at risk of harm and to inform future delivery.

These themes were then followed through in the annual safeguarding audit for schools through a thematic approach in order to judge impact of work undertaken and to prioritise actions for the coming year.

We have worked with schools to ensure they have a member of staff appointed as a Domestic Abuse and Sexual Violence Co-ordinator, both to raise awareness of the issues surrounding DASV and to ensure schools know what to look for and how to respond. The vast majority of schools now have a nominated member of staff in this role.





# Business Plan Priority 8

## Safeguarding focus within schools

### Achieved

In conjunction with MOPAC we have developed a Knives Protocol to ensure a consistent response from schools to incidents involving weapons. This protocol was launched at a conference attended by head teachers and designated safeguarding leads. The protocol is being used by the Metropolitan Police as a template to disseminate amongst other London Boroughs.

The CSCB Independent Chair met with school governors on 2 occasions to discuss with them the implications and learning from SCRs and their role in ensuring that children are safe in their schools.

Significant increase (**92% in 2016-17 from 22% in 2015-16**) in the number of school staff trained in FGM awareness.

**97% of schools** have attended “Workshop to Raise Awareness of Prevent” (WRAP) Training.

**72% of providers** have embedded awareness within their curriculum of Child Sexual Exploitation, and **improvement of 18% over** the previous year.

**94 schools** have nominated a lead to act as a single point of contact with the council’s domestic abuse service, which has led to increased engagement and referrals.

FGM training in schools and colleges has been extensive and comprehensive, raising awareness, increasing confidence and resulting in proactive engagement. See page 92.

An informal presentation on gangs and county lines has been offered **to all the Borough’s secondary schools, and taken up by approximately half.**

New county lines resource to warn young people of consequences will be ready for use **by all secondary schools and youth provision** by June 2017.

A **training event for secondary schools** on safeguarding and county lines has been booked for 20th June 2017.

**96% of schools** have completed a Section 11 Audit, representing 125 schools. Those that do not undertake the audit have an onsite s11 visit from the Safeguarding Education Team.

### Area for Development

Focus on knife crime and youth disorder, to understand the issues, ensure support and guidance available, a multiagency approach and young people are engaged in the dialogue.



# Business Plan Priority 9

## Child and Family Engagement

The insight offered by children and families provides a unique perspective which provides professional practice a further opportunity to improve and develop. The ways in which we engage with children and their families in their own communities is an area for improvement which can be done through co-ordination of specific projects, surveys and other activity.

Page 54



### **Achieved – Example of Voice of the Child in Central Croydon**

A new initiative has been developed in response to the views of young people in Croydon. Safer London has secured funding for a permanent worker for 3 years with the aim to create safe places for young people to go to when they feel unsafe or need to talk to someone.

An empty shop in Croydon town centre has been identified as suitable and will have a volunteer manager. Peer advisers (e.g. young people) will be trained to visit selected sites at key times where young people congregate to offer a listening ear and carry out surveys.

The peer advisers training will include understanding about child sexual exploitation. Interestingly, many young people stated that if they felt afraid they would go to somewhere they are familiar with and where there are likely to be people they know (e.g. McDonalds).

Local retail staff and security staff will be encouraged to undertake the CSCB on-line safeguarding training so they are aware of safeguarding children issues (e.g. vulnerability due to gang activities, child sexual exploitation, and vulnerability of children with learning disabilities)





# Business Plan Priority 10

## Respond to the recommendations of the Wood Review and Government reforms contained in the Children and Social Work Bill

Early discussions have taken place between the Independent Chairperson, DCS, Borough Commander and the Director of Quality and Governance of the CCG, whilst awaiting the conclusions of the Children and Social Work Bill.

The CSCB Independent Chair is working with the LB Croydon CEO, for the effective protection of vulnerable children and families to undertake a review of the local strategic partnerships to ensure that safeguarding is central

### CSCB Chair Challenges

The CSCB Chair has made 27 challenges in the year, of which 25 were resolved.

Challenges ranged from challenging partners attendance at CSCB meetings, challenging London Councils regarding the accuracy of policy and practice for the LADO. Challenging the Gateway services regarding safeguarding families with NRPf and to partners regarding their response to DASV.

Unresolved challenges include – Challenge to Railway children regarding withdrawal of funding. The Chairs Challenge to the Community Rehabilitation Company - is being taken up by the London LSCB Chairs.





# Inspection and review





# CSCB Response to Inspection

## The Joint Targeted Area Inspection May 2016

The Joint Targeted Area Inspection (JTAI), was conducted by a team of inspectors from Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP).

The Inspection reviewed the effectiveness of how children access services and focused on children who were missing from home, school or care or thought to be at risk of child sexual exploitation – "Partners are working together

effectively in many areas of practice to meet the challenges of increasing demand and complexity in the local population of the London Borough of Croydon", June 2016.

**The CSCB Partnership have developed a Joint Improvement Plan demonstrating the action they will be taking, this is monitored to respond to the findings from the inspection. The CSCB is providing strategic oversight of the joint actions with partners through the CSCB Executive.**

### Examples of Key strengths

- The Leader of the Council, Local Strategic Partnership and Local Safeguarding Children Board have prioritised CSE through a longstanding programme of work.
- Good examples of effective work by the LSCB to engage with young people and respond to identified need.
- Clear commitment from the CSCB partners to work together to protect vulnerable children.
- Operation Raptor was developed by the national crime Agency, the Metropolitan Police and children's social care in Croydon.
- Children missing and at risk of child sexual exploitation are supported by voluntary Agency specialist services.
- Highly effective practice to support Unaccompanied Asylum Seeking Children.
- Youth Offending Services workers have a good understanding of risk.

### Examples of Key Areas for Development

- Multi Agency Safeguarding Hub (MASH) is experiencing increasing levels of demand.
- MASH, the police and school nursing capacity issues are limiting the effectiveness of responses to children.
- There is inconsistent application of thresholds and the quality of contacts variable.
- The profiling of those who offend against children is underdeveloped.
- Quality of performance data requires improvement so that the partnership can have effective oversight of all areas of practice.
- The high number of children placed in Croydon by other boroughs present a challenge.
- No formal quality assurance process for the health assessment of both unaccompanied asylum seeking children and local children looked after.



# Review of the CSCB

The Independent Chair of the CSCB and Strategic Director of People commissioned a review of the form and function of the CSCB in November 2016. Following the review the independent reviewer and Independent Chair of the CSCB facilitated a workshop to support the CSCB partners identify a

work programme arising out of the review. Ten areas were identified which the Independent Chair and Business Manager have been supporting board partners to take forward.

Where we are now: must do's	Where are we now?
Review the capacity of the CSCB Business Unit workforce	Reviewed work of the LSCB business unit and recruited additional workforce to ensure key agendas are attended to
Review the LSCB Annex A (SIF)	Updated Annex A and all associated documents
Annual report – evidence to ensure compliance and rigour	Time line agreed by Executive for May sign off Board partners writing progress issues and risks 'Critical friend' commissioned to challenge
Governance – review the structure of the CSCB	Developed and signed off Governance framework Agency Compact
Develop the multiagency data set	Multi Agency data set developed – review through QAPP and outliers being reported to Executive
Voice of the child	Voice of Child being incorporated into and reported through all LSCB activities. Discussed with Leader of LBC
Produce 'position statements' against the Boards priority areas	Partner agencies, sub group Chairs reviewing priorities as part of Annual review
What difference have we made?	Sub Group Chairs asked members to identify impact of the work All board and Executive asked to complete learning outcomes each meeting Board development session on impact of changing demographics and issues for board
Section 11 process	Revised 6 stage S 11 process Revised S11 template to provide consistency for rating compliance
CSCB aligned priorities across strategic partnership boards	Joint meeting of Chairs of strategic groups to align priorities Reviewing governance across LSP/CSP/CFPB/HWBB – working with CEO and Strategic Director Review structure of board based on Annual review



# CSCB statutory duties and responsibilities



# CSCB Statutory Duties and Responsibilities

## As noted the core objectives of any LSCB are to:

- Co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established;
- And to ensure the effectiveness of what is done by each such person or body for that purpose.

Here we note our successful performance against those statutory duties and responsibilities. Working Together to Safeguard Children (2015) states that LSCBs should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

The CSCB's Learning & Improvement Framework (last reviewed in March 2016) sets out the full range of reviews, audits and other methods of monitoring effectiveness which are aimed at driving improvements to safeguard and promote the welfare of children in Croydon.

[Link to Learning & Improvement Framework](#)

## In this Section we give a summary in respect of the following duties:

- Child Death Overview Panel.
- Audit – multiagency and single Agency.
- Serious Case Review.
- Local Authority Designated Officer.
- Private Fostering.
- Section 11.
- Learning and Development.





# CSCB Child Death Overview Panel

Working Together 2015 sets out the requirements of the Child Death Overview Panel. The LSCB is responsible for ensuring that a review of each death of a child (under 18 years) normally resident in the area is undertaken by a Child Death Overview Panel (CDOP) and ensuring the rapid response arrangements are in place to respond when there is an unexpected death of a child. By reviewing each case the aim is to look at the reasons and whether any future child deaths could be prevented by taking action, such as through public awareness campaigns or improvements in the way health professionals work. Across London CDOPs work to the London CDOP protocol

[www.londoncp.co.uk/chapters/unexpected\\_death.html](http://www.londoncp.co.uk/chapters/unexpected_death.html)

The CSCB is required to publish a CDOP Annual report which is reported to the CSCB and published on the CSCB website.

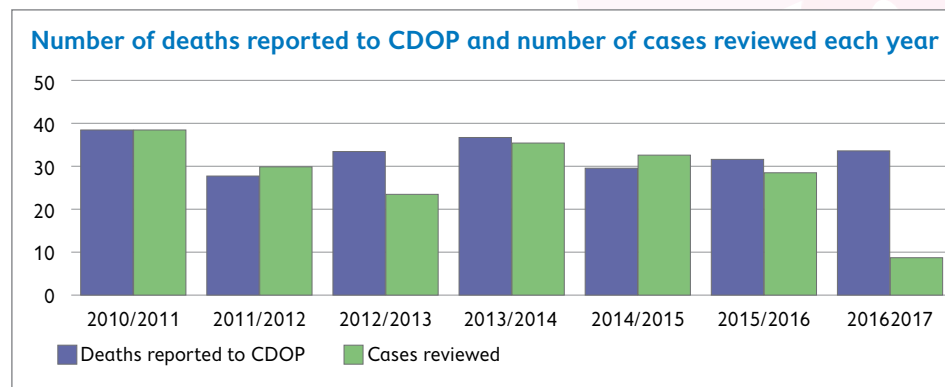
[Link to CSCB Child Death Report](#)

CDOP reviews all of Croydon's child deaths, these are invariably extremely sad and traumatic events for the child's family and friends. This is highly sensitive, emotive and challenging work.

## Number of child deaths and number of cases reviewed

Between April 2016 and March 2017, 34 deaths of children resident in Croydon were notified to CDOP, of which seven were reviewed in the same year. A further two cases were reviewed which were of children who died in the previous year (2015/16) making a total of nine cases reviewed in the year.

In 2016/7, two-thirds of all cases reviewed were neonatal (less than 28 days of age) or infant deaths (deaths of a child aged between 28 days and one year of age)."



Source: Croydon Death Overview Panel data

## Statistical relevance

It has been determined by the reviews that the most deprived geographical areas in Croydon have the highest number of deaths in children under a year of age.



# CSCB Child Death Overview Panel

## Achievements

Improving the quality of information returned by agencies (Form B's) for consideration at CDOP, to improve learning.

MultiAgency training developed around the role of CDOP. A presentation pack has been developed, which was initially aimed at schools, but also shared elsewhere. Presentations have been given to approximately 140 delegates to date:

- Education sub-group on 22 February 2017.
- Schools Designated Safeguarding Leads forum on 3 March 2017.
- Early Years Safeguarding Forum on 6 March 2017.

Meetings held with the Coroner & manager of South London Coroners' office to improve links and develop two-way information sharing between Coroner's office and CDOP. These talks covered arrangements for Rapid Response meetings and Regulation 28 "Prevent Future Deaths" reports.

The CDOP Chair was a member of the Healthy London Partnership (HLP) CDOP Steering Group and various CDOP members have attended the HLP and NHS England workshops to increase awareness about regional trends, learning, best practice and likely future changes in CDOP arrangements.

A review was undertaken of the local CDOP processes, including an assessment of adherence to Pan-London Child Protection guidelines, Working Together 2015 and Croydon CDOP's own Terms of Reference.

Croydon CDOP has been involved in a whole-systems approach with partners, led by the CSCB Health sub-group, to improve outcomes for babies who are at significant risk of Sudden Infant Death Syndrome (SIDS).

This was in response to local findings and national research which relates to the identification of risks present in cases of SIDS, smoking, co-sleeping, overcrowding/poor housing conditions, overheating, domestic abuse and alcohol use. It was recognised that risk factors needed to be identified at an early stage in order for health professionals to respond through antenatal 'targeted messages' and through enhanced Best Start services.

# CSCB Child Death Overview Panel

## Child Safety Awareness

Issues identified nationally by CDOP were included in local work by the Board for child safety week in June 2016, including information for parents and practitioners around baby slings and blind cord safety.

In conjunction with Trading Standards, the CSCB handed out packs containing token items with CSCB logo and website information, plus literature about child and home safety and blind cord safety cleats, plug socket covers, advice on nappy sack storage and carbon monoxide detectors.

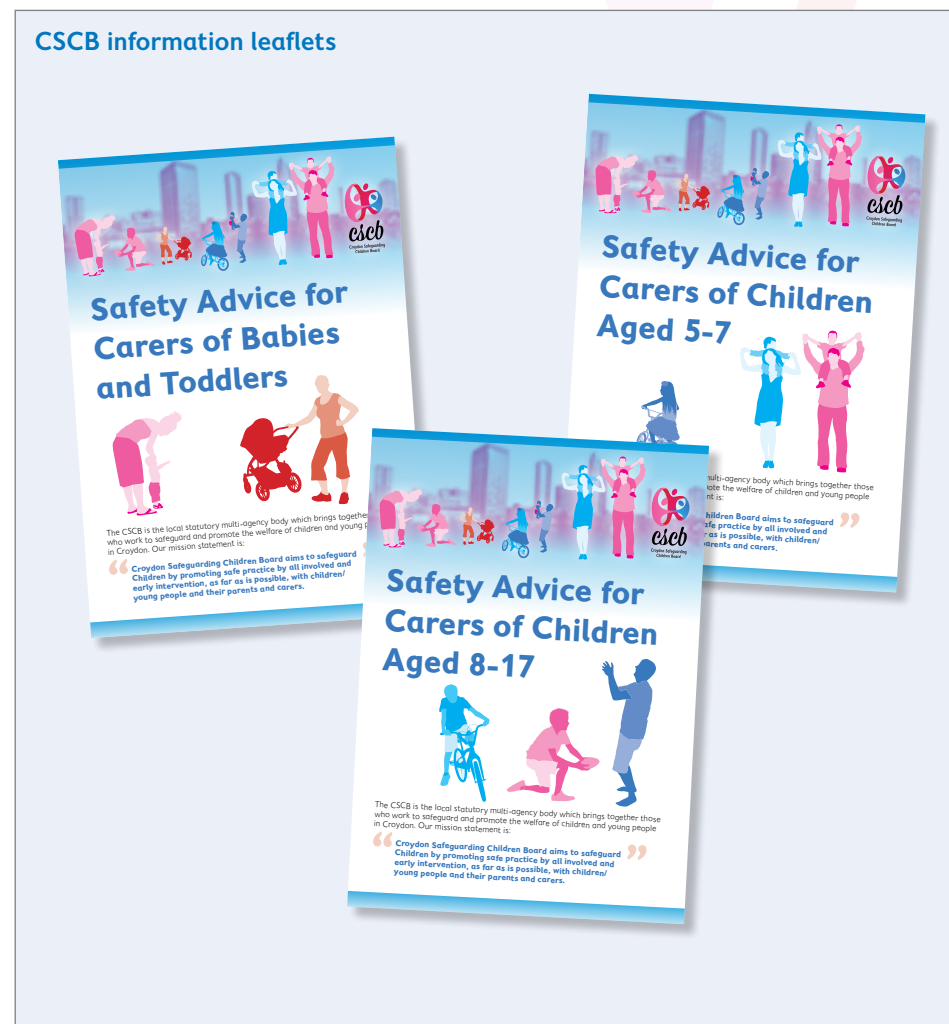
In total 600 packs were handed out either at this event or at subsequent events in the Whitgift Centre in Croydon town centre. A further promotion took place at the Croydon Safety Roadshow in September 2016.

There is now a permanent link on the website:

[www.croydonlcsb.org.uk/children-and-young-people/keeping-yourself-safe](http://www.croydonlcsb.org.uk/children-and-young-people/keeping-yourself-safe)

### Areas for Development – new actions for 2017/18

- Explore possibilities for family involvement in the CDOP process.
- Explore links around the risk of asthma deaths, air quality and local paediatric asthma services (as a result of national learning) - none have been reported as the cause of death for any Croydon children.







# CSCB Audits (overseen by the QAPP sub-group)

## Quality Assurance Policy and Practice

The QAPP Sub-Group brings together all of the key constituent agencies of the Safeguarding Board. In addition to overseeing Quality Assurance, Performance Monitoring and Policy Development, the Learning and Development Group also reports to the QAPP.

### QAPP is responsible for:

- Commissioning multiagency audit activity.
- Analysing single Agency audits from a multiagency perspective.
- Oversees Action Plans derived from audit activity.
- Oversees Performance information collected through the Board data set.
- Commissions and approves multiagency policy development, often in response to audit and performance activity.
- Oversees Learning and Development plans and ensures that they are consistent with the priorities of the Board and respond to issues derived from Quality Assurance activity and emerging performance issues.

In 2016/17 QAPP commissioned an independently overseen multiagency audit of cases that had been subject either to Step up or Step down processes between Children's Social Care and Early Help Services.

QAPP also commissioned a multiagency review of the Strengthening Families Framework for Child Protection Case Conferences. This gave a genuine insight into the experience for children, families and practitioners into the Conference process.

As part of the JTAI inspection a multiagency audit into CSE case was undertaken. That same process is to be followed one year on, to determine what progress has been made.

### In 2016/17 QAPP has also followed up previous multiagency audit Action Plans, particularly on:

- Children with Disabilities.
- Assessments.
- Child Protection Arrangements for Unborn Children and those Under One.

The QAPP has developed a clear methodology of ensuring that Action Plans are re-presented to the sub-group to ensure that recommendations are carried forward and improvements are identified.

### Two significant multiagency policies have been developed through the QAPP

- The Pre-Birth Protocol, which sets out the arrangements for raising concerns across agencies during pregnancy. All major agencies have been involved in this development.
- The CSCB Joint Working Guidance: The focus of this multiagency guidance is on safeguarding children and young people whose parents/carers' parenting capacity is impacted by mental health, substance misuse, learning disability and domestic abuse.





# Child Protection Case Conference

## Audit Findings

- Positive feedback from parent's and multiagency professionals on conferences.
- Conference Chairs' knowledge of individual families and their key role in meetings is recognised and valued.
- The whole systems approach of Strengthening Families Framework (SFF) is primarily embedded in child protection conferences only.
- Practice overall is inconsistent affecting the quality of the parent/child's experience, meetings, plans and core groups (identified in earlier audits and reviews).
- Staff turnover within agencies, particularly social workers and managers, since implementation in 2013, is an ongoing factor affecting quality.
- Management information and quality assurance arrangements need to be better co-ordinated to inform continuous improvements.
- More effective communication and varied approaches to learning is needed to assist cultural change.

Page 65





# Multiagency Step-up Step-down Audit (SUSD)

An Independent Strengthening Families Framework review was carried out and a report published in September 2016

## The findings were:

An independently led SUSD audit looked in detail at 12 SUSD cases. Agency frontline managers undertook single Agency audits in the first instance then came together as a multiagency network to collectively examine the cases.

Nine themes relating to good practice were identified plus 17 themes relating to practice requiring improvement, including:

- Lack on information sharing and multiagency working.
- SUSD processes not clear.
- Lack of contingency planning.
- Failure to challenge practice between agencies.

A joint improvement Action Plan has been developed in conjunction with the Child Protection Conference audit being led by a time-limited Task & Finish Group.





# Audit: Example of Single Agency Audit

## Children's Social Care and Early Help Practice Week

### Single Agency Audits

There is a greater requirement for single Agency audit information across the Partnership. The main Agency currently providing such information to QAPP is Children's Social Care.

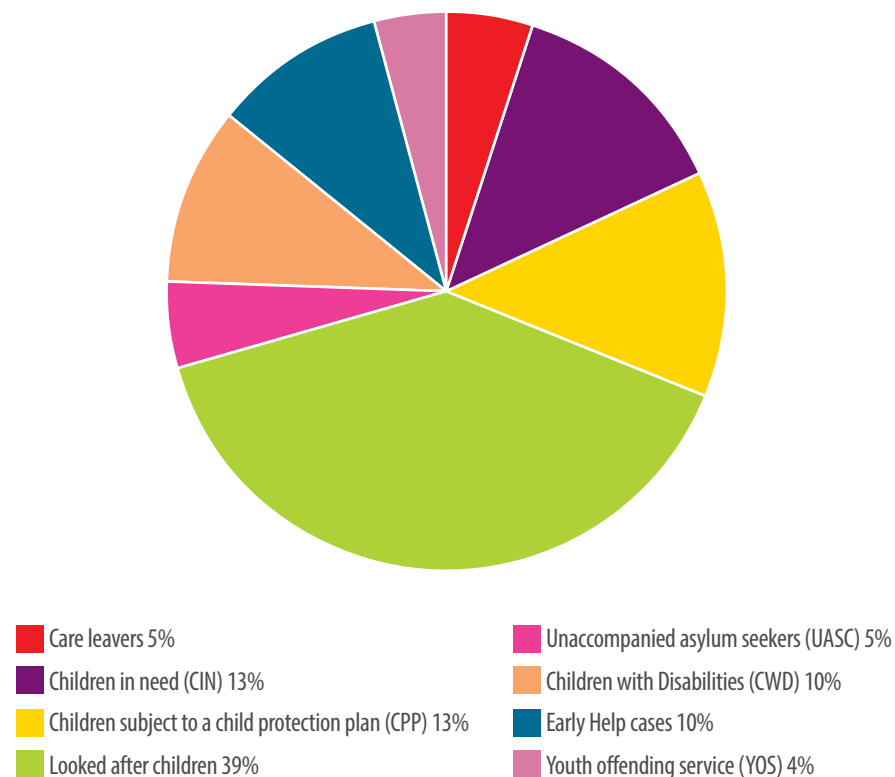
The Children's Leadership Team (CLT) undertook their first Practice Week in October 2016. The purpose of Practice Week was to support quality assurance of social work and influence front-line practice by facilitating reflection.

During this week CLT audited 99 cases, spoke to social workers, managers, foster carers; EH practitioners and managers and other professional partners. CLT observed supervision, core groups, LAC reviews, child protection conferences and spoke to children and families about the quality of service they had received.

All case audits were undertaken alongside the social worker or practitioner, and managers were regularly involved.

Practice Week provided detailed information about the quality of practice across all parts of Early Help and Children's Social Care with additional comment on joint work with Youth Offending Services. Practice Week discovered that overwhelmingly social workers and practitioners know risks, strengths and protective factors in their cases. There are excellent examples of direct work with children and parents.

Cases audited during Practice Week





In a significant number of cases practitioners have a plan of intervention in place for how we will help children and families. A large number of children, families and partners know what those plans are and their role in those plans.

There were also examples of outcome focused planning, however the quality of planning processes across the system are inconsistent.

A further challenge was the drift and delay in social work cases often caused by changes in social worker or internal transfer processes. Changes in staff (managers and practitioners) was identified as a primary factor impeding the quality of practice in Croydon.

The findings from Practice Week have informed the Children's Social Care Improvement Plan which includes actions to improve the quality of practice and recruitment and retention of social workers. The next Practice Week will be held in May 2017 which will provide further evidence on the quality of social work practice in Croydon.

Young people and families told us they are generally respected by practitioners who are described as helpful. Children described some trusting relationships with social workers, but they all want more information about rights and entitlements. For example, social workers personal assistants, foster carers and young people are not clear about 'Staying Put', their rights and the decision-making process.



#### What we have learned?

- Children in Need practice and processes are not being applied consistently.
- We are not using the pre-proceeding process.
- There are delays in permanency planning.
- There was evidence we do not parallel plan systematically.
- Pathway Plans are often being completed a few weeks prior to the young person's 18th birthday.
- Cases are transferred too often across systems depending on case status and changes of social worker.

#### What has been achieved and what are the areas for development?

- Quantity and quality of Supervision.
- Getting the basics right and doing the basics well.
- Improvement Board with a Single CSC Improvement Plan.

## CSCB Audits in 2017/18

The QAPP will oversee multiagency audits on work with children at risk through CSE or going missing in a follow up to the JTAI Action Plan to ensure that the actions taken have had an impact on practice.

The QAPP will also commission a multiagency audit on Neglect in support of the Board's priority area for 2017-18.

The format for multiagency audits should be reviewed in line with research evidence on best practice.





# CSCB Serious Case Reviews and Learning Reviews (SCRs and LRs)

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 which require the CSCB to undertake reviews of serious cases in specified circumstances.

## 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.

The decision to undertake either an SCR or LR follows a referral and recommendation to the CSCB Chair who makes the ultimate decision.

## Achievements

During the year 2016-2017 the SCR sub-group received referrals for 8 Serious Case Reviews.

- 4 Serious Case Reviews were commissioned.
- 1 Learning Review was commissioned.
- 1 was returned to the referring other local authority.
- 1 was agreed by the referrer to undertake a single Agency review and report the findings to the SCR sub-group.
- 1 was from a family, this request is on hold, whilst they explore formal complaints procedures.



Each SCR or LR has a Panel set up to oversee the Review and ensure that the learning is adopted as soon as themes begin to emerge.

The SCR Sub-group has a wide experience of different SCR methodologies and commissions independent reviewers to meet the needs of a particular style of Review. All our Reviews have a strong emphasis on Practitioner events and Learning. The SCR sub-group also monitors all multiagency Action Plans.

Two previous SCRs and their subsequent Action Plans were completed and signed off by the sub-group in 2016/17. The group is currently monitoring a further three SCR Action Plans.



The CSCB has published two Serious Case Reviews in 2016 -2017:

### Serious Case Review Claire

Link to SCR Claire: [click here](#)

This is a case of a Looked After Child sexually abused by her Foster Carer.

#### Findings and Learning

The Review has eleven findings with a significant number of comments on each of those findings. Of note these include:

- Assessment, approval and matching of foster carers
- Kinship care (connected person)
- Multiagency working to protect children from harm
- Multiagency involvement when a child is looked after

Learning was identified throughout the SCR process and has been shared with numerous children's practitioners.

#### Specific changes have been implemented as a result of the Claire SCR resulting in:

- increase in the number of Multiagency Strategy Meetings
- improvement in assessments of Connected Persons; and disruption meetings
- launch of CSCB Escalation Policy
- LADO safeguarding training to the Fostering Panel and LAC Permanence Teams
- Joint training for social workers and foster carers on children's health – including sexual health.

### Serious Case Review R,S,W undertaken jointly with Lewisham LSCB

Link to SCR R,S,W: [click here](#)

This is a case of Child Neglect and Injury.

#### Findings and Learning

The Review has brought together five main areas of learning:

- Assessment of neglect
- Interface between Early Intervention and Statutory Intervention
- Challenges faced by young parents
- Interpretation of procedures
- The children's lived experience

#### Each LSCB has developed their own Action Plan to pursue identified issues, in Croydon these include:

- guidance issued in respect of Transfer-in Child Protection Case Conferences
- an audit will be undertaken in April 2017 in Transfer-in and Transfer-out CP Case Conferences
- a multiagency audit into Step-up Step-Down cases between Early Help and CSC.

In March 2017 the CSCB re-launched the Threshold document, Indicators of Need with guidance as to pathways of intervention, a training programme to accompany this guide has been established.

## Voice of the Child and Family

Family and child involvement is a high priority in all of our Serious Case Reviews and Learning Reviews. We have actively sought the views of children, parents, grandparents, as well as aunts and uncles. We have been highly focused on ensuring that we have involved family members and gained their perspective on services available to them and the child at the time of the incident.

Whilst we have not been 100% successful, we have been extremely persistent, and often able to help represent the family views in a specific situation, e.g. in adding more information to assist with contact between a child and their grandparent. It would seem that the independent role of the CSCB within the SCR has helped encourage family members to be able to speak up.



## Publication

The Board has been mindful of the impact of publication of SCRs on the children, and family members. Preparation for the publication is discussed with the respective parties and carefully planned, the safety and welfare of the child has to be of the paramount concern. For example with Claire, independent Legal Advice was sought on her behalf in respect of publication, in addition to gaining her views and that of her family. Police support was enlisted for the foster carer and the mother was supported to be relocated elsewhere for her own safety.

## Out of Borough Serious Case Reviews

The CSCB is also supporting two SCRs in Medway and Wolverhampton. The families subject to the reviews both were in receipt of a No Recourse to Public Funds service from Croydon. As a consequence the Independent Chair of the CSCB sought assurance from the Gateway team that safeguarding of children and adults is a significant feature of all assessments.

## Learning Review

Whilst the CSCB has a statutory duty to undertake SCRs in specific circumstances, the Board is also able to commission Learning Reviews.

The SCR Panel sub-group agreed to a Learning Review to be undertaken in the case of a man with a previous conviction of killing his child and detained in a Psychiatric Hospital was released into the community without reference to MARAC. He only came to notice when he committed a further offence. See MARAC Section for impact.

A Learning Review undertaken between Croydon and Merton highlighted issues around sexually harmful behaviour (SHB) where the focus had been on the young person as a perpetrator rather than considering him as a victim.

The findings of this review prompted cooperation with the **LARC 7 – sexually harmful behaviour project** in conjunction with the National Children's Bureau, Research into Practice and the University of Bedford.





# CSCB Section 11 Process

Section 11 of the Children Act 2004 [http://www.workingtogetheronline.co.uk/chapters/chapter\\_two.html](http://www.workingtogetheronline.co.uk/chapters/chapter_two.html) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

- From November 2015 a new Section 11 process was introduced using a S11 Panel. Chaired by the CSCB Chair with representatives from the Board, agencies presented and were challenged on their Section 11 Audits. Previously these had come as presentations to full Board meetings with little evidence of challenge.
- 15 Partner Agencies completed presentations, Action Plans were agreed, and followed up approximately 6 months later.

## Commissioned Services

- LBC Commissioned Services Team, now have a more robust focus on Safeguarding and Safer Recruitment embedded in every contract. Work for 2017 includes direct challenge by the CSCB to see how this is contract managed and how it has impacted services delivered since its inclusion.

## ● Summary and Process for 2017

- Initial analysis of the Section 11 audits noted Senior Management being able to evidence compliance with Standard 1, but much harder to evidence the same for all staff (Standard 2) across the Agencies. Action Plans were targeted to improve this standard, and this was evidenced at the post Action Plan review. Challenges to evidence improvements has led to a change in the Section 11 process for 2017/18. This means Action Plans are SMARTer from the outset.
- The 2017 Section 11 process is a 3 year programme with 6 areas of challenge, creating a more engaging, broader spectrum of challenge and allows for better scrutiny at all practitioner levels. The process will also be documented in Huddle, an innovative and accessible platform for all partner agencies where the audits and Action Plans are easily shared and commented on. This process is transparent, enables open challenge and understanding as well as providing excellent evidence of challenge.

Percentage of Agencies meeting (or not) the relevant standard at 31.03.17

	Standard	Met	Partially met	Not met
1	Senior management commitment to the importance of safeguarding and promoting children's welfare	75%	19%	6%
2	There is a clear statement of the Agency's responsibility towards children and this is available to all staff	75%	19%	6%
3	There is a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children	62%	31%	7%
4	Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.	44%	56%	0%
5	There is effective training on safeguarding and promoting the welfare of children for all staff working with or, depending on the Agency's primary functions, in contact with children & families	75%	25%	0%
6	Safer recruitment procedures, including vetting procedures and those for managing allegations against staff are in place	81%	19%	0%
7	There is effective inter-Agency working to safeguard and promote the welfare of children	88%	12%	0%
8	There is effective information sharing	75%	24%	0%

Agency feedback was sought to understand how effective the process had been.

### Themes and findings

- Audit process not user friendly: forms difficult to complete (formatting issues), insufficient scope to cover Agency and department variances, and where to seek assistance.
- Panel process, more robust and more useful to Partner Agencies than previously.
- Panel concern, Audit is completed by senior members with little assurance that staff have same grasp of standards and what they mean within their day to day work.
- Evidencing the voice of the child difficult for many agencies.
- Policies and Procedures well documented, embedded and understood, but little evidence of how they actually improved children's lives.
- A shared database would make better use of inter-Agency co-operation.
- Agencies open to an on-line Audit Tool.
- Agencies commit to improved engagement with MASH for better referral standards.
- Challenge Event useful as an alternative method.
- Pressure on staff to complete Audits is already high, concern that self Audits at all staff levels may not yield truly representative results.

### CSCB Section 11 Process for 2017

Element	Definition
<b>Section 11 Audit Panel</b>	<p>6 weeks prior to Panel the Agency is requested to complete a Section 11 Audit using the new tool.</p> <p>Within 3 weeks, the Audit is returned to the QA Officer, who reviews it and returns it to the Agency with relevant comments.</p> <p>The Agency has the opportunity to amend its Audit, prior to it being sent to the Panel members.</p> <p>The Panel members review the Audit ahead of the Panel.</p> <p>The Agency Lead presents its audit to the Panel, who ask questions and agree the final version of the Action Plan.</p>
<b>Action Plan Review</b>	Usually a telephone interview by the QA Officer, 6 months after a Section 11 Panel, to review the progress of the Action Plan.
<b>Statement of Compliance</b>	The Agency lead completes this declaration to confirm that they have checked their safeguarding arrangements are in place as required.
<b>Practitioner Self Audit</b>	In consultation with the QA Officer, an agreed number of Self Audit forms will be completed by Practitioners at all levels of the Agency.
<b>Challenge Event</b>	A specified date when a number of Agencies meet, with the Panel, to review and challenge their Section 11 audits. Facilitated by an independent person.
<b>Panel Visit</b>	A specified date when two or three of the Panel visit the Agency concerned to ask questions of staff and service users where possible.



# CSCB Private Fostering

Private fostering is an arrangement made between the parent and the private foster carer, who then becomes responsible for caring for the child in such a way as to safeguard and promote his/her welfare. The Local Authority is not involved in the making of this arrangement

A privately fostered child is a child under the age of 16 (18 if a disabled child) who is cared for more than 28 days and where the care is intended to continue and provided with accommodation by someone other than:

- a parent
- a person who is not a parent but has parental responsibility
- a close relative
- a Local Authority.

If a period of care is less than 27 days but further periods are planned which total more than 28 days, then the child is privately fostered.

A relative is defined as a grandparent, brother, sister, uncle or aunt (whether of the full-blood or half-blood or by affinity, i.e. marriage or a step-parent). There is no stipulation as to the age of the relative.

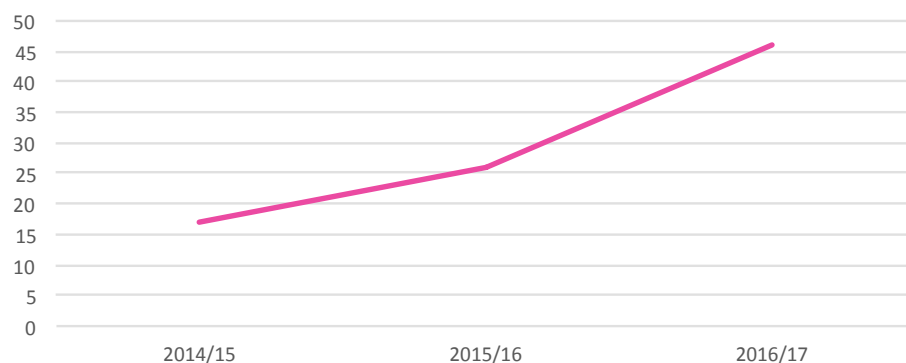
## Achievements

- Permanent Appointment of dedicated PF social worker.
- Increase in referrals in last 12 months by 176 per cent.
- Established Strategy plan for developing Private Fostering.
- Established links with local Language Schools.
- Raised awareness with local schools re PF.
- Surveyed sample of GPs as to how to improve awareness of PF.
- Initiated monitoring systems to review levels of referral and action/assessment.
- Integrated Strategy Group and Oversight Panel.

# CSCB Private Fostering

In Croydon on 31 March 2017 there were 47 Privately Fostered Children

PF Referrals by year



Page 76

## Impact

- Increased referral rates.
- Whilst increased referrals, the ease with which referrals have increased raised further questions as to the true level of PF in Croydon
- GP Questionnaires aimed to establish the extent to which local procedures were being adhered to and to evaluate the efficacy of arrangements in place to safeguard and promote the welfare of the children at risk of being privately fostered

## Areas for development

- Need to develop increased awareness of PF within schools and Schools Admissions Team
- Capacity demands on lone worker with increased referrals- Business case may be required to CSC
- Dependency on one member of staff to assess and monitor PF referrals/ cases can result in over centralisation of knowledge and skills.
- Performance in visiting and Panel reviewing needs to develop and become established.

## PRIORITY AREA:

- Children visited within 7 days of notification 28 % successful
- Children placed within 12 months with 6 weekly visit requirement 49 % successful
- Children placed for more than 12 months with 12 weekly visit requirement 67 % successful

## The visiting rates are a priority;-

- Recording systems are being addressed
- Performance is expected to improve by using the wider team Duty support.
- Permission has been granted to recruit a second PF Social worker
- This will address the backlog and establish improved performance.



# Safeguarding Children – LADO (Local Authority Designated Officer)

## Achievements

- Involvement in Schools safeguarding visits, in conjunction with School Standards, to address specific issues and concerns regarding safeguarding in schools.
- Establishment of London wide LADO and National LADO Forums for peer reflection and lobbying of national partner agencies
- Established quarterly reporting of performance to Board.
- Provided Training to Internal Foster carers, Supervising social workers, and Panel members on allegations management, and SCRs.
- Annual Report to CSCB.

## Impact

- Increased consultations means raised awareness and clear commitment to making agencies and services safer for children in Croydon.
- Improved oversight by Board of LADO activity and performance.

## Areas for development

- Ensure all strategy meetings to have minutes completed to a good standard.
- New Bail regulations likely to have an impact on effective and safe management of cases during investigation. Requires increased partnership working with CAIT.
- Avoidance of complacency in allegations management.
- Rise in areas where behaviour in private life potentially impacts upon professional work with children. Need to increase awareness and ability to manage of this among partner agencies.

## LADO service

**40%** increase in LADO consultations

**2x** increase in consultations from Health

**33%** increase in Faith referrals

**65%** of attendees at LADO Safer Organisations training rated it 'Excellent'

**35%** of attendees at LADO Safer Organisations training rated it 'Good'

▲ increased referrals from Internal Fostering Services

▲ improved consideration of complaints and allegations against Foster Carers at Fostering Panel



# Safeguarding themes



# Introduction to Safeguarding Themes

As part of the CSCB statutory duties and responsibilities, the CSCB is required to evaluate and monitor the effectiveness of the partnership in safeguarding children and promoting their welfare.

This Section of the Annual Report gives a brief overview of some of the safeguarding issues facing Croydon's children. These Sections detail some of the partnership work undertaken to address identified issues.



# Multiagency Safeguarding Hub (MASH)

The Multiagency Safeguarding Hub (MASH) is the ‘front door’ to manage all child protection referrals and to consider the most appropriate support available for families in need of help

The aim of Croydon’s Multi Agency Safeguarding Hub (MASH) is to provide safer outcomes for children, who are referred to them. The MASH is made up of co-located staff from Children’s Social Care, Police Public Protection Desk, Health, Education, Youth Offending Service, Early Intervention and Support Services, Youth Services and Probation. The MASH take referrals Monday to Friday, 09:00-17:00.

The Joint Targeted Area Inspection specifically looked at the operation of the MASH and recommendations have been followed through an Improvement Plan, one of which was to complete a review of the MASH operation, which was undertaken in August 2016 and made very similar findings to that of the JTAI Inspection Team.

There has been an increase in the number of managers to manage the volume of contacts that they receive from partners and from the public and to ensure that there is management oversight. This has greatly improved the efficiency and effectiveness of dealing with contacts and referrals in a timely manner.

The CSCB Chair, spent time observing and discussing how MASH operates with MASH colleagues.

There is improved performance information. A monthly dashboard is shared with managers from all agencies giving a range of activity indicators within the service. This has helped with individual analysis of the contacts that result in No Further Action and has led to a specific analysis by Health of two-weeks of contacts to address the quality of contacts and referrals.

Senior managers are also able to use ‘real time’ information on the workflow of contacts and referrals. They undertake monthly audits on contacts where there is a recommendation for ‘no further action’.

## MASH Service Data 2016/17.

MASH indicators	2016-17
Number of contacts	21,161
% of contacts to referral	23%
% of re-referrals	19%
% of referrals to NFA	10%
% of contacts actioned in 24 hours	76%

Source: CSC Performance Report April 2017

The MASH consultation line number is **020 8726 6464**





# Safeguarding – Child Protection

As at 31 March 2017 there were 368 children with a Child Protection Plan

## What has been achieved?

An audit into the Strengthening Families Framework Child Protection Model was commissioned by the Board and is reported in the Audit Section on page 48.

Other Issues identified outside of the audit have also been addressed:

- School nurse attendance at CPCs and provision of reports had significantly declined. A review of the role of school nurses in CPCs and in health assessments was undertaken and a new pathway has been developed. This is to be reviewed in May 2017 to determine if there has been any impact on attendance.
- GPs are not sufficiently involved in the CP process, in order to address this:
  - regular meetings have taken place between the named GP and the Quality Assurance (QA) manager
  - changes made to the invite process and distribution of decisions and minutes from CPCs
  - joint workshop between GPs and social workers
  - communication plan has been developed
  - further joint workshops have been set up to ensure this plan is carried out.
- Changes have been made in how Housing Services and CAMHS are invited to CPCs. This has led to a rise in attendance and contribution to CP plans from Housing Services. Further work is still needed with CAMHS.

## Child Protection Data 2015-17

Child protection	2015-16	2016-17	Trend
Number of s.47s	1,113	1,343	▲
Number of s.47s to ICPCs	517	550	▲
Number of children to a CP Plan at 31.3.2017	397	368	▼
Number of ceased CP plans in the year	388	441	▲
% of ceased CP Plans lasted 2 years or more	8%	3%	▼
% of new CP Children for a 2nd or subsequent time	11.6%	12%	▶
% of CP Children reviewed in timescales	100%	95%	▼
% of CP Children visited in last 4 weeks	76%	86%	▲

Source: CSC Performance Report April 2017

S47 = Section 47 Children Act 1989 Local Authority duty to investigate

## Safeguarding – Child Protection

- 1,505 strategy meetings have been held during the course of the year. This is a slight increase from last year. Audits of strategy meetings have been completed throughout the year evaluating threshold and decision making.
- There have been 1,343 S47 investigations this year an 14% increase from the previous year. This figure is 8% higher than our statistical neighbours and is 18% higher than the England average. S47 practice has been subject to audit in 2016 and will continue to be in 2017. The number of S47s leading to an Initial Child Protection Conference (ICPC) has also increased with approximately 37% of all s47s in 2016/17 resulting in an ICPC.
- The total numbers are comparative with statistical neighbours however our conversation rate requires further analysis. The percentage of children whose ICPC was held within 15 working days of their Section 47 was 59%. This performance needs to be improved. Children's Social Care are using daily child protection reports to monitor and improve this performance.

- 368 children are currently subject to a child protection plan in Croydon with a further 441 children whose child protection plan has ceased through the course of the year. There has been a steady increase in the numbers of Children with Disabilities who are subject to a child protection plan which are now specifically monitored in the monthly report and through 3 recent audits.
- There has been an increase in the numbers of child protection plans lasting 2 years or more although statistically the number remains low and can be accounted for my two large sibling groups. All children subject to a child protection plan for more than twelve months are subject to a panel review. We have seen an increase in the numbers of children subject to a child protection plan for a second or subsequent time however Croydon is performing well in comparison with statistical neighbours and national performance.
- The percentage of review conferences held within the required timescales was 95% an improvement from last year. Statutory visits to children subject to child protection plans within required timescales remains challenging. We are visiting children within statutory timescales in 86% of cases against a target of 100%. Children's Social Care now use a daily performance report to ensure visits to children are within timescales or actions are being taken where families might be refusing to engage in the plans or when children might have left the country.
- Children's Social Care provides the Independent Chair of the LSCB with access to its monthly performance report as well as regular reports on the child protection conferences system and is currently implementing an improvement plan following a Board commissioned evaluation of Croydon's Child Protection Conference process.





# Safeguarding – Child Protection Conferences

There are insufficient Professional reports provided to conference. A new multiagency CPC report template has been drafted in order to simplify and shorten it in the hope that professionals will be more confident about using it. This is currently out to partners for consultation.

At present there is not good quality data about attendance by professionals at CPCs or the provision of reports. There is currently a plan to identify a resource to be able to do this. This will enable the Board to be provided with evidence about the performance in this area and be able to provide the necessary challenge and scrutiny to effect positive change.

Children subject of a CP plan for over 12 months are reviewed by QA and the social work managers on a monthly basis.

Evidence of improvement, in that there has been a reduction in the number of children whose CP plan has gone over 2 years. There are currently only 3 families who have been subject of a CP plan for between 18 months and 2 years. However the number of children who've been subject of a CP plan over 2 years remains higher than previous. This is due to there being a number of children/families where there has been previous drift and delay. However there are clear plans in place to progress these cases so it is hoped that this cohort will reduce by June 2017.

There has been a rise in the number of children who have become subject of a CP plan for a second or subsequent time. All the cases for 2016/17 have been reviewed:

## Areas for development

- CiN plans are not always being followed.
- The stepdown process is not being appropriately adhered to.
- Over-optimism of the professional network especially in relation to domestic abuse.





# Safeguarding – Looked After Children (LAC)

As of March 2017 there were 793 children in Croydon's care. 393 Unaccompanied Asylum Seeking Children (UASC) and 400 local children

This amounted to 85 of every 10,000 of Croydon's children are in the care of the Local Authority. This is higher than the national average of 60 per 10,000 as might be expected given that Croydon has a much higher than average number of UASC in our care.

The Looked After Population in Croydon has stayed around 800 during the year. The majority of these children are cared for in Foster homes and a lower than average number (compared to national data) have been placed at a distance from their homes.

Page 84

## Achieved

- The Care Plan, Pathway Plan and Review documentation has been revised and made more user friendly for staff and families.

## Looked After Children Data 2015-2017

LAC	2015-16	2016-17	Trend
Total number of LAC	800	793	▼
Total number of LAC with Disability (CWD)	44	46	▲
Total number of LAC who are UASC	430	393	▼
Total number of LAC who are UASC	57%	70%	▲
Percentage of LAC with up-to-date	90%	89%	▼
Percentage of LAC cases which were reviewed within required timescales	80%	82%	▲

Source: CSC Performance Framework April 2017





# Safeguarding – UASC Looked After Children

## Unaccompanied Asylum Seeking Children (UASC)

The London Borough of Croydon is in a unique national position with regard to UASC due to the presence of The United Kingdom Visa and Immigration Department offices within the Borough.

This means that all children and young people making a direct presentation to that office are designated as Children in Need within our area according to Section 17 of the Children Act 1989. If they require to be looked after children, and the vast majority of them do, then this is the responsibility of this Local Authority. For many years, this has placed a major additional responsibility upon the Council and on other local services.

The JTAI Inspection in May 2016 looked at the arrangements for managing new referrals to services including the reception arrangements for UASC. This was noted as an area of highly effective practice.

UASC children are offered the same level of social work service as that offered to local looked after children, they are subject to the same legislative and regulatory framework.

They are allocated an Independent Reviewing Officer and will have their case and their Care Plan reviewed in the same way as local children.

- They are unlikely to have family members available to them and are encouraged to use the Independent Visiting Service and Independent Advocates. From November 2016 the Home Office, the IROs, the foster carers, and the social work teams are working together to prepare the majority of new unaccompanied minors for successful and stress free transitions to other boroughs within as short a time span as possible.
- There are challenges in ensuring the needs of these vulnerable young people are fully considered during this process but overall this will reduce the population of LAC in Croydon gradually over the next 3 years.





# Safeguarding – Looked After Children

The SCR Claire identified specific learning for Fostering and Fostering Panel. This SCR has helped achieve positive changes for the benefit of Looked After Children

## Achieved as a result of the Serious Case Review Claire

- Improved potential foster carer assessments, using nationally recognised models of working,
- Clearer decision making.
- LADO trained all foster care staff and foster carers.
- Increase in safeguarding awareness from the Fostering Service.
- The Fostering Panel developed in knowledge, skills and confidence.
- Greater representation at Fostering panel from safeguarding services.
- Fostering Panel specific learning and development plan and is regularly quality assured.
- Working to improve reporting and use of performance information.

## Areas for development for LAC

- Improve timeliness and quality of pathway plans for 16 and 17 year olds and deliver workshops on skills for independence.
- Identifying cases where drift and delay occur.
- Improved engagement with Children in Care Council.
- Support the Corporate Parenting Panel to offer creative solutions to issues faced by LAC.

## Priorities

Challenges in completing health assessments for LAC within the expected timeframes have been identified, resulting in poor compliance with national requirements.

14% of initial health assessments carried out within 20 working days of brought into care.

60% of looked after children in care for at least 12 months for whom health assessments are up to date

The LAC service has been working closely with the health commissioner and the Designated Nurse for LAC in order to identify the underlying cause(s) for this poor performance and agree an Action Plan which will address the issues identified. This includes robust planning of service delivery through the improvement of systems and the need to address capacity issues through the commissioning process.

## Chairs Challenge

The Strategy to improve the rate of LAC Initial Health Assessment has slipped and there is a backlog again.



# Safeguarding-Looked After Children Independent Reviewing Officers

## Annual Review of Croydon's IRO service presented to Board in November 2016 – summary points

Page 87

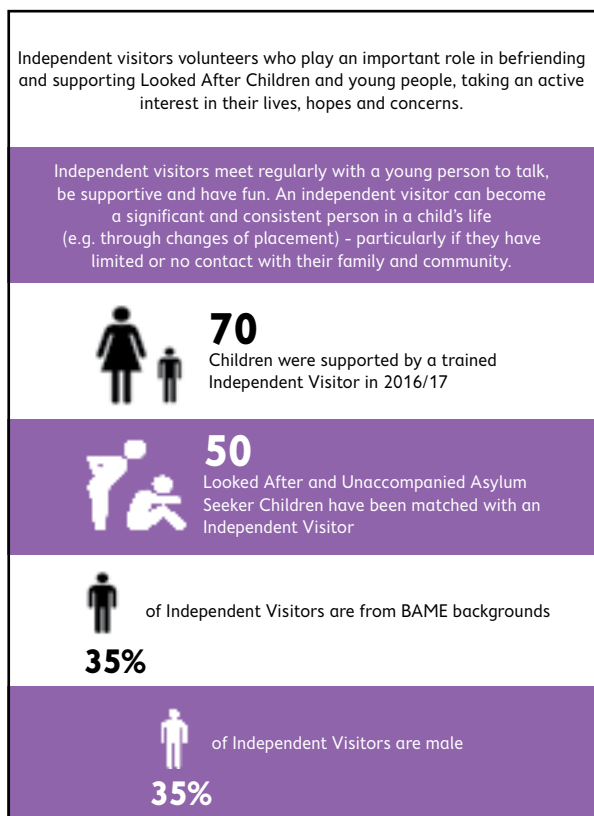
### Achieved

- More children now accommodated under Sec. 31 Full Care Orders than Sec. 20; testament to ongoing efforts of the “caring for the right children agenda.”
- Stability of placements continues to be above the national average.
- Improved delivery of health assessments/services to LAC.
- Majority of young people tell us they are happy with their placement.
- The IRO service has successfully recruited staff and the service is now 100% staffed with permanent employees.
- Heightened scrutiny by the Judiciary of the role of the IRO in preventing delay in achieving permanency for children and young people.

### Areas for development

- Challenge drift and delay in the Care Planning process, ensure permanence decisions by second review issues are addressed.
- Ensure cases in proceedings are progressing appropriately.
- Develop the expertise and practice of staff to improve the outcomes for the LAC population.
- Capture the voice of children.
- Concerns regarding transition planning to Leaving Care Service and preparation for adulthood and independence.

### Independent visitors





# Safeguarding – Early Help

## 1,166 Early Help Assessments completed in 2016/17

The Early Help Offer was subject to an external review in November 2016 and the EH Board will become a sub-group of the CSCB w.e.f. 1 April 2017, in order to hold the partnership to account for the improvement plan.

Early Help is a partnership activity. It is clearly important that children and families receive the support that they need as early as possible in order to prevent more serious and potentially damaging problems developing later.

Croydon has a well-established four stage intervention approach – using the wedge’ model - to provide appropriate and proportionate support for children and families Early help support is provided through partner agencies, potentially with the advice and co-ordination of Council officers.

The Early Help Pathways Guidance has been refreshed and approved by the CSCB in March 2017.

The review identified a number of strengths in the current offer, but made the following recommendations:

### Early Help Improvement Plan

- Develop a coherent strategy for the engagement of children and families and how their voice shapes service provision.
- Review whether further integration of commissioning arrangements can reduce duplication and maximise impact of scarce resources on outcomes for children.
- CSCB to review thresholds document and training to reflect recent changes to services, and build better understanding across all agencies on the operation of thresholds.
- Develop a strong multi layered communication strategy as part of the improvement programme to strengthen engagement of all stakeholders.
- Put in place a quality assurance framework that systematically pulls together evidence from data analysis and practice quality evaluation to measure quality and impact across the whole system.





# Safeguarding-Best Start

## **Croydon Best Start is intended to give Croydon's children from conception to 5 years of age the best possible start in life.**

- The programme intends to improve early intervention services for families with young children with the aim of maximising life chances and reducing the call on later more costly interventions.
- Research shows that the early years are the most influential time in the development of a child, when their brain grows the fastest and when love and security are crucial. The council and its partners believe that it is vital that all young children get the best start in life and propose to bring together key services including health visiting, children's centres, early years and the voluntary sector into an integrated service model.
- It is intended that the Croydon Best Start model will offer a more effective service by strengthening the way that agencies work together as a 'whole system' enabling the whole to be more than the sum of the parts.

## **The Successes so far in Best Start are:**

- 3 planning areas with working groups and governance groups either have parents Chairing them or this is in progress.
- Wide range of commissioned provision.
- A vibrant and active Community Builders programme.
- Range of volunteering opportunities identified through co-design and high levels of interest from parents.
- Best Start Buddy approach has been popular in Kensington Avenue CC.
- Weekly trans-disciplinary work groups established in the 3 Priority Areas demonstrating improved knowledge and working relationships.
- Active management and sub groups established and achieving outcomes on specific areas of implementation (monthly reports available).

- Family Partnership Model training delivered to 50% of workforce and guidance developed for trans-disciplinary staff.
- Social workers integrated into local delivery teams.
- Availability of shared 'touchdown' spaces for staff.
- New registration process in place supported by midwives so that families are encouraged to register with Best Start during pregnancy.
- Attendance at monthly ante-natal clinics is raising awareness of Best Start.

## **Priorities for 17/18**

Croydon Best Start has developed an Implementation Programme for 2017/18 which includes:

- Best Start Steering Group/ Best Start Leadership Group
- Best Start Planning Area Steering Groups
- Leadership and Management
- Transforming Practice
- Workforce Learning and Development
- Transforming Provision
- Communication including Enabling Technology & information
- Best Start outcomes



# Safeguarding-Assessments and Children in Need

The number of assessments of Children in Need has stayed consistent over the past two years. Children's Social Care has invested in staffing within the Assessment Service. An increased number of ASYE staff have been supplemented with more experienced Agency staff. Stability within the management team has assisted in increasing the numbers of assessments completed within timescales from 69% in 2015-16 to a provisional figure of 81% in 2016-17. The quality of assessments has been subject to independent audit demonstrating an improvement.

Page 90

The Emergency Duty Team covers both Children and Adult Social Care. It is a stable team of permanent and experienced staff.

551 children were supported by a CiN plan in 2016-17 compared to 754 in 2015-16. The previous year had shown a considerable increase in numbers, leading to an increased investment in staffing and two dedicated teams for vulnerable young people, which was identified as one of the sources of the increase. It has been identified that this is an area where there needs to be an increase in the effectiveness of our partnership interventions, leading to an application to the DoE Innovation Fund. Our application has been shortlisted and we are currently awaiting the decision.





# Safeguarding-Health

The safeguarding agenda for both adults and children evolves continuously, so the **CSCB Health Sub group** reviews and develops its work in order to ensure that there is an appropriate response to local and national requirements. The sub group work plan summarises the planned activity and shows the work to be undertaken.

## Achieved

- Increased Health presence in **MASH**.
- Sample **Review of MASH** Contacts.
- Improved communication with GPs.
- Joint work on direct feedback to GP practices re **outcome of recent SCRs**.
- Development of the **Multiagency Pre-Birth Guidance**.
- **Private fostering questionnaires** were sent out to all GP practices.
- Successful bid to NHSE London for funding to support **Prevent awareness training** in primary care.
- Joint GP and Social Worker quarterly **Child Protection improvement meetings**.
- **Targeted approach to risk of Sudden Infant Death Syndrome**.

## Areas for Development

- Impact of demographic changes.
- Analysis and outcome of MASH Contact Review to Board.
- Think Family Across the Generations.

## Chair's Challenge – re demand and capacity

- What plans are in place to address the increase in demand for community midwifery and health visiting? And the associated Health Visiting Caseloads which are in the region of 700+ (guide 400).
- Advise the Board as to current school nursing arrangements, as no school nurses representation at initial case conferences, with children with significant health concerns.

## Number of births by Financial Year and Month

Month	2014/15	2015/16	2016/17
April	408	409	457
May	425	452	525
June	406	458	486
July	427	500	529
August	440	422	505
September	403	464	490
October	442	454	530
November	428	456	443
December	422	482	474
January	418	454	455
February	399	471	398
March	399	411	477
<b>Total</b>	<b>5,017</b>	<b>5,433</b>	<b>5,769</b>



## Safeguarding-Health

### School nursing – Achievements in 16/17

- Recruitment – 90% of posts currently filled.
- Safeguarding pathway – new safeguarding pathway for school aged children subject to the CP process.
- Successful HEE Bid – upskilling the 0-19 health and social care workforce to support delivery of the Health Child Programme.
- New model of service delivery designed to maximise service impact and makes the best use of resources.

### Challenges for 17/18

- Increasing demand – The low establishment in comparison with other boroughs and a rising population. The service is working with commissioners and public health to identify the most appropriate level of service delivery within existing resources to maximise provision.
- Recruitment – the availability of suitably qualified staff continues to be a challenge in successfully recruiting to vacant post. Commissioners are working with the service on remodelling provision and developing a team with a more flexible skill mix and a more resilient service.

### Health visiting – Achievements in 16/17

- Recruitment – current vacancy rate of 12%, this will be less than 5% by October 17.
- HV workshop – family journey workshop to better inform partners of families care pathways and contribute to continuing work to develop a demand and capacity model.
- Performance – In 16/17 the service increased its performance on three of the five mandated reviews:
  - antenatal visits, 6-8 week checks and 2-2.5 year checks.
- Breastfeeding – infants being totally or partially breastfed at 6-8 weeks has increased from 66% in 15/16 to 71% in 16/17.

### Challenges for 17/18

- Performance – although performance has increased in some areas throughout 16/17 there continues to be issues with fluctuations in birth rates in the borough and the service's resilience to deliver a full service during these periods.
- Caseloads – The national recommendation for the number of children on a FTE HV caseload is a maximum of 400 children. Once at full establishment, a FTE HV in our service has a caseload of 650 children. In addition the HV service at full establishment will have 7 vacant caseloads.
- Increasing demand – The context for the HV service is gradually increasing demand, a low establishment in comparison with other boroughs and rising population. The service is working with commissioners and public health to identify the most appropriate level of service delivery within existing resources to maximise provision of a universal HV service within Best Start.



## Safeguarding-Health

### Child and Adolescent Mental Health Achievements

- 1,757 Children and Young People (CYP) were referred to Specialist CAMHS. The service accepted 68% of referrals – this is an increase of 14% from 15/16.
- The Single Point of Access into Mental Health and Well Being Services has been rolled out across the whole borough. This includes specialist CAMHS, the voluntary sector and the LA Early Help service.
- Specialist CAMHS Crisis Team has been fully recruited and embedded within Croydon University Hospital. It operates from 9am-10pm weekdays and all day Saturday. Outside of these hours an on call psychiatrist will come to CUH to see a CYP.
- The aim is for CYP in Mental Health (MH) crisis to be seen within 4 hours, for urgent appointments within one week and routine appts within 8 weeks.
- That CYP MH services are all meeting National Waiting Time Standards
- Eating Disorders has a dedicated phone line so that CYP and their families can self refer into specialist services.
- Cues Ed and Happy Being Me continue to be rolled out across schools and colleges in the borough.
- Off the Record Croydon's on line counselling platform is fully operational giving CYP increasing access to therapeutic services.
- The Croydon CAMHS wait for neurodevelopmental assessment has been reduced from 18 months to 6 months.

### Challenges for 17 / 18

- Development of a Sexually Harmful Behaviours Strategy that sits across YOT, social care, MH and education.
- Development of a Self Harm Strategy that is coproduced with YP, their families and partners.
- Delivery of the Child House – part of the Child Sexual Assault package of integrated clinical care in partnership with the MoJ, Police, DoH, MOPAC and the South West London Boroughs.
- Reduce the wait for neurodevelopmental assessment further, building on recent progress.







# Safeguarding – Domestic Abuse and Sexual Violence

As a direct result of the Joint Adults and Children Sub-committee collaboration a new Domestic Abuse and Sexual Violence Group has been set up led by Councillor with portfolio lead for community safety

Page 94

A priority throughout 2016-2017 was to ensure that universal settings are joined up to the domestic abuse services to reduce barriers in accessing support.

A cornerstone of this workstream alongside the Independent Domestic Violence Advocate (IDVA's) has been the development of named leads, who are trained to help victims, survivors and their families' access pathways for support or feel better able and more resilient to support people directly.

- The successful recruitment of a police IDVA is having a positive impact and provides immediate support to victims as a part of a first response when taken along to domestic abuse call-outs.
- An IDVA at Croydon University Hospital, working primarily in the emergency department and maternity ward, completes assessments onsite when pregnant women or those in A&E disclose domestic abuse. Such is the success of this post that the hospital is now directly funding this post.
- 3 Best Start domestic abuse advisors provide a flexible and accessible domestic abuse service involving completion of risk assessments on DASV victims, signposting to other services and making appropriate referrals; therefore ensuring greater reach to all communities.
- A DASV duty worker in MASH 5 days a week – early involvement of specialist, support timely accurate signposting.

Croydon has made a successful joint bid for DCLG funding in relation to domestic abuse services in particular with the Refuge, bespoke support for BME women with NRPF and EEA migrant women.

## Areas for development

There is a need to develop a support structure for victims and survivors beyond the point of immediate risk through the development of a community based volunteers programme.

Work is required with Schools to promote a healthy relationship programme, as well as targeted support for young people experiencing or perpetrating abusive or risky behaviour.

A greater partnership approach to disrupting those who perpetrate (or exhibit or engage) in abuse would be beneficial through behaviour change approaches or through legal processes.





## Safeguarding – Domestic Abuse and Sexual Violence

### MARAC

The MARAC partnership is in a strong position, with partnership attendance, engagement and their accountability being clearly evidenced as having an impact on the lives of those impacted by abuse.

The partnership has demonstrated real tenacity in cases that have come to MARAC on multiple occasions or where there are significant complexities and demonstrated the ability of MARAC to increase the safety of those who have little or no Agency in affecting their own change.

There were 575 MARAC referrals over the period April 2016 – March 2017, an increase of 29% compared to the previous year. Of these 58% have been identified as having children

There are not the proportion of referrals into MARAC from Children's Social Care that would be expected, this will require targeted work in 2017.

**I really must express OUR SINCERE gratitude for all the support and help you gave us during our traumatic time.**

**We were very fortunate to have you by our side every step of the way to guide and prepare us for the court case which we were all dreading not thinking we'd be able to get through – to think back now it was YOU who gave us all the strength to get through that difficult time. They are so young to be going through a tough and traumatic event but yet you were able to make it so much easier for them.**

**We are now stronger and looking forward for a brighter and happy future thanks to you and of course to housing officer and the others who were in the background working alongside you.**

Service user



# Safeguarding – Housing

There has been a significant increase in homelessness, temporary accommodation numbers have doubled in 5 years, this has been from a combination of factors, e.g. Welfare Reform which has resulted in more out of borough placements, in addition to population growth

## Achievements

- Housing have increased representation within the CSCB, with representatives at CSCB & QAPP, and 2 designated Housing Safeguarding Lead Officers.
- S11 audit completed, recommendations & Action Plan presented to Panel.
- Previous SCR identified lack of Housing rep at Conferences. Robust process now in place – Managers attend CP conferences, case officers attend core group – 15 Case conferences attended in 16/17. Highlighted need for Children safeguarding co-ordinator role.
- Children Safeguarding Lead officers attend DASV group to ensure joined up working.
- Managers from Tenancy & Gateway took part in CSCB audits.
- Service Head key role in 2 SCRs, and Housing Managers taking part in Practitioner Events.
- Rehousing co-ordinated for mother of Child Claire, joint working across Gateway and CSC to provide emergency accommodation, floating support and partner engagement.
- Data provided to Huddle on numbers of families.
- Identified single point of contact for MASH in Gateway.

## Areas for improvement

- How to escalate and challenge.
- Review Notify and cross borough placements – s208\* notifications.
- Tracking system for Housing safeguarding referrals.
- CSCB L&D are working with Housing Safeguarding Lead Officers and service heads across Housing to implement recommendations from SCRs and lead behavioural change– i.e. understand responsibility.
- All housing staff will attend Children Safeguarding training – thresholds etc.
- Business case for Children Safeguarding Co-ordinator role.

### \* Section 208 Housing Act 1996 Discharge of functions: out-of-area placements

- (1) So far as reasonably practicable a local housing authority shall in discharging their housing functions under this Part secure that accommodation is available for the occupation of the applicant in their district.
- (2) If they secure that accommodation is available for the occupation of the applicant outside their district, they shall give notice to the local housing authority in whose district the accommodation
- is situated.



# Safeguarding – Education

Agreed provision for an additional 1,500 primary and 4,000 secondary spaces with a further 750 spaces for children with special educational needs

## Achievements The Education Sub-group has:

Monitored the number of Children Missing from Education each quarter, with a total of 443 children reported to the Local Authority from September 16 to March 17.

Information regarding the new regulations surrounding reporting CME has been circulated to all educational establishments in the local authority.

Despite relatively high numbers of referrals there has been a significant improvement in the number of open cases.

Monitored the numbers of Electively Home Educated Children throughout the year, and the declared reasons for them becoming home educated.

Been vigilant to the possibility of Illegal schools in the Borough.

Engaged with Croydon Faiths Together to raise awareness of this issue.

No safeguarding concerns have been raised in the past year during school inspections.

More work to be undertaken with staff in educational settings about understanding and applying appropriate thresholds – 565 referrals to MASH only 278 cases were successfully allocated to a social worker which represents an uptake of just 49%.

## Areas for development

Capture more “Voice of the Child” views when considering risks and priorities for children and young people in schools, working with them to co-design solutions.

Support schools in making MASH referrals, use the Early Help pathways, to improve understanding of thresholds and support high quality referrals.

Deliver a Youth Congress in July 2017, bringing children and young people together. These will include, but are not limited to, Looked After Children, Care Leavers, children who are Electively Home Educated, pupils in special schools and PRUs, LGBT young people, uniformed organisations, Croydon Youth Arts Collective and other voluntary groups.



# Safeguarding – Children with Disabilities

## 1,720 disabled children and young people on the Disability Register

The 0-25 Service was created in April 2016 and moved under the management of Adult Social Care and All Age Disability Service on November 1st 2016. This integrated the management of SEN and social care services for disabled children and young people into one service spanning this age range in response to the SEND reforms introduced in the Children and Families Act 2014.

It created 3 age based social care teams working with disabled children and their families:

- an Early Years Team (0-7)
- a Middle Years team (8-15), and
- a Transition Team (16-25).

All these teams retained responsibility for child protection and safeguarding for the approx. 450 disabled children who meet the criteria for specialist support.

The principles behind the age based structure was to provide a more effective and accessible care pathway for children in their journey and promote closer working arrangements and alignment of agencies and professionals involved with children at particular ages of development. This would enable an earlier identification of and response to safeguarding and child protection concerns.

A learning and development plan for the new service has been implemented and delivered workshops for the service including safeguarding and child protection training. This was supported by a multiagency Action Plan arising from the findings of previous SCR's and the annual DCSs case audit in 2016.

Practice development in the service has been focused on supporting staff to develop risk identification and analysis in completing assessment and reviews, promoting the voice of the child and young person in their plan and engaging with the professional network to contribute to the development of the CIN and short break plan.

Closer working relationships have been developed with the MASH to ensure that a better shared understanding of safeguarding thresholds for disabled children has been developed. This has led to a clearer and more effective response to initial referrals and the decision to initiate S47 inquiries.

An audit for the Disabled Children Services was completed in March 2017, which it showed a greater understanding of safeguarding within the Service the need for a practice focus on identifying and recording clearer outcomes for children in promoting their welfare was identified.

A revised multiagency action and learning and development plan to safeguard disabled children has been implemented.

Currently 438 children/YP who meet the criteria for and are supported by the Children with Disabilities Social Care Service.

In the last 12 months there have been 32 Section 47 Investigations of which 16 progressed to ICPC and there have been a total of 9 children on a plan during the last 12 months. Currently there are 8 children on a plan.

This is an area of work of which the CSCB has not had effective oversight. This is a **priority area** for the 2017 Business Plan.

### Chairs Challenge

The independent Chair of the CSCB has met with managers of these services and has raised some concerns regarding the eligibility criteria, children with disability being home educated and how the voice of children with disability is captured. The Independent Chair of the CSCB has asked the All age disability service to present to the CSCB Executive.

# Safeguarding – Young Carers

All identified Young Carers are referred to the Young Carers Project (YCP) for a young carer's assessment

All identified Young Carers are referred to the Young Carers Project (YCP) for a young carer's assessment. Questions about safeguarding are raised at point of referral, harmful and inappropriate caring can take many forms and therefore, it is important to combine the screening, assessment, outcome measuring tools to get a full picture of the identified needs and concerns raised.

Page 99

Safeguarding cases are normally resolved as part of the care plan put in place for the young carer and family members – this may include liaising with schools and social care for both children and adults. If concerns are not resolved, referrals will be made to the MASH.

Ongoing cases where safeguarding remains a concern, are discussed regularly through individual support and team discussions. YCP staff work closely with Early Help and cases are escalated/deescalated to CIN and CP.

Increased partnership working has strengthened many of the opportunities available to Young Carers and their families. Increased awareness of young carers and the issues they face as well as training and clarity on referral processes.

## Areas for development

- Better communication with MASH, social care, voluntary and statutory services.
- Increased awareness of the complexity of issues facing young carers and their families.
- Increased partnership working to address the needs of the families though working with a range of services.

**Our ambition is that young carers and family members are safeguarded from harmful and inappropriate caring, as well as having the same opportunities to thrive and fulfil their ambitions as their peers.**

Young Carers Project





# Safeguarding – Missing Children

## Missing from home, missing from care

Croydon continues to have the highest number of children reported missing of any London authority. This is a total figure and it should be remembered that Croydon has the highest population of young people of any London authority. Nevertheless, this is a significant issue and is affected by the large number of looked after children placed within the Authority, both those looked after by Croydon and those placed within Croydon by other Local Authorities.

Overall, in 2016-17, there were 2,672 reports of children being missing to the police in Croydon. These referred to 574 separate individuals.

41.5% were **children looked after** by LB Croydon.

19% were **children looked after by other authorities**.

40.5% were regarding children **living at home**.

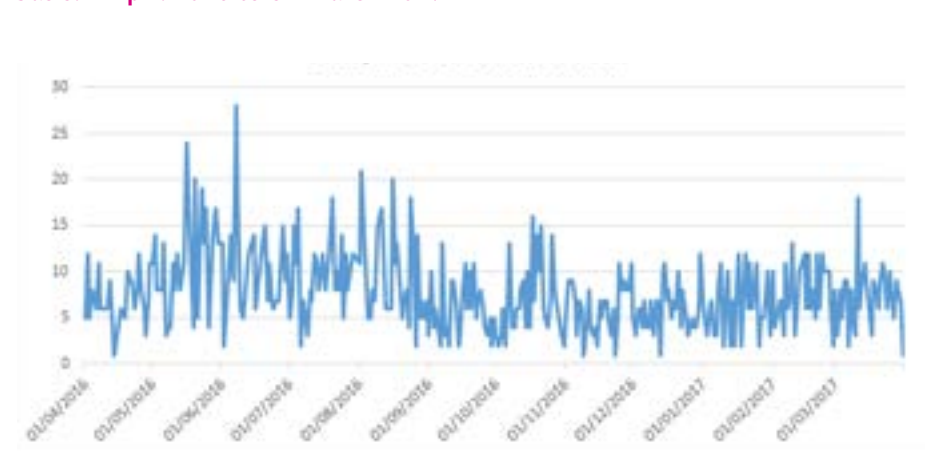
Looked after children are generally more likely to be reported as missing than children living at home. (Although there is an increased number of reports, the recording is more accurate than in previous years).

### Achievements

- Missing Children Panel meets to discuss plans for children who are reported missing and how they should be located. The panel enjoys consistent membership representing all key partners and disciplines and meets regularly with excellent attendance by both members and social workers.
- Increased resources including an analysis post has helped with data collection and analysis and to maintain a robust research methodology to the data management.

- Greater understanding of the missing profile and are more able to make links between multiple vulnerabilities such as county lines, CSE and gang involvement.
- Strengthened the join up between children missing from home/care and Children Missing from Education.
- IROs are more actively involved in the management of missing episodes – ensuring that missing strategy meetings are convened.
- We produce a daily missing report (DMR) that is sent to all managers in CSC.
- Social workers are now able to manage missing episodes within the CRS.

Total number of children starting a missing episode on a daily basis: 1 April 2016 to 31 March 2017



# Safeguarding Missing Children

## The Missing Project

The Missing Project captures the experiences and voice of young people through group sessions, focus groups and feedback forms: DATA



I feel more confident and safer. I have also learnt not to mix with the wrong group

My attitude towards boys has changed. I now know my worth, and that boys I used to go see before are not good enough

I would recommend the Missing Project to a friend... before I started it I didn't care and I would have thrown away my education, but now I want my education, it's what starts my life right and I know a lot of people that need this help

I am a completely different person after having these meetings (with my YPA), you wouldn't recognise me before and after this. I'm bright, smart, mature and beautiful

I am more confident so will make better choices

My YPA really helped me and she understood me

I would say that the Missing Project is wonderful as they help keep you safe



# Safeguarding-Missing Children

## Children Missing Education (CME)

### Key theme identified

High levels of pupil migration in and out of the borough:

- 957 CME referrals were received Sept 2015 to August 2016
- 13% of these related to children moving into Croydon
- 65% related to children identified as moving out of Croydon
- **22% were cases referred for pupils living in borough**

### Achievements

- Worked with Croydon Schools to identify early when pupils were moved abroad.
- Established partnership with the Home Office to trace children.
- Established links with other boroughs to identify if pupils leaving Croydon are resident in another LA and whether they are receiving education.
- Partnership panels in place to identify pupils out of education and to ensure they are placed in education at the earliest opportunity.
- **Missing Monday Panel** which was established in September 2015 has brought together partners to identify children missing education and provide an holistic approach to returning young people to schooling. Partners such as CSC, Early Help, CAHMS, YOS and Education Services met weekly to review cases at panel and identify actions and a lead Agency.
- **Fair Access Panel** provides a mechanism where “hard to place” pupils are found an education placement and pupils at risk of exclusion are offered a managed move to another school as an alternative. The LA operates Fair Access Panels every month with excellent attendance from Croydon schools.





# Safeguarding-Other Local Authority Children

## Areas for development

- All authorities with children placed within Croydon have been asked to update their records to give a more accurate position and a process has been established for a quarterly report.
- Currently there are 550 children placed by OLAs in Croydon. CSC has written to LAs and are collating responses. The Director of Children's Services will write again to those who have not responded and escalate further in cases where LAs are not complying with their legal responsibilities.
- Health partners have policies in place which relate to the safe and efficient transfer of information both internally and across geographical boundaries. However, systems are not always as effective as they should be and direct work is completed with practitioners when issues have been identified through audit or SCRs.
- The introduction of the Child Health Information System Hubs across London will improve sharing and co-ordination of information.
- There is still not a coordinated and agreed process for notification of children with CSE concerns placed in the Borough.
- Better join up required and some additional administrative resource is required to increase our capacity to notify other boroughs about vulnerable OLAs.

## Safeguarding Other Local Authority Missing Children

- During the year there were 98 missing episodes for children placed in Croydon by another Local Authority (57 unique individuals).
- Need to strengthen arrangements for sharing information and intelligence on children placed by other local authorities (OLA), it is a challenge to get OLA compliance.

## Other local authority missing children

19 Local Authorities	57 children with a missing episode
Barnet	2
Brent	1
Bromley	4
Buckinghamshire	1
Hackney	4
Hounslow	1
Lambeth	15
Lewisham	5
Lincolnshire	1
Merton	3
Newham	1
Nottingham	1
Reading	1
Southwark	5
Surrey	1
Sutton	1
Wandsworth	7
Westminster	2
Unknown	1

# Safeguarding-Child Sexual Exploitation

## MASE PANEL (Multiagency Sexual Exploitation Panel)

The MASE Panel brings together key professionals working with children at risk of CSE. The Panel benefits from efficient information sharing and intelligence prior to Panel meetings, enabling members to engage in joint decision making and co-ordinate responses to children at risk of CSE.

- MASE has developed a new template for gathering intelligence, in conjunction with the new analytical capacity, this has enabled intelligence briefings, profiling and data about CSE patterns in Croydon.
- Drawing on intelligence from multiagency partners to provide demographic data and analysis of patterns and behaviours, has extended the profile of survivors and perpetrators of CSE, as well as showing the links between perpetrators and survivors.
- Improved tracking of the data has enabled monthly monitoring
- There have been a number of children discharged from the protocol recently, reflecting improved safety around the young people.
- One young person stated that she now knows the risks and is no longer involved in her previous sexualised behaviour.
- In another example, the young person had physically distanced herself from her previous associates, recognising that they were not good friends, and her attendance at school has improved.
- There have also been successful outcomes in terms of charges being brought against perpetrators, including one young man (the former boyfriend of the victim), who was arrested for four counts of sexual assault against her.

### Areas for development

- Work with boys is underdeveloped.
- Every young person on the MASE protocol should have regular 6 weekly meetings with their social worker to review CSE concerns, this is occurring in very few cases, this must improve.
- There is insufficient oversight of Croydon children being monitored by other boroughs.



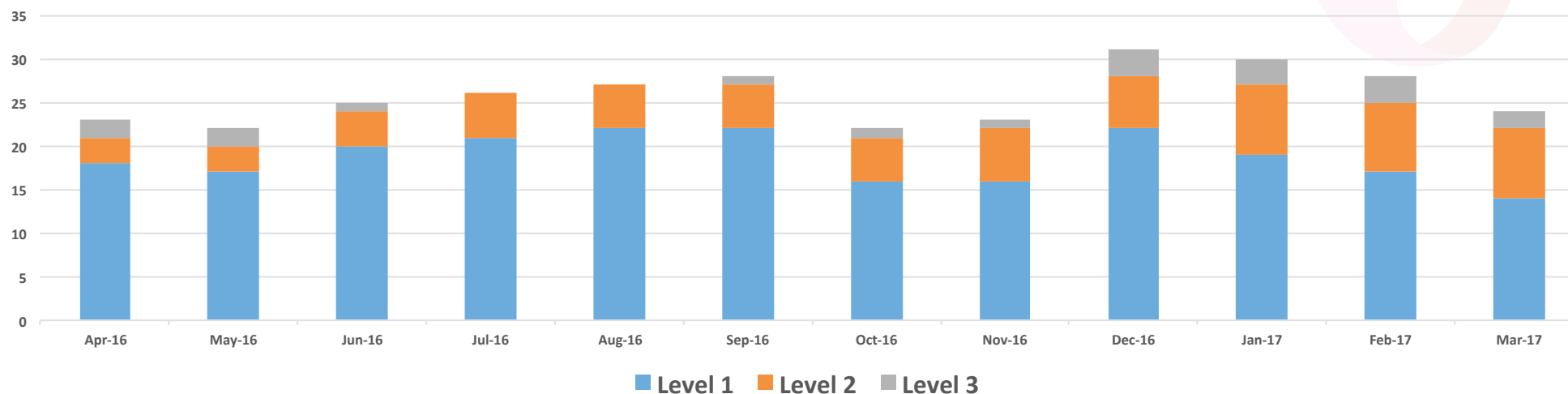


# Safeguarding-Child Sexual Exploitation

## Individuals on the MASE protocol on a monthly basis



Page 105



**Level 1** - a vulnerable child or young person, where there are concerns they are being targeted and groomed and where any of the CSE warning signs have been identified. However, at this stage there is no evidence of any offences.

**Level 2** - Evidence a child or young person is being targeted for opportunistic abuse through the exchange of sex for drugs, perceived affection, money or goods.

**Level 3** - a child or young person whose sexual exploitation is habitual, self-denied and where coercion/control is implicit.



# Safeguarding-Child Sexual Exploitation

## CSE Operations

The CSE Partnership have been jointly proactive in engaging with the community to raise awareness of CSE and with local businesses in particular to alert them to risks to children coming to their attention. In addition, there has been a drive to ensure gaining greater understanding of the risks and impact of CSE on local children. To further those aims, three separate Operations have been undertaken.

### **Operation Rosario**

Is a new innovative CSE partnership led operation. It is designed to test the understanding of staff within hotspot venues, such as hotels and provide the partnership with the vital information as to how messages and training has been received by local businesses and highlight areas to develop further knowledge and minimise the risk to vulnerable people.

### **Operation Makesafe**

This is an ongoing operation which focuses on key issues effecting CSE throughout the Metropolitan Police area. Throughout the last year Operation. Makesafe has focused on areas such as education of staff within Hotels, Schools and churches to increase the knowledge of children/young people and those working with them of the risks and signs of CSE.

### **Operation Raptor**

This is the second year this operation has been run, Croydon has led the field with this operation. The focus is to better understand the profile of CSE within Croydon, map and react to changes within the profile to ensure as a partnership we have focus on methods to engage and disrupt young people away from CSE. The operation focuses on the links between CSE, Missing, Gangs and the emerging threat of County Lines (Drug running).

### **Plans for 2017/18**

All of these Operations have been very successful and will be repeated during 2017/18. Hotels targeted during Operation Rosario are keen to be included in the future and assist with the ongoing operation, which has been agreed.



# CSE in Croydon - the Churches' Response

On November 30, 2016 over 90 Christian Church leaders gathered to consider the role of the faith community in the work around sexual exploitation of children.

Members of the Multiagency Sexual Exploitation (MASE) panel facilitated the evening. The Independent Chair of the Safeguarding Board, Sarah Baker shared in opening remarks.

The idea for the forum came out of a meeting with the Croydon Church leaders and the Council CSE Lead at their breakfast in October. That group of leaders were inspired to bring together as many church leaders to discuss how the churches could support the young people and their families in their individual congregations and develop a unified strategy amongst churches. It was an important evening as participants learned more about CSE and the current Croydon profile. There were lots of thought provoking table conversations as they grappled with how the church and youth ministry can respond the dangers of exploitation.

Many commitments were made from the churches present to work alongside the Local Authority within their churches and communities to safeguard our most vulnerable young people.





# Safeguarding – Child Sexual Exploitation

## CSE Licensing

The Council Licensing Team have been key players in the collective delivery of Operation Makesafe.

The CSCB is named in the Croydon Council's Licensing Policy as a 'responsible authority' competent to advise on matters relating to the licensing objective 'the protection of harm from children' – and to whom copies of applications should be sent.

### **Licence applications received during 2016/17 were:**

- 81 New premises applications
- 18 Full Variation premises applications

Enquiries were made of Children's Social Care records regarding all applications, but no information was considered to be of relevance under the licensing objective 'the protection of children from harm'. In all cases the subsequent information they provided was sufficient and no representations were required. There were no reviews initiated by the CSCB during the year.

Our aim from April 2017 is to contact new license applicants proactively if their premises has a particular focus on children as customers or visitors and offer advice and promote the CSCB Safeguarding Children Policy for Licensed premises.

### **Example of Progress**

In one case, a new application considered by the CSCB was regarding a premises which had a focus on arts and children as customers and visitors.

The applicant was contacted and provided with advice on safeguarding children issues and relevant local training.

They agreed to review their own safeguarding children policy in line with the CSCB Safeguarding Children Policy for Licensed Premises (which was published in March 2017).





# Safeguarding – Serious Youth Violence

Whilst overall levels of youth crime are reducing levels of serious youth violence remain high

Page 109

- The vast majority of youth crime is peer on peer and as a result Croydon has a high number of young victims of crime.
- Increased focus to reduce and protect young people at risk of violence (knife crime and robberies) as the majority of this cannot be attributed to gangs or known gang members.
- The numbers of young people coming to the attention of YOS in 2016/17 was around 600 young people compared to 670 in 2015/16. This represents 2% of the total 10 to 17 year old population.
- The average age is 16/17 but we have a small but significant number of 13/15 year olds involved in serious offending.
- The gang partnership team have been working with 14 – 25 year olds and 25% have successfully exited gangs in 2016/17.
- Overall 80% are male with 65% from a BME background.
- The average length of an order remains between 9 and 12 months.
- There has been a reduction in custody numbers from 42 to 33 young people sentenced to custody and between 30 and 40 young people involved in gangs.
- Croydon YOS has the highest volume of offences in London at 1000 plus offences.

## The main offences in 2016/17 were:

- **Violence against the Person** 32% (including robbery and possession of knives).
- **Drugs offences** 14% (increase “County lines” activity).
- **Theft** 10%

- **Criminal damage** 7%
- **Public order** 6%
- **Sexual offences** 1.5% – small numbers but increasing number of young men involved in harmful and inappropriate sexual behaviours.

There is a strong correlation between young people who offend and those who are at risk and vulnerable. Young people known to the YOS have increased in complexity and risk with 60% of cases assessed as intensive or enhanced levels of risk and/or vulnerability.

## Based on an analysis of young people assessed by YOS in 2016/17 the following risk factors were present:

- Entrenched behaviours in families: low investment in education, family conflict and the absence of an adult providing boundaries, advice, discipline and support.
- A criminal family member, domestic abuse
- Significant need-many families & children are often already known or previously known to mainstream/statutory services prior to offending.
- About a third have a mental health problem
- ADHD, SEN and Speech and Language issues
- Homelessness or in unsuitable accommodation
- At risk of school failure through truancy/school refusal or exclusion.
- Post 16 young people are not engaged in education, training or employment.



# Safeguarding—Young People involved in County Lines

- “County line” describes a situation where a person, or more frequently a group from an urban area crosses one or more police boundaries to a more rural or “County” force, setting up a secure base to conduct day-to-day drug dealing. The gangs groom vulnerable young people aged 13 upwards promising vast amounts of cash and place them often in a drug addict’s home in the chosen location/ market. This young person will then deal crack and heroin for periods ranging from days to weeks. These young people will often come to attention via missing reports. If found and or arrested they will rarely talk to professionals about their experience.
- As a partnership we are aiming to establish a protocol that treats these young people as victims of Exploitation and Human Trafficking rather than perpetrators of drug dealing. The issue of county lines has emerged as a significant issue in the last 12 months and cuts across many areas such as Gangs, Missing from Education and CSE.

## Achievements

- The main location for Croydon young people engaging in county lines has been identified in Portsmouth and the wider county of Hampshire as a pilot location
- An intelligence sharing arrangement has been set up whereby intelligence packs are shared 6 weekly, followed by a teleconference between Hampshire police, YOS and Gangs and our equivalent’s here.
- This joint approach enables each to spot trends, agree enforcement and provide safeguarding.
- Young people arrested for drug dealing in known county lines locations have been referred to the National Referral Mechanism in relation to child trafficking. This has proved challenging as the outcomes have led to a variety of issues including the CPS not pursuing prosecution at short notice, and the ability to safeguard those young people.

- Effective liaison with Trident Command and Croydon has been established and the first case before the criminal court where the perpetrators have been charged under trafficking legislation, the outcome is awaited.
- Croydon Gangs Team have delivered training on gangs and county lines to the two YOS teams in Hampshire as well as to the Portsmouth and Southampton police intelligence teams.
- A MOPAC Local Assessment Process (LAP) was completed in March 2017 which highlighted good practice around county lines, gangs and vulnerability across the professional network. The findings were fed back to the Croydon Youth Crime Board
- Gangs training including a Section on county lines has been delivered four times in the year with positive feedback.

## Youth Offending Service priorities 2017/18

- Improved partnership working to reduce and protect young people at risk of violence (knife crime and robberies), sexual exploitation, gangs and County Lines
- To reduce and protect young people at risk of serious youth violence and exploitation
- Reduce the numbers of young people re-offending
- Improved identification and targeting of young people involved in gang activity and provide opportunities and support to exit gangs
- To improve post 16 ETE performance
- To contact and engage all identified victims of crime to offer relevant support and the opportunity to engage in direct or indirect restorative interventions.

# Safeguarding Children

## Female Genital Mutilation (FGM)

In Croydon, there are estimated to be 3,480 females who have been affected by FGM at some point in their lives, equivalent to 1 in 104 females.

It is estimated that 3% of maternities in Croydon are to women affected by FGM, this equates to around 200 births per year. Croydon has been leading a whole systems approach to FGM prevention, protection and support.

### Achievements

- In March 2016, the Croydon FGM Risk Assessment Tool and Referral Pathway was officially launched, and is now being used successfully across the multiagency partnership.
- Sutton and Islington local authorities are now using the same tool and the US Federal Government also requested permission to amend the tool for use in the USA.
- The tool is recommended as an example of good practice by the Home Office, London Councils and NHS England to local authorities across London and nationwide.
- Awareness raising events have included an FGM Conference, House of Commons Exhibition, professional pledges, wear a badge/lanyard for FGM.
- Close working with Croydon police has resulted in a pilot using FGM Protection Orders as a proactive prevention tool.
- The Monthly FGM Community Support Group was launched in December 2015 with 10 regular attendees.
- FGM is discussed with all pregnant women and parents via Midwives, Health Visitors and School Nurses.

- There is a fast track Mental Health Pathway for FGM survivors.
- There is an Accredited Community FGM Advocacy Programme delivered by a local FGM Charity.

### Safeguarding Children – FGM – Achievements

**2,500** children received lessons on FGM

**2,000** professionals trained in FGM risk assessment, identification and procedures

**67** safeguarding leads received specialist training

**12** schools received whole staff training





# House of Commons FGM Exhibition

Croydon presented an exhibition of Art at the House of Commons with the Artist and some of the women FGM survivors who had sat for the paintings

Page 112

**Very inspirational and heart felt. Provided positive meaning to what we do. Women were very courageous to share their stories. Will always remember and factor this into what we do as an organisation.**

**This is a wonderful exhibition of FGM warriors – with powerful speeches about FGM.**

**As a survivor it is never easy to tell your story but knowing it will help another woman is all worth it.**



# Safeguarding Children

## Modern Slavery

Modern slavery is a complex crime that takes a number of different forms. It encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment. Victims may be sexually exploited, forced to work for little or no pay or forced to commit criminal activities against their will. Victims are often pressured into debt-bondage and are likely to be fearful of those who exploit them, who will often threaten and abuse victims and their families. All of these factors make it very difficult for victims to escape.

Page 113

### Achievements

- The Modern Slavery sub-group developed an Action Plan linked to the 4-Ps strategy:
  - PURSUE** Prosecuting and disrupting individuals and groups responsible for modern slavery.
  - PREVENT** Preventing people from engaging in modern slavery.
  - PROTECT** Strengthening safeguards against modern slavery by protecting vulnerable people from exploitation and increasing awareness of and resilience against crime.
  - PREPARE** Reducing the harm caused by modern slavery through improved victim identification and enhanced support.

### Concerns

- Concerns for 28 children with Modern Slavery in 16/17.
- 16 Children with Modern Slavery concerns at 31 March.

### Areas for development

The JACS have agreed to review progress and future direction of the Modern Slavery agenda.

### Supporting foster carers of child victims of human trafficking and modern slavery: Croydon pilot for Albanian & Vietnamese UASC

Croydon is one of the UK's local authorities with highest numbers of children identified as Victims of Human Trafficking and Modern Slavery being referred into care, with children from Albania and Vietnam making up the majority of all cases.

In common with many other local authorities across London and the UK, Croydon faces issues with these children going missing from care. This project therefore proposes a new approach to supporting the foster carers who receive these children, and the children themselves, to reduce the likelihood of their going missing.

The pilot project aims are: to increase the confidence and capacity of foster carers and social workers to look after children survivors of modern slavery, including with specific cultural information on Albania and Vietnam; and secondly, to directly support UASC who have been trafficked or are at risk, by developing effective and culturally tailored information to improve their understanding of foster care, the support offered and the risks of leaving care.

The involvement of International Organisation for Migration (IOM). Albanian and Vietnamese country offices will also contribute to a greater understanding of the context that these youth are coming from and enhance cultural awareness for foster carers.





# Safeguarding Children

## MAPPA (Multiagency Public Protection Arrangements)

The MAPPA are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. The requirement is that the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. This is done by way of a monthly MAPPA Panel.

- However the continued levels of high volume and the demand upon all the agencies involved means that managing the risks of the individuals concerned is becoming increasingly challenging.

Page 114

- The MAPPA Panel discusses on average 8-10 cases per month.
- Croydon MAPPA has reviewed 105 Level 2 cases in 2016/17, this is a significant increase on the 76 cases reviewed in 2015/16. Many of the Level 2 cases are discussed over several months due to the complexities and risks involved that are inherently linked to issues over housing and accommodation.
- There have been two or three level 3 cases this year.
- MAAPA made a referral to the SCR sub-group to undertake a Review on case where a man with a conviction of Manslaughter and sentenced to a Hospital Order because of a psychiatric diagnosis was released into the community without reference to and the knowledge of MAPPA.
- The SCR sub-group agreed to undertake a Learning Review, and the issues it raised have resulted in an improvement in early referrals from SLAM and other MH agencies
- We are seeing an increase in the youth cases being referred into MAPPA which does reflect the increase in anxiety surrounding serious youth violence in Croydon at the moment.
- In general the agencies involved in the Croydon MAPPA are fully engaged and can identify and present risk in a coherent way which assists the process in managing the risks involved.

### Level 1

Ordinary Agency management is for offenders who can be managed by one or two agencies (e.g. Police and/or Probation). It will involve sharing information about the offender with other agencies if necessary and appropriate.

### Level 2

Active multiagency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multiagency public protection meetings about the offender.

### Level 3

Same arrangements as level 2 but cases qualifying for level 3 tend to be more demanding on resources and require the involvement of senior people from the agencies, who can authorise the use of extra resources. For example, surveillance on an offender or emergency accommodation.



# Safeguarding Children

## Preventing Radicalisation

We are not a designated priority borough – however Croydon is a pilot borough for the Home Office’s Dovetail project (one of only two in London) which looks to transfer much of the administrative side of Channel to the local authority, funding has been provided to employ a Local Authority Channel Coordinator.

Anti-radicalisation activity is delivered in line with the National Prevent strategy is focussed on the **Channel process**.

### Achievements

- Channel takes referrals of people of all ages identified as being at risk of radicalisation and seeks to keep them from engaging in activity that could be deemed criminal.
- Channel meets monthly (as well as having occasional emergency panel meetings) and in the year 2016/17 considered four child referrals (three males, one female). Three were exited from the process as not being at risk, but enquiries continue around one boy.
- There was also the continuing oversight of one family, the father having been convicted and imprisoned for exposing one child to beheading videos.
- 52 Workshops to Raise Awareness of Prevent (WRAP) training sessions delivered in 2016/17.
- 32 of these were delivered to schools and colleges, in addition to presentation to school assemblies.
- Was a priority to the JACS committee and led to joined-up thinking and planning cross adults and children.

### Impact

Number of discussions with schools regarding concerns about the behaviour of certain pupils. Whilst the outcome has been that the behaviour is not presenting any radicalisation or counter-terrorism related risk, it does indicate that as a result of WRAP training schools are aware of the process and are prepared to use it.

### Areas for development

- Increase training – Monitoring impact.
- Operation Dovetail.
- Channel Panel protocol being developed.

The CCG safeguarding team were successful in a bid to NHSE London in 2016 for funding to support Prevent awareness training in primary care with a child and adult safeguarding perspective.







# Learning and development



# Learning & Development Summary Review 2016/2017

This is a summary version, the full CSCB Learning and Development 16/17 Report is available at [www.croydonlscb.org.uk](http://www.croydonlscb.org.uk)

The 2016/17 learning and development programme was developed in response to known local safeguarding learning needs as identified through audit and serious case reviews. A mixture of face to face events and e-learning was provided.

## 2016/17 courses

The learning and development programme is on offer to those who work with children and families within Croydon. The face to face learning events delivered included:

- Domestic Abuse.
- Early Help.
- Critical Thinking in Assessments.
- Child Sexual Exploitation.
- Engaging Fathers.
- Families Affected by Child Sexual Exploitation.
- Female Genital Mutilation.
- Gangs.
- Level 3 Safeguarding.

- Missing Children and Young People.
- Parental Mental Health.
- Parental Substance Misuse.
- Preparing Men for change (working with domestically Violent Men).
- Prevent.
- Safer Organisations.
- Serious Case Review Briefings.
- Young People Substance Misuse.

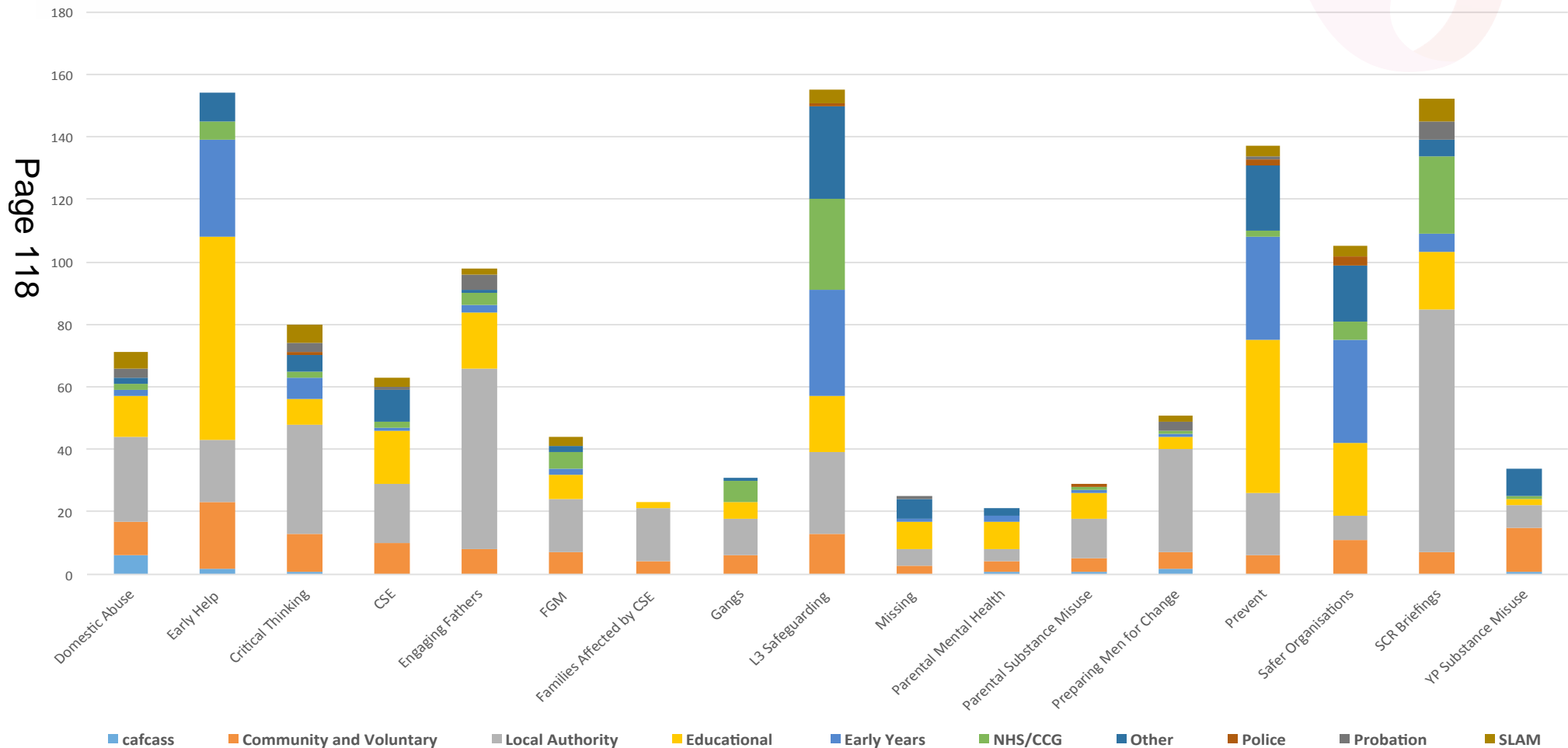
## Agency Engagement with Learning and Development

Engagement with the learning events has been positive with a range of organisations and different setting types attending the training. See attendance Chart.



## Learning & Development Summary Review 2016/2017

# 2016/17 Attendance by Course and Setting Type





## Learning & Development Summary Review 2016/2017

### Overall attendance

- During 16/17 there were 1,329 attendees at face to face learning events.
- Compared to 15/16 attendance rates, 16/17 attendance was 34% lower than 15/16 attendance (2002). There are a number of possible factors as to why attendance was lower during this period including:
  - Workload pressures restricting staff's ability and willingness to attend, and also workplace pressures restricting the release of staff.
  - Core content was similar to 15/16 therefore we would not expect practitioners to attend same courses each year.
  - Changes in the booking system may have resulted in some practitioners choosing not to create an account. If unable to create an account, support and guidance is provided.
  - Overall recruitment and attrition rates across the Borough are unknown which makes it difficult to reasonably estimate expected rates.
  - Additionally, 15/16 was the first full year of current learning and development operations, 16/17 being the second, therefore benchmarking for attendance data will be more effective in 17/18.

### 'No Show' Rates

- As identified in the previous year, there continues to be an issue with delegates booking for an event but failing to attend without prior cancellation. Where delegates fail to attend this can adversely impact the structure of the event planned, the quality of the shared learning and may even lead to the event being cancelled at very short notice, including on the day if insufficient number of delegates fail to arrive. Overall 23% of all those booked onto a training session failed to attend the event.

- Of particular concern is attendance for Parental Mental Health and Parental Substance Misuse. Both of these issues are common features in local and national Serious Case Reviews - therefore more needs to be done to raise the profile of these issues as core to safeguarding practice and for practitioners to develop their awareness, knowledge and skills in working with families where parental mental health and parental substance misuse feature.
- The issue of 'no shows' has been included for in the 17/18 Learning and Development Business Plan.





## Learning & Development Summary Review 2016/2017

### E-Learning courses 16/17

The CSCB supports e-learning as a route by which safeguarding learning can be easily accessed by a range of professionals and volunteers. The CSCB currently commissions four e-learning courses (below) and actively promotes other e-learning which supports or contributes to safeguarding children (e.g. domestic abuse, information sharing). There has been a continued increase in course registrations and completions.

Course	Number of successful completions 2015-16	Number of successful completions 16-17	% Increase in completions
Safeguarding Children (L1)	919	<b>1,647</b>	<b>79% (+728)</b>
Safeguarding Children (L2)	444	<b>805</b>	<b>81% (+361)</b>
CSE (L1)	26 (purchased late in the year)	<b>237</b>	<b>811% (+211)</b>
CSE (L2)	21 (purchased late in the year)	<b>197</b>	<b>838% (+176)</b>

Course	Number of successful completions 2015-16	Number of successful completions 16-17	% Increase in completions
<b>Total</b>	<b>1,410</b>	<b>2,886</b>	<b>104% (+1,476)</b>

Evaluations of the E-Learning courses completed shows that overall the vast majority of those who completed the courses online have found the courses interesting, that they have improved their awareness and knowledge of the subject and will be able to apply the knowledge gained from the course to their day to day working.



The learning and development programme and priority planning areas for 2017-18 has been informed by the current Board priorities and full CSCB L&D 2016-17 report. The full CSCB L&D Report 16/17, the Learning and Development Strategy 2017-19 and the 2017-18 Learning and Development programme can be viewed on the Learning and Development page of the CSCB website.



## Learning & Development Summary Review 2016/2017

The current rate of completed surveys is an average of 59%. Whilst the data from completed surveys does not fully represent the views and experiences of all delegates, there is sufficient data to consider it significant.

During this period only post training surveys were undertaken. It is therefore recognised that the current evaluation surveys provide only limited insight into the application of the transfer of learning into practice.

The delegates intended shift in practice is captured but during this period there has been no activity to assess and evidence if delegates actually shifted their practice, this is to be addressed in 17/18.



### Serious Case Review Briefing

- Being more curious and vigilant
- Avoid making assumptions about a child's safety
- Ensuring that the child is seen alone
- Improving the presence of the child's voice in assessment and decisions
- Being more alert to the challenges of cross borough cases
- Improving communication and information sharing

### Level 3 Safeguarding

- Ensuring professional challenge and escalation are used where needed
- Being more vigilant and keeping child's needs central
- Understanding safeguarding responsibilities and roles
- Better joint working



# Priorities for 2017 onwards





# Business Plan Priorities 2017 onwards

The CSCB develops and leads a strong partnership to deliver the safeguarding agenda across Croydon in line with statutory guidance. Partners understand and comply with their statutory responsibilities

## Neglect

Children at risk of neglect are seen, **heard** and helped.

They are effectively protected from harm of neglect by a robust and coordinated multiagency intervention and support.

### CSCB Action

To work with partners to develop and deliver a comprehensive strategy that tackles Neglect and evaluate the impact on children and young people.

## High risk vulnerable adolescents, with a focus on:

- Understand the concept of risk taking
- The impact of early maltreatment: the relationship between childhood experiences and adolescent risk-taking
- Risk factors for anti-social and offending behaviours
- Building resilience

### CSCB Action

Develop a robust and co-ordinated multiagency intervention and support.

## Early Help

Children receive effective early help and appropriate interventions when needs are identified.

### CSCB Action

To evaluate the effectiveness of early help arrangements across Croydon.

## Children with Disabilities

Children with disability are seen and **heard**. They are effectively protected from harm by a robust and coordinated multiagency intervention and support.

### CSCB Action

To work with partners to develop and deliver a comprehensive strategy for children with disability and evaluate the impact on children with disability.



# Glossary



# Glossary

<b>ADHD</b>	–	Attention Deficit Hyperactivity Disorder
<b>BME</b>	–	Black and Minority Ethnic
<b>CAFCASS</b>	–	Children and Family Court Advisory and Support Service
<b>CAMHS</b>	–	Child and Adolescent Mental Health Service
<b>CCG</b>	–	Clinical Commissioning Group
<b>CIN</b>	–	Children In Need
<b>CLT</b>	–	Children’s Leadership Team
<b>CME</b>	–	Children Missing Education
<b>CP</b>	–	Child Protection
<b>CPC</b>	–	Child Protection Conference
<b>CPS</b>	–	Child Prosecution Service
<b>CRS</b>	–	Croydon Recording System
<b>CSC</b>	–	Children’s Social Care
<b>CSCB</b>	–	Croydon Safeguarding Children Board
<b>CSE</b>	–	Child Sexual Exploitation
<b>CYP</b>	–	Children and Young People
<b>DASV</b>	–	Domestic Abuse & Sexual Violence
<b>DCLG</b>	–	Department for Communities and Local Government
<b>DCS</b>	–	Director of Children’s Services
<b>DoH</b>	–	Department of Health
<b>EEA</b>	–	European Economic Area
<b>EH</b>	–	Early Help
<b>ETE</b>	–	Education, Training & Employment
<b>FGM</b>	–	Female Genital Mutilation
<b>HEE</b>	–	Health Education England
<b>HLP</b>	–	Healthy Living Partnership
<b>HV</b>	–	Health Visitor
<b>ICPC</b>	–	Initial Child Protection Conference
<b>IDVA</b>	–	Independent Domestic Violence Advocate
<b>IOM</b>	–	International Organisation for Migration
<b>JACS</b>	–	Joint Adults & Children Safeguarding
<b>LAC</b>	–	Looked After Child
<b>LADO</b>	–	Local Authority Designated Officer
<b>LGBT</b>	–	Lesbian, Gay, Bisexual and Transgender
<b>MAPPA</b>	–	Multi Agency Public Protection Arrangements
<b>MARAC</b>	–	Multi Agency Risk Assessment Conference
<b>MASE</b>	–	Multi Agency Sexual Exploitation Panel
<b>MH</b>	–	Mental Health
<b>MoJ</b>	–	Ministry of Justice
<b>MOPAC</b>	–	Mayor’s Office for Policing and Crime
<b>NHS</b>	–	National Health Service
<b>NRPF</b>	–	No Recourse to Public Funds
<b>PF</b>	–	Private Fostering
<b>POMSIC</b>	–	Prevention of Modern Slavery in Children
<b>PRU</b>	–	Pupil Referral Unit
<b>QA</b>	–	Quality Assurance
<b>QAPP</b>	–	Quality Assurance, Policy and Practice
<b>RHI</b>	–	Return Home Interview
<b>SEN</b>	–	Special Educational Needs
<b>SEND</b>	–	Special Educational Needs and Disabilities
<b>SIDS</b>	–	Sudden Infant Death Syndrome
<b>SLAM</b>	–	South London and Maudsley
<b>SN</b>	–	School Nurses
<b>UASC</b>	–	Unaccompanied Asylum Seeking Children
<b>YCP</b>	–	Young Carers Project
<b>YOS</b>	–	Youth Offending Service
<b>YOT</b>	–	Youth Offending Team
<b>YPA</b>	–	Young Person’s Advocate



You can read more about the Croydon Safeguarding Children Board and the business unit at:

**[www.croydonlcsb.org.uk](http://www.croydonlcsb.org.uk)**

### **Approval process**

This annual report is published in accordance with the guidance from Working Together 2015. This report has been approved by CSCB members at the Board meeting May 2017 and subject to scrutiny at the Croydon Overview and Scrutiny Committee.

The report is received by the Chief Executive of Croydon Council, the Leader of Croydon Council, the Local Police and Crime Commissioner and the Chair of the Croydon Health and Wellbeing Board, in addition to a number of other forums. Link to Working Together 2015.

# Agenda Item 6

For general release

<b>REPORT TO:</b>	<b>Children &amp; Young People Scrutiny Sub-Committee 28 November 2017</b>
<b>SUBJECT:</b>	<b>Missing Children statistics</b>
<b>LEAD OFFICER:</b>	<b>Barbara Peacock Executive Director (People)</b>
<b>PERSON LEADING AT SCRUTINY COMMITTEE MEETING:</b>	<b>Philip Segurola Interim Director, Early Help and Children's Social Care</b>

<b>ORIGIN OF ITEM:</b>	The Sub-Committee agreed at its previous meeting to consider statistics on missing children in the borough
<b>BRIEF FOR THE COMMITTEE:</b>	To consider trends in children going missing and attending Return Home Interviews (RHIs).

## 1. EXECUTIVE SUMMARY

1.1 At its meeting on 17 October 2017, the Children and Young People Scrutiny Sub-Committee resolved that the following meeting should include an item on statistics relating to children going missing in the borough and the number of Return Home Interviews carried out on their return.

1.2 These statistics are set out in Appendix A of this report.

---

**CONTACT OFFICER:** Ilona Kytomaa, Member Services Manager

**BACKGROUND DOCUMENTS:** None

This page is intentionally left blank

## Missing Children – Data Briefing – 14<sup>th</sup> November 2017

This briefing note sets out the key data for missing children in Croydon. There are five key areas which are looked at month by month –

- **No of children who went missing** – this is the number of children who went missing from home or care during the month; if a child goes missing more than once in a month, they will only be counted once
- **No of children with RHI done** – this is the number of children who had a return home interview (RHI) done during the month; there may be children with more than one RHI in a month
- **No of missing episodes** – this is the total number of all missing episodes which happened during the month – a single child may have multiple episodes and each would be counted
- **No of RHIs done** – this is the total number of return home interviews which are done in a month; a child may have more than one RHI per month and each would be counted
- **% of episodes with RHI** – this is the % of episodes which have an RHI, the higher the better for this figure

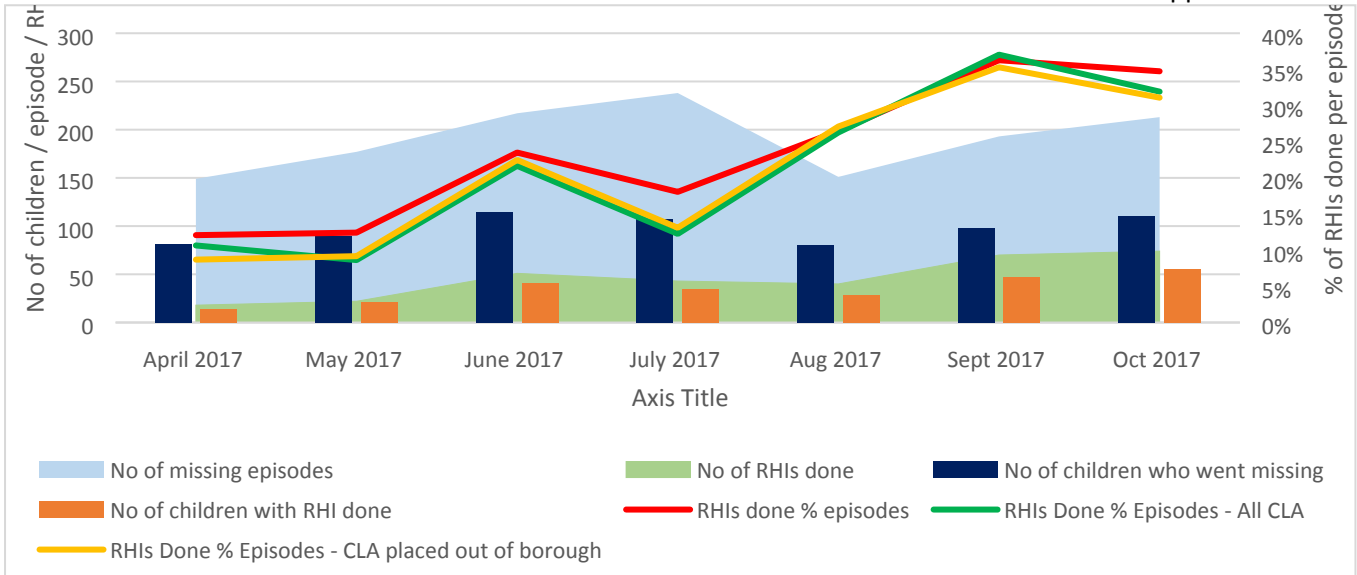
This new reporting methodology and improvement in our recording practice to capture all missing episodes, means information previously provided differs slightly (including information included in the 903 return to DfE) from the new dataset.

**Important note** – the figures below do not include OLAs (children who are looked after by another Local Authority), as it is not the responsibility of Croydon to carry out the RHI

The table and graph below show the data for April 2017 to September 2017 -

	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17
<b>No of children who went missing</b>	81	90	115	107	80	98	110
<b>No of children with RHI done</b>	14	21	41	35	29	47	56
<b>No of missing episodes</b>	149	177	217	238	151	193	213
<b>No of RHIs done</b>	18	22	51	43	40	70	74
<b>RHIs done % episodes</b>	12.08%	12.43%	23.50%	18.07%	26.49%	36.27%	34.74%
<b>RHIs Done % Episodes - All LAC</b>	10.66%	8.63%	21.67%	12.25%	26.28%	37.04%	31.93%
<b>RHIs Done % Episodes - LAC placed out of borough</b>	8.70%	9.17%	22.48%	13.10%	27.10%	35.29%	31.09%





Whilst the trend for the number of children who went missing and the number of missing episodes remains relatively flat for the period, the trend for the number and percentage of RHIs being done are on a generally upwards trajectory, reflecting the focus and attention that this area has been given. The plan is that LAC who are placed out of borough will have arrangements made when they are being placed with local providers so that any return interviews can be 'spot' purchased. All return information will then be forwarded to the allocated social worker.

An update report on the impact of the newly implemented missing team will be provided to Children's Scrutiny Panel in March 2018.

**For general release**

<b>REPORT TO:</b>	<b>Children and Young People’s Scrutiny Committee</b>
<b>SUBJECT:</b>	<b>Use of pre-birth assessment and legal planning to support early permanency decision making</b>
<b>LEAD OFFICER:</b>	<b>Barbara Peacock, Executive Director, People</b>
<b>CABINET MEMBER:</b>	<b>Councillor Flemming</b>
<b>PERSON LEADING AT SCRUTINY COMMITTEE MEETING:</b>	<b>Philip Segurola, Director of Early Help and Children’s Social Care</b>

<b>ORIGIN OF ITEM:</b>	This item was added to the work programme for this sub-committee at its 17 October meeting.
<b>BRIEF FOR THE COMMITTEE:</b>	To outline current practice in relation to use of pre-birth assessments and legal planning processes to secure early permanency decisions, and identify actions to improve outcomes for children

## **1. EXECUTIVE SUMMARY**

- 1.1 The recent Ofsted inspection (June – July 2017) identified that early permanency planning for babies and young children is not ambitious or assertive enough to ensure that a range of permanence options are considered and pursued. The use of Public Law Outline (PLO) was not fully embedded and numbers of cases in pre-proceedings were low. Inspectors commented that contingency and parallel planning for vulnerable babies, including those subject to pre-birth assessment are often not evident and which leads to avoidable delays for children when a preferred care plan, such as a family care arrangement, proves to be unviable.
- 1.2 One of the cases escalated by the Ofsted inspectors under Annex H related to the very young child of a care leaver. No assessment of the baby’s needs had been undertaken and despite the vulnerability of the mother, there was no clear plan in place to safeguard her child or clarify her support needs.
- 1.3 A second Annex H case related to a baby aged 3 weeks at the time of the inspection. His mother has learning disabilities and is unable to care for her three older children, all of whom live with their respective fathers. A child protection conference and legal planning meeting were held prior to birth and legal proceedings were instigated following a premature birth; the child was made subject to an interim care order. The inspector’s concern was that parallel planning for adoption and use of the Public Law Outline (PLO) prior to birth was not in place.

1.4 Recommendations relevant to this areas of practice are as follows:

1.4.1 **Recommendation 6.** Ensure that thresholds are rigorously applied at all levels, including care thresholds and the timely and proportionate use of the pre-proceedings phase of the PLO, so that children who cannot live with their parents find permanent alternative homes as quickly as possible.

1.4.2 **Recommendation 8.** Review the roles and responsibilities of managers at all levels in relation to decisions about children’s permanent care, to ensure that they are confident and competent enough to make these decisions. Establish robust tracking processes to ensure that plans are progressed and delay is minimised.

1.4.3 **Recommendation 9.** Ensure that there is routine and comprehensive oversight of all decisions and actions relating to children who are subject to pre-proceedings or court proceedings, to eliminate all avoidable delay in deciding permanent arrangements for children.

1.5 This paper summarises:

- the current performance data in relation to use of pre-birth assessment
- current use of PLO
- recent audit activity to test the quality of work in this area
- current partnership working
- emerging themes and challenges
- the practice development work which has been undertaken to date to address the identified challenges and associated actions with timescales
- the impact of good, early permanency planning for our most vulnerable babies illustrated through case examples.

## **2. Current performance in relation to pre-birth assessment and use of PLO**

### **2.1 Pre-Birth Assessments**

2.2 There were 2,095 assessments carried between April 2017 and September 2017, of which 86 were pre-birth assessments. This represents 4% of the total assessments. Of these assessments 26 (30%) resulted in no further action (NFA), although this includes cases stepped down to early help services which the system does not currently report on. The average duration of the assessment was 28 days.

2.3 17 parents of these unborn children have been a subject of a previous referral and 7 of these parents were open cases to the service at the time of the pre-birth assessment (open between 02/02/2015 and 30/06/2017).

2.4 5 of these parents are currently allocated to care planning & permanence teams, 1 is allocated to the leaving care team and 1 to the assessment team.

### **2.5 Summary Tables on pre-birth assessments**

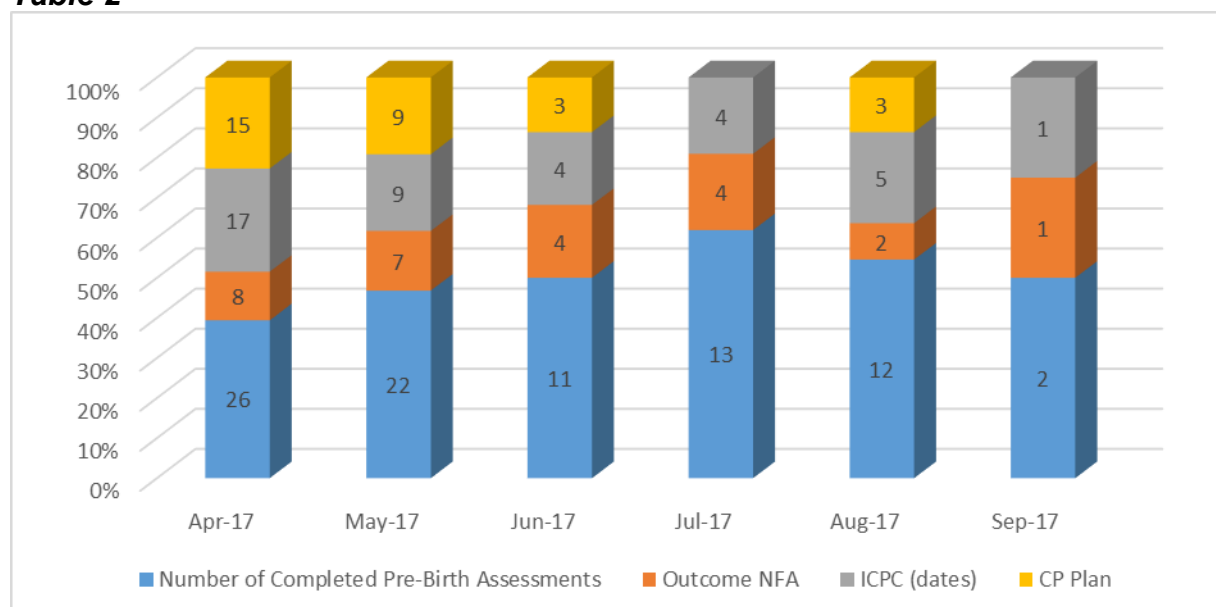
#### **Table 1**

*Please note that the numbers are based on the completed assessments. The September figure is low as some*

assessments started in September are yet to be completed.

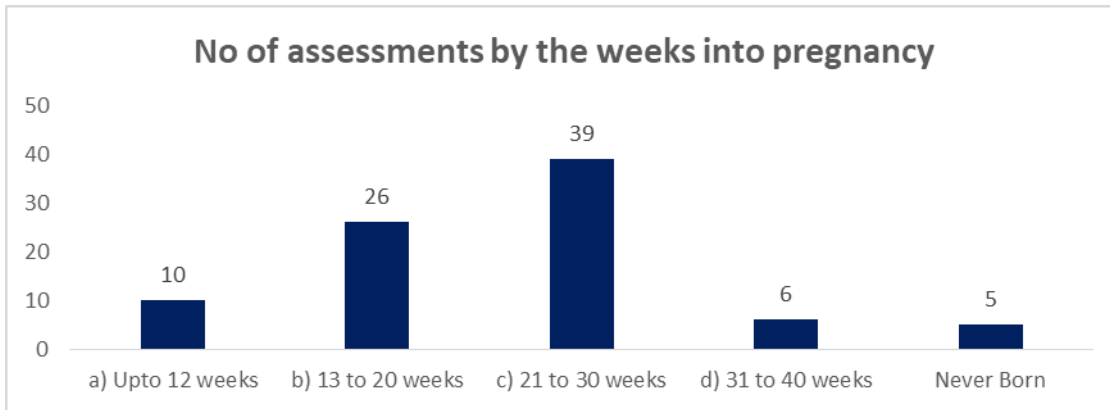
Month of Assessment start	Number of Completed Pre-Birth Assessments	Outcome NFA/early help	ICPC	CP Plan
Apr-17	26	8	17	15
May-17	22	7	9	9
Jun-17	11	4	4	3
Jul-17	13	4	4	
Aug-17	12	2	5	3
Sep-17	2	1	1	
<b>Total number of pre-birth assessments</b>	<b>86</b>	<b>26</b>	<b>40</b>	<b>30</b>
% based on total pre-birth assessments		30%	47%	35%

**Table 2**



- 2.6 47% of assessments progressed to an initial child protection conference (30 of these have gone on to become subject to a CP plan). Average time taken from assessment to Initial Child protection Conference (ICPC) is 33 days.
- 2.7 The contributing factors were recorded for 70% of these pre-birth assessments. 29% of these recorded domestic violence, 24% mental health & 62% alcohol or drug misuse.
- 2.8 12% of assessments were carried out in the first 12 weeks of pregnancy. 7% of assessments were carried out in the last 10 weeks of pregnancy.

**Table 3**



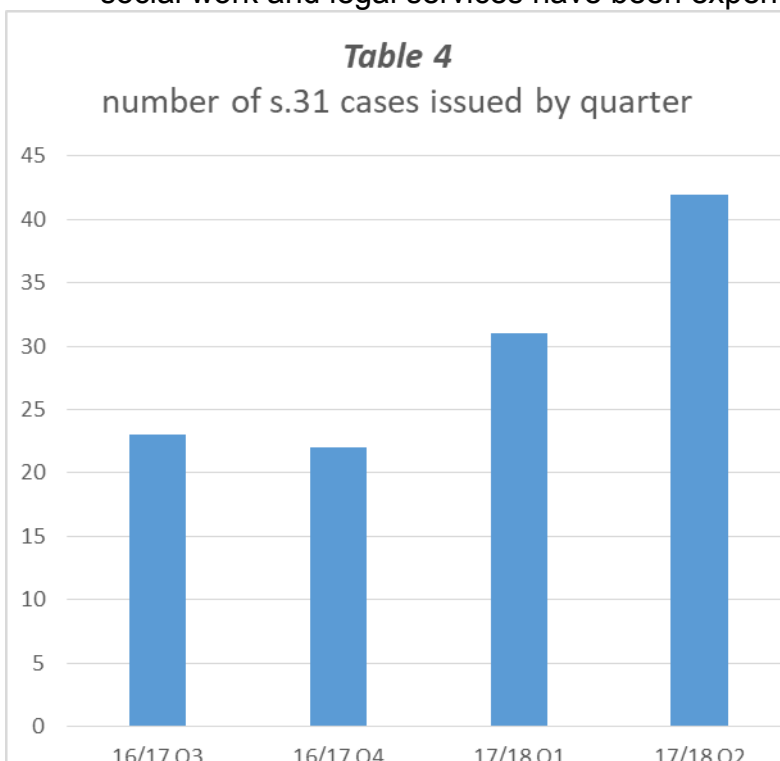
## 2.9 Use of Care Proceedings and pre-proceedings April to September 2017

### 2.9.1 Care proceedings

2.9.2 As of end October there are 98 cases (a case is a family which may include one or more children) within s.31 care proceedings; this is approximately 24% higher than the average taken over the 12 months prior to the Ofsted inspection. There are a further 6 cases which are anticipated to be issued in the next 10 days.

2.9.3 The reasons for this increase relate to a more robust review of thresholds for proceedings at legal planning meetings, including those cases which have progressed through pre-proceedings and no progress has been made, as well as some continued legacy cases which had been subject to previous drift and have now been proactively moved forward into proceedings. There has also been a significant number of new-borns (see table below).

2.9.4 The bar chart below reflects the increase in number of applications, by quarter over the last 12 months. This correlates to the increased pressure that the social work and legal services have been experiencing.

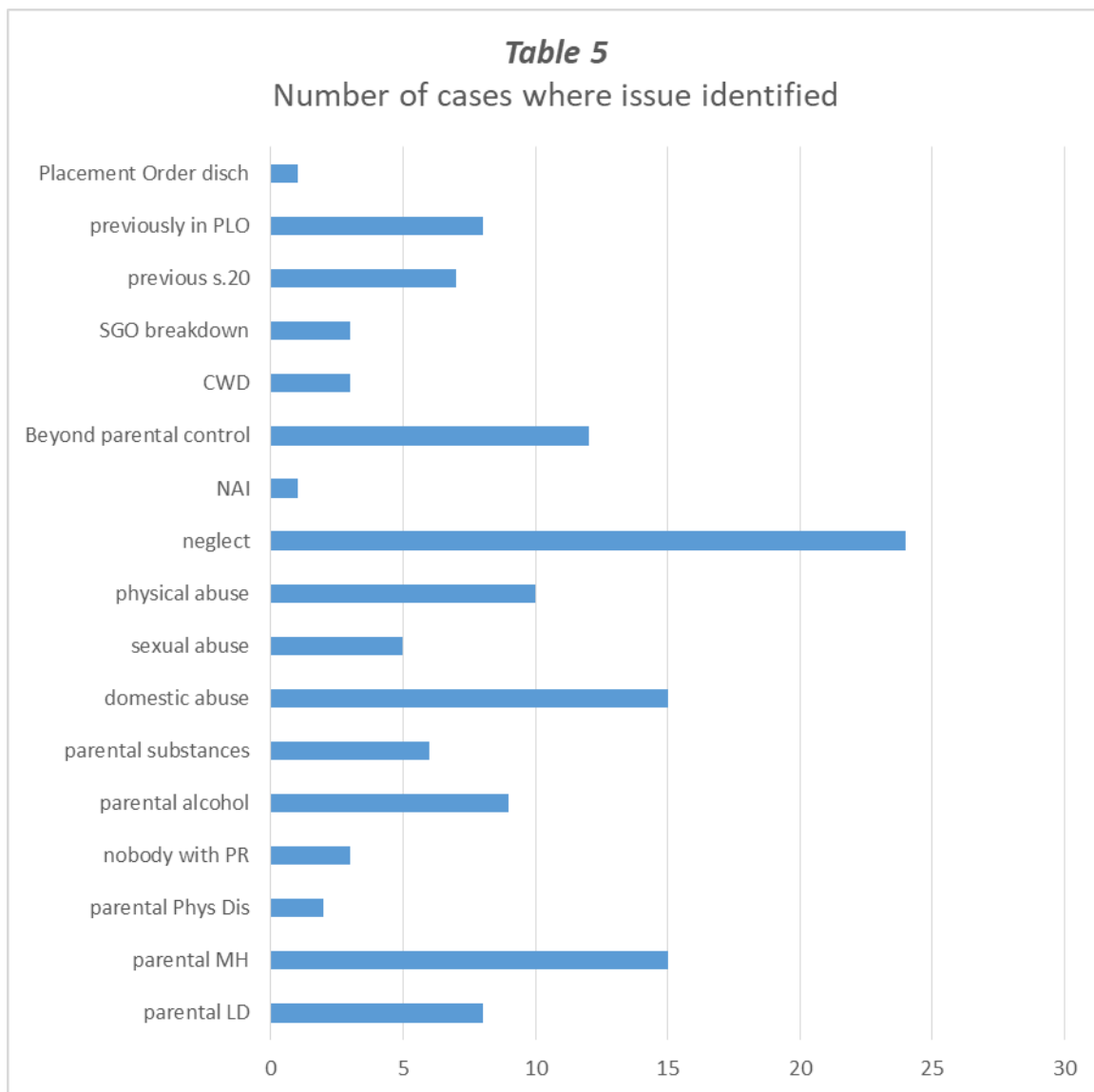


## 2.10 Predictions

- 2.10.1 In the financial year 2015/2016 Croydon issued 76 s.31 court applications in this 12 month period. In the financial year 2016/2017 Croydon issued 113 s.31 court applications. This increase of 37 cases is a 48% increase upon the number of proceedings in the previous year.
- 2.10.2 Croydon has now issued 92 cases in the first 5 ½ months of this financial year. If this trajectory continues then the total number of applications for 2017/18 is predicted to be in the range of 180-200. This would be a 78% increase from the last financial year.
- 2.10.3 This trajectory has been similarly reflected in other East London Boroughs who were rated 'Inadequate' by OFSTED; Bromley report at 104% increase in proceedings post Ofsted and Tower Hamlets report a 120% increase.

## 2.11 Profile of Proceedings

- 2.11.1 This report explores reasons why Croydon have issued proceedings over the last 6 months. The information has been gathered from discussions with social workers about their understanding of the reason that proceedings were issued, or a view from the court manager using the case summary on CRS to elicit the information.



2.11.2 Some of the cases had multiple issues identified and some cases had single issues identified. A more detailed look at these cases in the future will provide a more accurate picture of the presenting issues. Within the category ‘beyond parental control’ there are a range of issues, including gangs, missing, CSE and Secure Accommodation applications.

2.11.3 A more in depth analysis of these cases would also identify how many repeat proceedings there are, and how many cases relate to parents who have been in care themselves; this information would assist with the targeting and development of services and early help. This information may help with determining whether developing a service such as ‘Pause’ would be of benefit in Croydon. ‘Pause’ works with women who have experienced, or are at risk of, repeat removals of children from their care. It offers an intense programme of support with the aim of breaking this cycle.

2.11.4 This table reflects the age profiles of the children Croydon have issued Court applications in respect of over the last 6 months (N.b. some gaps have been identified where the age of only one child in the family has been recorded).

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
---	---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----



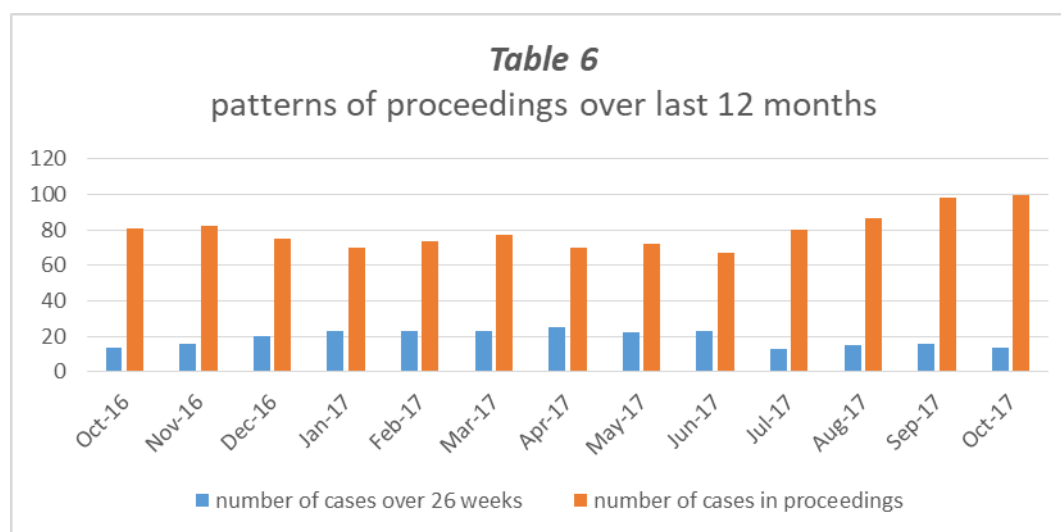
19	4	1	5	4	7	4	8	3	5	4	2	6	7	6	8	6
----	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

2.11.5 It should be noted that a significant number of court applications are in relation to babies or unborn children.

## 2.12 Performance

2.12.1 Despite the stark rise in court applications, Croydon's performance with regards to cases concluding within 26 weeks is an improving picture.

2.12.2 The chart below shows the number of cases which have been over 26 weeks in duration against the number of s.31 proceedings, by month, for the last 12 months.



2.12.3 There are ongoing difficulties and challenges with compliance with Court orders. These include social workers not providing timely instructions to the legal department, and not filing statements and other evidence when it is due to be filed with the Court. The increase in staffing should begin to improve practice in this area because social worker's caseloads will feel more manageable. However this is currently mitigated by the rise in numbers of cases in proceedings which is placing additional pressures on both children's social care and legal services. Additionally legal workspace (a CRS system based module which will support use of and monitoring of legal processes) will provide a mechanism for improved oversight of what is due and when (please see strategies for improvement section below).

2.12.4 The following table shows Croydon's statistics over the last 6 months in relation to the number of cases heard at legal planning meetings each month. The table compares the number of cases with a decision to issue proceedings each month against the number of applications made to Court. The report also considers number of cases have been issued outside a decision at legal planning meeting which reflects that there has been an increase in emergency applications to Court over the last 3 months.

2.12.5 The final columns reflect Croydon's statistics for the average length of weeks in proceedings and the percentage of cases concluded within 26 weeks for each month.

**Table 7**

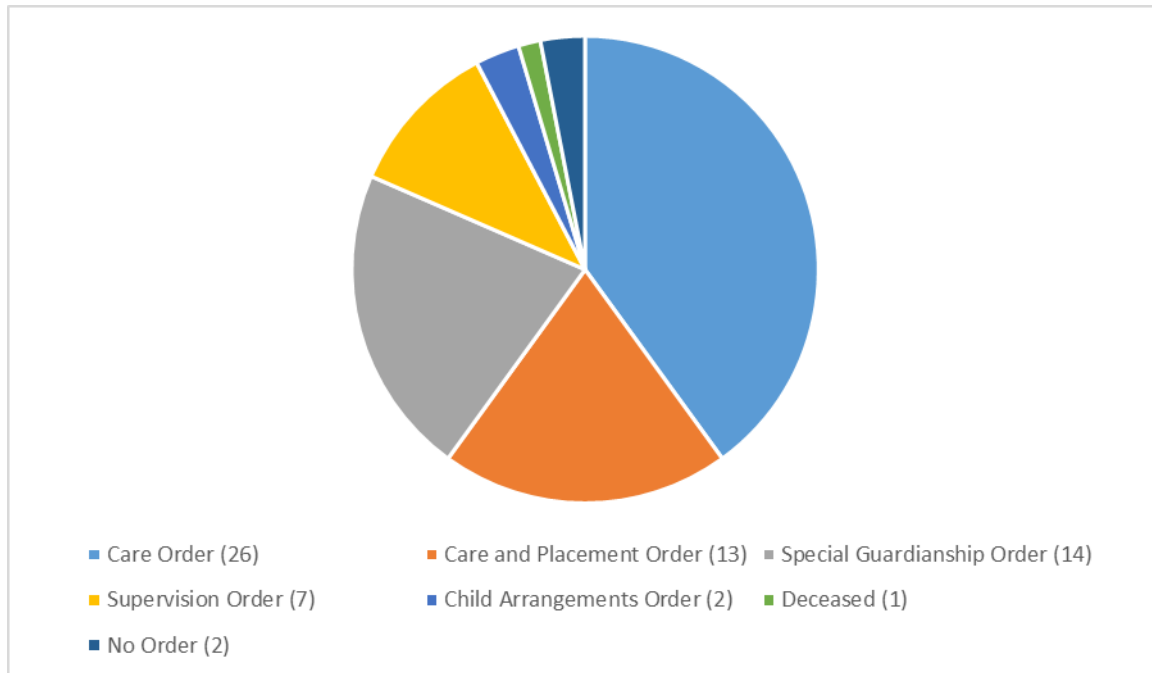
<b>Month</b>	<b># cases heard at LPM</b>	<b># cases with issue decision at LPM</b>	<b># cases issued each month</b>	<b># cases issued having been to LPM</b>	<b># issued outside LPM</b>	<b>Average weeks in proceedings</b>	<b>% cases concluded within 26 weeks</b>
<b>April</b>	10	2	10	7	3 (designation 1)	27	37.5%
<b>May</b>	16	6	9	7	2	31.6	55%
<b>June</b>	14	6	12	8	4	32.3	37.5%
<b>July</b>	18	14	13	10	3	40.2	25%
<b>August</b>	17	5	13	8	5 (Designation 1)	26	50%
<b>September</b>	27	15	16	9	5 Designation 1	23.5	86%
<b>October</b>	12 so far		16 so far	5	7 Designation 1		

## 2.13 Outcomes

2.13.1 This pie chart (table 8) shows the final orders made at the conclusion of all of the s.31 proceedings which have concluded in the last 6 month period.

2.13.2 This reflects the outcomes for Croydon children at the conclusion of care proceedings, with the overwhelming majority concluding with a combination of Care Order (including combined with Placement Order).

**Table 8**



## 2.14 Pre-proceedings

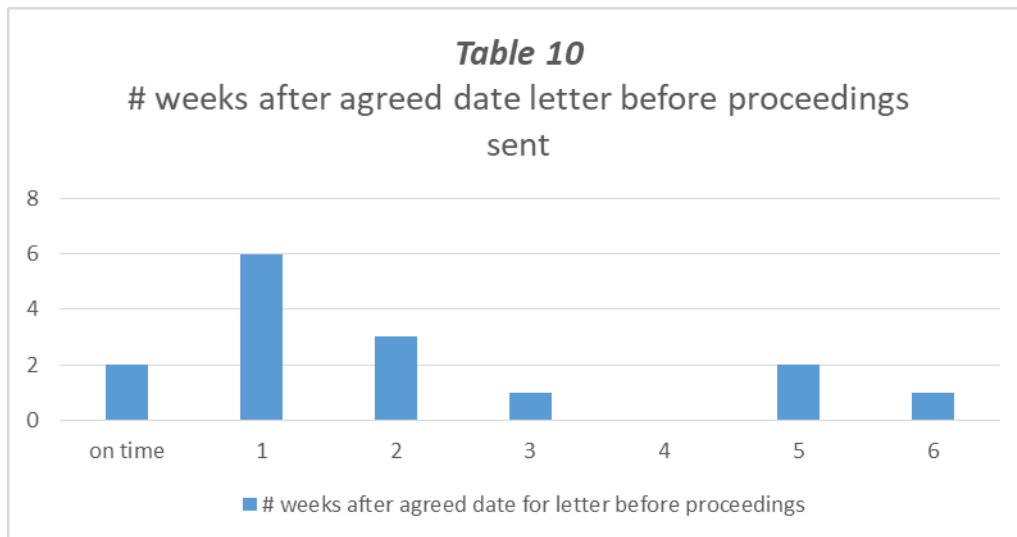
- 2.14.1 Croydon currently has 27 cases in PLO pre-proceedings. This is a formal meeting process to ensure parents understand the concerns and agree what needs to happen to protect the child from harm, so that court proceedings can be avoided. The local authority will then issue a 'letter before proceedings' to the parents, which sets out what the local authority is worried about, what support has been given, what the parents need to do and information about how to obtain legal advice.
- 2.14.2 Whilst this number is low considering the volume of active proceedings, there has been a gradual improvement over the last 6 months.
- 2.14.3 The number of cases in pre-proceedings does not reflect the number of cases identified for pre-proceedings at legal planning meeting. This seems to be as a result of there being significant incidents on cases once pre-proceedings decisions have been made meaning that the threshold for moving directly into legal proceedings is crossed, and/or parents refusing to work with the local authority within pre-proceedings.
- 2.14.4 This table (table 9) shows Croydon's pre-proceedings statistics for the last 6 months. The table demonstrates that there is little difference in pre-proceedings outcomes between proceedings being avoided or issued at the conclusion of pre-proceedings.

**Table 9**

Month	# LPM cases presented	# cases where pre-proceedings agreed at LPM	# cases where pre-proceedings commenced (i.e. letter sent)	Pre-proceedings cases concluded	Cases where pre-proceedings avoided proceedings	Cases from pre-proceedings where cases issued
April	10	4	3	2	2	0
May	16	6	3	1	0	1
June	14	3	4	2	0	2
July	18	1	1	1	1	0
August	17	6	1	0	0	0
September	27	9	3	4	1	3
October	12 so far					

**2.15 Performance**

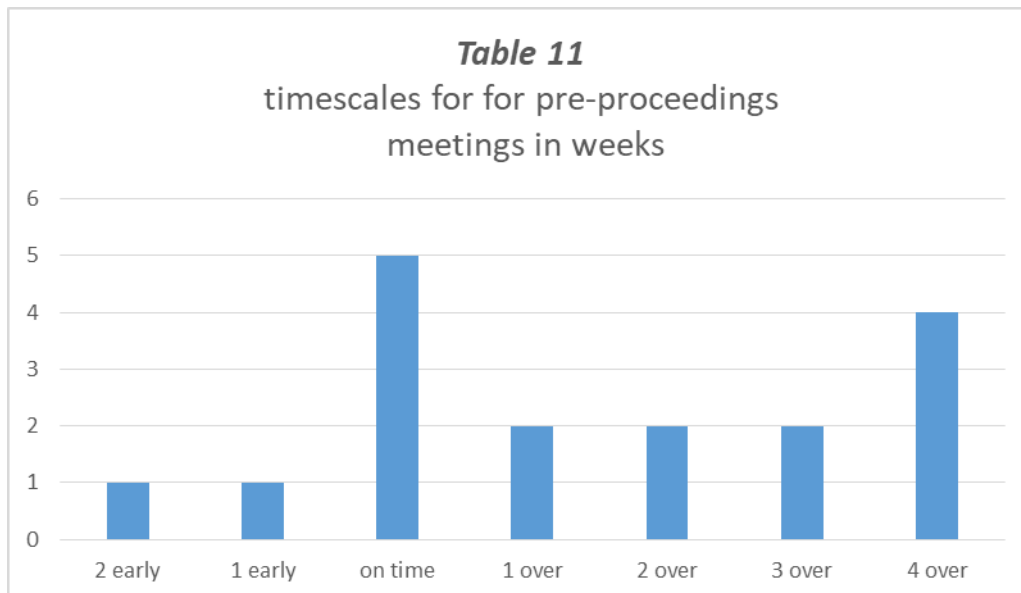
2.15.1 This chart (table 10) shows how accurately Croydon are meeting the timescales for the pre-proceedings letter before proceedings being sent to the family. This is based on the agreed timescale for the letter being 1 week after legal planning meeting.



2.15.2 It is clear from this that Croydon is not meeting the timescales set for our families and there needs to be increased management oversight in following up pre-proceedings decisions made following legal planning meetings.

2.15.3 This data has not previously been reported; in order to provide more oversight on this area of work, the care proceedings case manager will keep this information up to date manually in the interim period until legal workspace is operational (reference strategies for improvement below).

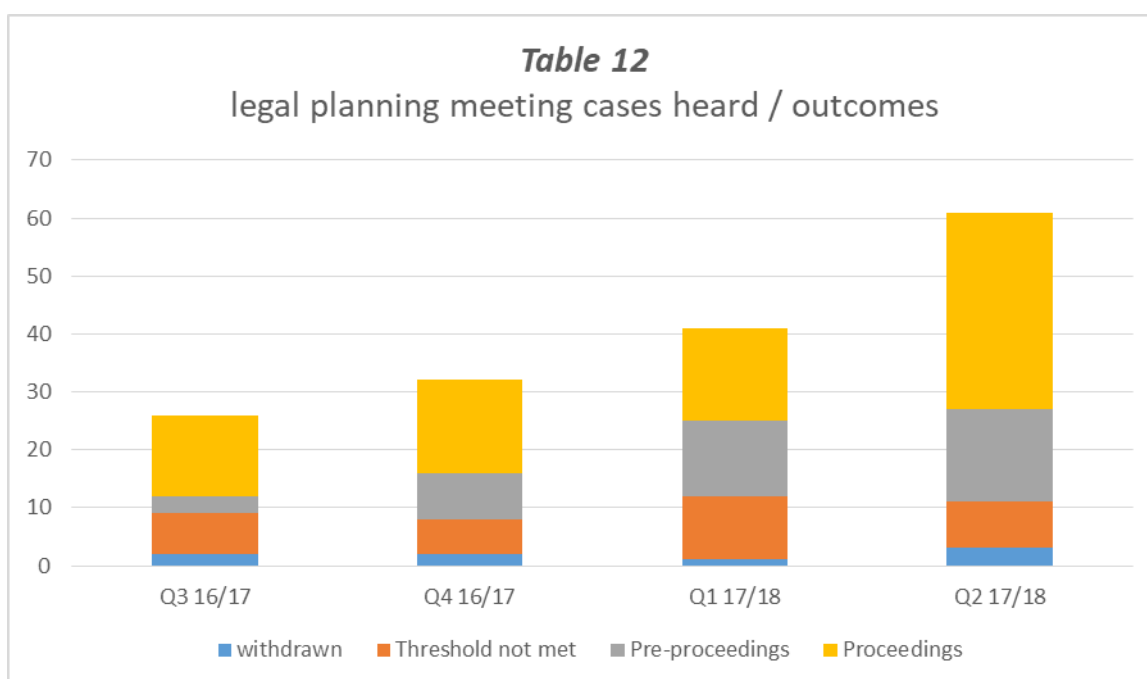
2.15.4 This graph shows how well Croydon are meeting the timescales for the pre-proceedings meeting being held. This is based on the usual guidelines for the meeting to be 3 weeks after the date of LPM. It is important to note that the delays are not always with the local authority because the meeting date needs to be agreed by others.



## 2.16 Legal planning meetings

2.16.1 Legal planning meetings are held weekly on a Friday morning. Additionally there is a duty solicitor available every day for social workers to be able to discuss urgent cases outside legal planning meeting.

2.16.2 This chart shows the numbers of cases heard at legal planning meeting per quarter over the last 12 months. The different colours depict the decisions made at LPM.



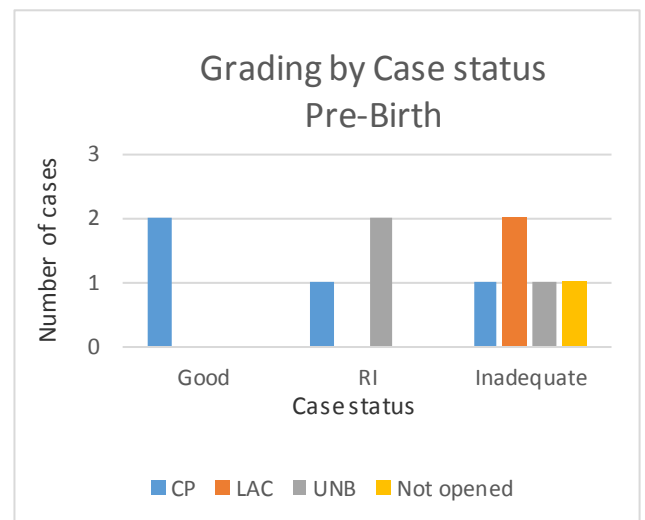
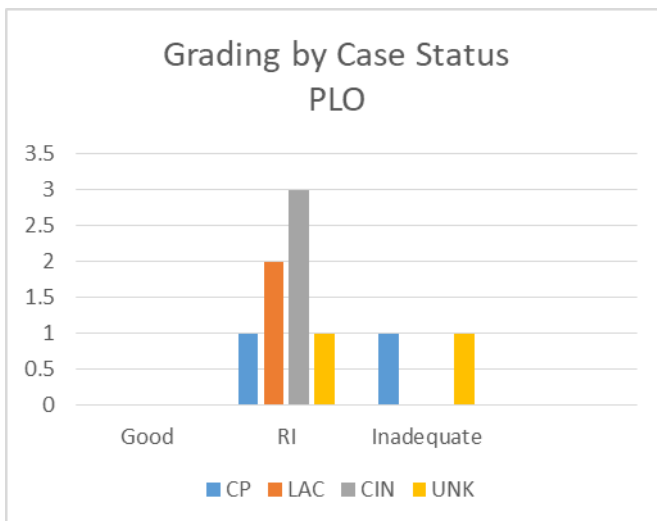
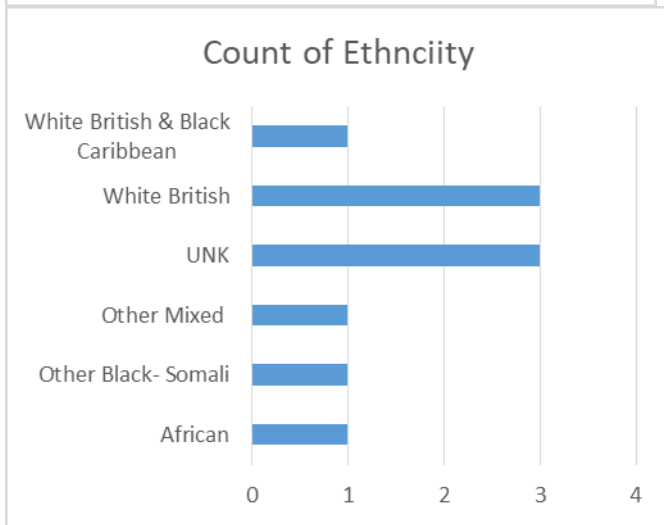
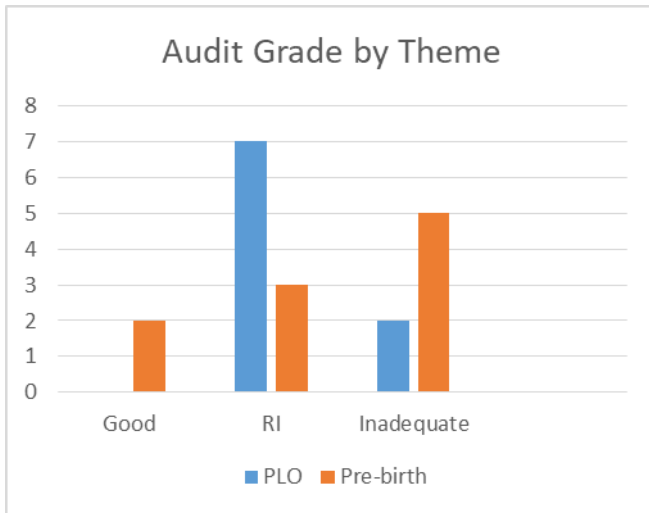
- 2.16.3 There has been a stark increase in the volume of LPM referrals over the last 2 months. Previously there were averagely 3 to 4 referrals per week and more recently there have been between 9 and 12 LPM referrals per week.
- 2.16.4 Until September 2017 the capacity for legal planning meeting was 4 cases per week, and this capacity usually accommodated the number of LPM referrals. Since September the capacity has been increased to 6 cases per week to accommodate the rise in cases requiring legal advice and several cases have been presented to the duty solicitor outside LPM for legal advice.
- 2.16.5 If the volume of legal planning meetings remains high over coming months then the legal department will need to reconsider how many legal planning meetings they have capacity to hear within the formal LPM setting each week.

## **2.17 Recent Audits**

### **2.17.1 Audit activity**

- 2.17.2 Audit activity has been carried out as part of this 'deep dive' report.
- 2.17.3 A total of 19 cases were audited; 10 pre-birth and 9 PLO which represents around 10% of cases in each category. 2 of the cases were held within Leaving Care, in light of the lessons learned from the Ofsted Annex H case. The 9 PLO cases included cases that are currently under PLO and those that had been concluded, to look at practice.
- 2.17.4 In relation to the Pre-Birth cases, 2 were graded good, 4 requires improvement and 4 inadequate. The two Leaving Care cases were grade good and inadequate.
- 2.17.5 In relation to the PLO cases, 7 were graded requires improvement and 2 inadequate.

### **2.18 Key Data Highlights**



2.18.1 Analysis of the identified concerns/risk within each family case reveals the following-

- 13 of the 19 (68%) cases had features of domestic abuse
- 7 had features of substance misuse



- 7 parental mental health
- Majority of families previously known to CSC ( only 1 had no known previous history with CSC)
- 3 cases involving care leavers (2 pre-birth/1PLO)
- 4 cases had elements of DV, MH and substance misuse (“toxic trio”)
- 4 cases involved young parents

## **2.19 Practice Highlights**

2.19.1 In many cases there were elements of some good social work with families and children. There is also evidence of good communication with partners (midwifery in particular) alerting CSC to pregnancies, usually in a timely manner.

## **2.20 Practice Concerns**

2.20.1 There is ongoing evidence of inconsistent quality supervision.

2.20.2 The use of the C&F assessment is not fit for the purpose of quality pre-birth assessments; there is a need for a more meaningful format. Other practice concerns include:

- Chronologies often absent or of poor quality
- Plans lacking clear direction
- Limited or lacking evidence of considered analysis
- Limited discussion of direct work
- Supervision lacking reflection, task oriented, inconsistent

## **2.21 Outcomes for children**

2.21.1 Action had been taken to assess needs and progress plans appropriately in 7 out of the 10 cases, 4 of which resulted in timely legal proceeding and Interim Care Orders, 1 in a child protection plan and 2 in child in need plans. In relation to the two cases which had not been progressed in line with good practice, one child is subject to a child in need plan but this case has been escalated with a view to take the case back to an Initial Child Protection conference and the other case (the baby of a care leaver) has been escalated for an assessment. Three of the audited cases are still unborn.

## **2.22 Specific actions resulting from audit**

- 2 cases were escalated to Heads of Service regarding safeguarding concerns to be addressed with some urgency
- The learning from this audit has been discussed with the Practice Development group and actions agreed – summarised below.
- DV Consultant Practitioner will be delivering DV training starting in November, and this will be incorporated into our core training programme.
- The new supervision template based on Strengthening Families model has been launched

- Reflective group supervision for social work teams is becoming embedded.

## **2.23 Partnership activity**

### **2.23.1 Health**

2.23.2 The Vulnerable Woman's group is a multi-agency panel which meets monthly at the hospital. The group accepts referrals for pregnant women where there are concerns about the unborn baby. The cases are discussed with the aim of identifying support needs to be met by all partners. A social worker from the MASH attends this meeting which enables early mapping of potential vulnerable women. From this forum a decision can be to refer the case to Social Care (some cases are already open) which enables early planning, pre-birth assessment where required and early recognition of vulnerability.

2.23.3 There is a weekly Psycho social meeting attended by a MASH worker. This is a multi-agency forum where health discuss cases that have presented at A and E. This can include vulnerable women where a pre-birth assessment is required.

### **2.23.4 Adult Services**

2.23.5 All adult services staff are trained in child safeguarding. All their clients are expected to have had a 'child need and risk screen' completed and where there are any risks identified there is a link to generate a referral to Croydon Council Multi Agency Safeguarding Hub. Staff are expected to work to a Think Family approach and to keep the child (or unborn) in mind when working with adults who live with or share responsibility for children and young people. When planning interventions, for example Mental Health Act Assessments, staff must have regard to a child or unborn, and seek to mitigate against any potential trauma as a consequence of the assessment or intervention. There are good relationships between the Approved Mental Health Professionals (responsible for Mental Health Act Assessments) and colleagues in Children's Social Care.

2.23.6 It is not currently possible to identify the number of referrals for pre-birth assessments that have been received from adult services, as they would be categorised as 'other local authority department'.

### **2.23.7 Legal Services**

- Legal services colleagues have worked with children's social care to develop a court proceedings action plan and data sets incorporating feedback and consultation with the courts.
- A series of engagement and action planning meetings are now scheduled between the Head of Legal services and the director of children's social care with judges for the coming year
- Monthly legal performance meetings are now held with senior managers, care proceedings manager and head of legal services.
- Legal services convene a diary meeting every Monday morning with the care proceedings case manager to raise non-compliance issues

- A duty solicitor is available each day from 9am to 5.30pm and a member of the legal team offers surgeries with social workers every day from 10am to 12 noon

## **2.24 CSCB – application of thresholds**

- Multi-agency understanding and application of thresholds, early recognition of vulnerability and availability of a range of early help services are all part of the current work plan of the CSCB.
- Improved data and analysis will support all partners to develop a better understanding of the need for early permanency planning and timely intervention. This should be tested by multi agency auditing of cases which progress to early permanency planning and removal of young children, to identify opportunities for a different range of interventions.

## **3 SUMMARY OF THEMES AND CHALLENGES**

### **3.1 Child and family factors**

3.1.1 This 'deep dive' exercise has demonstrated a number of features of the families we are working with to plan for the needs of unborn children in a timely way. Domestic abuse, mental health, substance misuse and young parenthood are common needs. The ability of all multi agency professionals to identify the risks associated with these factors and the availability of a range of services to support families to address these challenges, will all require attention moving forward if we are to continue to manage and reduce the level of risk for our children.

### **3.2 Capacity and capability of front line staff**

3.2.1 The rising volume of work, particularly in use of PLO and cases moving into legal proceedings, continues to challenge the service. The work is complex and requires knowledge of court processes and ability to prepare well evidenced reports for court. Proceedings are time consuming and time spent in court will impact on the worker's ability to undertake the statutory requirements of other cases they are responsible for including visits and reviews. This level of work must be well managed and workloads adjusted to reflect the demands on individual workers and teams – this is being addressed through the establishment of additional posts in the care planning service.

3.2.2 Developing skills and ability of our staff to prepare reports for court which are well written and timely will continue to be a priority.

### **3.3 Management oversight**

3.3.1 Audit activity and performance data continue to evidence that poor supervision leads to drift and delay in decision making. Focused work with unit managers, support and training, and updated pro-forma for recording will continue to address this.

### **3.4 Timeliness of responses**

3.4.1 There is an improving picture in relation to timeliness, which impact on planning for children. Court timescales are improving despite the rise in volume and the audits evidenced that where legal action was deemed necessary, this was instigated in a timely way at birth.

### **3.5 Parallel planning**

3.5.1 Although there has been an increase in pre-birth assessments linked to earlier identification of vulnerabilities, and earlier discussion at legal planning, there is a still a challenge to the service to ensure that parallel planning rather than sequential planning becomes embedded. This means early involvement of the adoption service, twin tracking child protection and legal planning processes, and identification of the right placement resources, which for some children, may mean 'foster to adopt' placements. Whilst numbers of foster to adopt placements have been limited there are carers who are willing to consider this placements and there is a recognition of a need to continue to recruit 'foster to adopt' carers.

### **3.6 Partnership engagement**

3.6.1 There has been positive impact of work through the MASH with health colleagues to identify risk at an early stage in pregnancy and begin to plan to meet the needs of the unborn. This is evidenced in audit and in our performance data which shows that assessments are being triggered when the pregnancy is confirmed. However there is a need to continue to raise awareness of the risks to unborn babies of parental mental health, substance misuse and domestic abuse with all professionals who may be in contact with parents.

3.6.2 Work is ongoing with colleagues in legal services to improve the quality and timeliness of our work which is already evidencing improvement in practice – see above.

### **3.7 Corporate parenting responsibilities**

3.7.1 There is a need to continue to be mindful of the needs of young parents, particularly those who have been in our care and are vulnerable themselves. Recognising the risks and ensuring support is in place for young people for whom we are corporate parents is important. This will be addressed through assessment of the needs of any care leaver who is to become a parent and a commitment to put in place early help services in every case, with additional support and intervention where risks to the baby are identified.

## **4. ACTIONS TO RESPOND TO ONGOING CHALLENGES**

### **4.1 Pre-Birth Assessment**

4.1.1 A pre-birth timeline has been developed as a joint piece of work across care planning and permanency services to support social workers in parallel planning, use of PLO alongside Child Protection processes, and identifying the right placement for the child at an early stage, supported by any necessary legal action.

4.1.2 This is attached as Appendix 1. It will be discussed with the Practice Development group and launched through training and supervision.

4.1.3 A decision has been made to develop a dedicated pre-birth assessment tool to assist social workers to assess critical aspects of the family's life in order to reach a judgement about the plan, and evidence good practice. This will be aligned with our new social work practice model and built into CRS. This work is being led by the Principal Social Worker and will align with our new practice model.

4.1.4 Timescale: develop January 2018 and launch with the new SW model

## **4.2 Staff training and development – PLO processes**

4.2.1 The care proceedings case manager has designed and delivers on a weekly basis a rolling programme of training sessions to staff. These are bite-sized to make attendance more manageable. Training topics are: statement writing, PLO pre-proceedings, s.20, preparing for court and giving evidence. Legal colleagues are supporting delivery of these training sessions.

4.2.2 Our colleagues in legal will also be delivering two Court Skills training sessions in the next 6 months. This will be day long training to help social workers improve court practice and presentation.

4.2.3 The care proceedings case manager spends individual time with social workers to help them prepare for giving evidence, and to assist with writing statements. She also offers drop in consultation to staff who have questions or need support regarding Court matters.

4.2.4 Additionally guidance notes and exemplars on all of the Court templates in use have been produced as well as documents to aid pre-proceedings such as templates for letters, written agreements and meeting agenda.

4.2.5 In the last few week our colleagues from the legal department have started sitting within the social work team to offer drop in consultation support; this is daily from 10am-12 noon.

4.2.6 **Timescale:** training delivered weekly

## **4.3 PLO pre-proceedings**

4.3.1 To increase our effective PLO pre-proceedings work, more work is needed to identify those cases which require legal planning with a view to pre-proceedings at an earlier stage. This process has started and is showing some improvement but numbers remain low for an authority the size of Croydon.

4.3.2 To support this process, a review of all cases where the child has been on a child protection plan for more than 9 months, and all cases where the CP chair has recommended attending an LPM will be held in October and November 2017. This process is likely to instigate an initial rise in legal planning meeting referrals; however it will ensure that the child protection plans for children are reviewed, and pre-proceedings instigated where required which will make ongoing overview and monitoring of these cases easier moving forward.

- 4.3.3 Additional plans to improve the way our cases are managed in pre-proceedings include a planned training session with care planning unit managers to model a pre-proceedings meeting. This will improve the quality of practice regarding pre-proceedings meetings.
- 4.3.4 **Timescales:** Review of all cases where child has been subject to a CP plan for 9 months or more by end November 2017.
- 4.3.5 Training for care planning UMs by end December 2017

#### **4.4 Legal workspace**

- 4.4.1 When legal workspace (a module on CRS to support tracking and oversight of cases in PLO) is operational on CRS this will alleviate the manual tracking currently required for care proceedings cases, pre-proceedings cases and legal planning meeting outcomes. Legal workspace is anticipated at the end of October 2017.
- 4.4.2 This system will need to be manually maintained by legal business support who will input information directly from Court Orders onto the system; this will provide tracking for dates and directions. There will be easy access for all levels of management to be able to view what is due for compliance on each case and when; unit managers, service leads and heads of service will be able to have better oversight of what is due for individual workers or units, on specific cases.
- 4.4.3 **Timescale:** Legal workspace in use by mid-November; reporting facility operational by December (dependent on business support capacity to input all information into system).

#### **4.5 Legal Planning Meetings**

4.5.1 Since April there has been a legal planning meeting outcomes tracker. This was developed to monitor cases where a decision has been made to issue proceedings and to track when the Court application is made. This tracker was developed when it was identified that there was drift in legal planning meeting decisions being implemented, and it is used on Monday morning management meetings where heads of service can raise the delays with unit managers to seek resolution.

4.5.2 Timescale: in use

#### **4.6 LIFT and FDAC**

4.6.1 The London Infant and Family Team (LIFT) are a multi-disciplinary assessment and treatment service for Court directed assessments within proceedings. LIFT are funded by the NSPCC and so this is a free resource to the local authority. LIFT is only a service for families where children are under 5 years old, the children must either be separated from their parents or within a mother and baby foster setting.

- 4.6.2 On cases where LIFT is agreed by the Court and parties, LIFT undertake a 12 week multi-disciplinary, attachment focussed assessment and at the conclusion will make recommendations as to whether therapeutic intervention is advised for the family. If the decision is that therapeutic intervention is not advised then the Court often has all of the information required to make a final decision for the child. If therapeutic intervention is advised then the family engage in a 5 month therapeutic intervention process with the LIFT team, this is reviewed regularly and can be terminated by the Court at any time.
- 4.6.3 In order to determine whether the LIFT assessment and intervention provides better outcomes for the child than services as usual a research trial commenced on 16<sup>th</sup> October 2017. This research trial will assess children at three points over a 2.5 year period, considering their attachment and development at each stage. The families who opt into this research trial at the outset of proceedings will be randomly allocated 50% into LIFT and 50% into Court assessment services as usual. The research trial will be running in the background for families in both groups. This is the first randomised control trial involving the Judiciary and Children's Services and this has been endorsed by Lord Justice Mumby.
- 4.6.4 Croydon is also participating in the Family Drug and Alcohol court (FDAC) which will start on 1<sup>st</sup> January. FDAC aims to help parents stabilise or stop using drugs and or alcohol and, where possible, keep families together. Where this isn't possible, the court aims to make swift decisions in order to find children a permanent, stable home. It is based on a model widely used in the USA which is showing promising results. The process involves coordinating and fast tracking a range of services so that a family's needs and strengths are taken into account, with everyone working towards the best possible outcome for the child.
- 4.6.5 Timescale: LIFT in use; FDAC from January 2018

## **5. IMPACT OF OUR WORK**

The following two case summaries are examples of how early assessment and planning can either support a parent to care for their child, or facilitate early removal and permanency planning.

### **5.1. Remain with Parents\_Unborn B**

- 5.1.1 Ms B has a history of being in violent and abusive relationships, alcohol misuse, depression and Ms B's failure to protect her children. Care proceedings were initiated for two of her three older children, D (a son) and L (a daughter); the courts granted a Special Guardianship Order in respect of D to his paternal grandmother and a care order was granted in respect of L. L remains in long term foster placement. Care Proceedings were not initiated for her eldest son B at that time because of his age.
- 5.1.2 In early May 2016 Ms B and her partner Mr W (Unborn B's father) were deemed intentionally homeless through failure to pay rent by a south coast Council. They moved to the Croydon area and were sofa surfing between the addresses of their extended family in the Croydon area.

- 5.1.3 The referral for Unborn B was received at the end of June 2016 from both the social worker for L and the Community Midwifery Matron in south coast District General Hospital. The case was considered to be a high risk case as Ms B has had previous children removed, suffers from depression, had a history of alcohol abuse, a long history of being in domestically abusive relationships and is considered very vulnerable. Professionals were also concerned that Ms B and Mr W may have been moving around in order to avoid further social care intervention.
- 5.1.4 On the 16.09.2016, Unborn B became subject to a Child Protection Plan, following a unanimous agreement by professionals that the threshold had been met and the PLO process was commenced prior to Unborn B being born and continued after her birth in December 2016.
- 5.1.5 A parenting assessment was undertaken in the first two weeks of Unborn B's life the outcome of which was positive. This was followed by further assessment reports and work with the family which were also positive. Due to this outcome, the decision was made to end the PLO process.
- 5.1.6 Towards the end of the PLO process, the family moved back to the south coast area with the intention to remain living there. A review CP Conference took place in early July 2017, at which time it was deemed that the concerns regarding the couple's ability to safety parenting Unborn B had been resolved and the matter was stepped down to Child in Need (CiN).
- 5.1.7 The case was subsequently transferred to the south coast Children Services as a CiN matter.

## **5.2 Placement Order: Unborn P**

- 5.2.1 Ms P has had seven children in total. Her two oldest children were removed and adopted outside of the family in 2001 and 2004. Her third and fourth children were the subjects of care proceedings in another London borough in 2012-13 which concluded with permanent removal from Ms P's care and a residence order to their father. Her fifth child was permanently removed from her care and placed under an SGO with her maternal aunt. During these former proceedings there have been psychiatric assessments, parenting assessments and many viability assessments. All have concluded that Ms P cannot care for her children or protect them from harm. T, born in August 2014, is her 6<sup>th</sup> and Unborn P, born in August 2016, is her 7<sup>th</sup> child; both were subject to care proceedings together in Croydon.
- 5.2.2 T is the son of Ms P and Mr M. Unborn P is the daughter of Mr N and Ms M. Ms P and Mr M are both deaf. Mr N and the children are hearing.
- 5.2.3 About six months after T's birth Ms P fled to the midlands where she resided with Mr M to escape domestic abuse perpetrated by Mr M (including verbal, physical and sexual violence). Ms P was supported to settle in another London borough and T was made the subject to a CP Plan. This was transferred to Croydon after the family were housed in the borough in May 2015.
- 5.2.4 In January 2016 Ms P advised that she had entered a new relationship some



months previously with Mr N and she was pregnant. Throughout the pregnancy there were frequent police call-outs to domestic incidents in which Mr N would physically assault Ms P leaving her with injuries. Mr N was believed to misuse drugs and alcohol. The Local Authority issued care proceedings in relation to T in June 2016 after further episodes of domestic violence. T was made the subject of an Interim Care Order on 8th July 2016.

- 5.2.5 On 1st August 2016 Unborn P was born and the Local Authority was granted an Interim Care Order on 3rd August 2016; Unborn P was removed and placed in a separate foster placement from T on this date.
- 5.2.6 In March 2017 Mr N was remanded back into custody following a further assault on Ms P and it is understood he is now serving that sentence in custody.
- 5.2.7 The final hearing for the case took place in July 2017 ( these proceedings were long due to the complexity of working with deaf parents and the difficulties encountered by the Court in securing interpreters for hearing dates.)
- 5.2.8 A Placement Order and Care Order were made with regard to Unborn P and she is currently being matched with prospective adopters. A Special Guardianship Order was made regarding T and he was placed with his paternal grandparents.

## 6. **RISKS AND ISSUES**

- 6.1 The recent rise in court proceedings is anticipated to continue in the short to medium term requiring addition legal and social work time.
- 6.2 If this results in case management failings and avoidable delays, the council could be subject to costs awarded against it.

## 7. **FINANCIAL IMPLICATIONS**

- 7.1 Potential for costs awarded against the council for case management failings in court cases.
- 7.2 Additional staffing costs to manage the increase in workloads.

## **Appendices**

Appendix 1 – Pre-Birth timeline

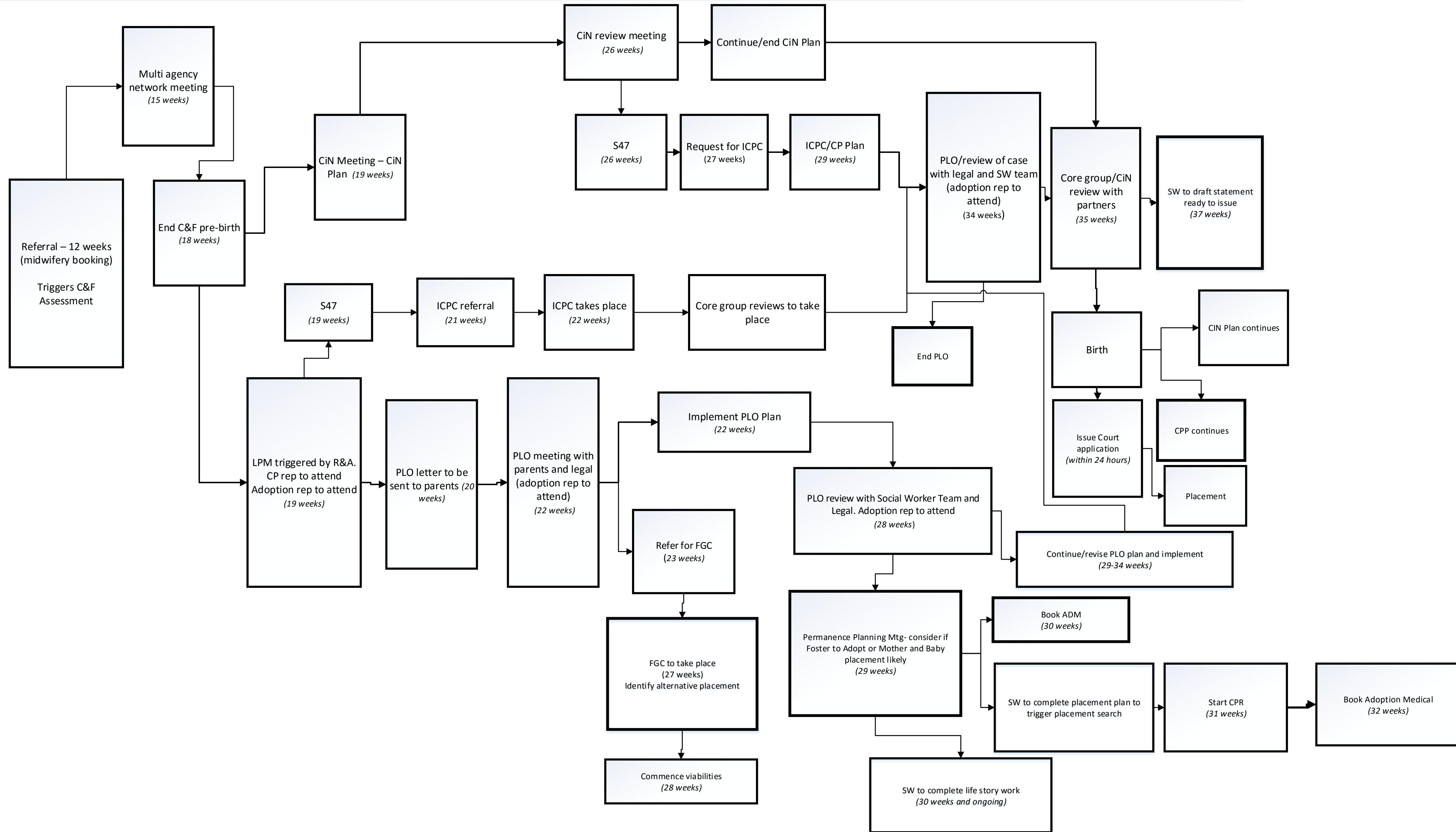
---

**CONTACT OFFICER:** Philip Segurola, Director of Early Help and Children's Social Care

**BACKGROUND DOCUMENTS:** None

# Item 11 Appendix 1- Pre-Birth Timeline

12 weeks      18 weeks      19 weeks      20 weeks      22 weeks      26 weeks      27 weeks      29 weeks      36 weeks      40 weeks



This page is intentionally left blank

For general release

<b>REPORT TO:</b>	<b>Scrutiny Children &amp; Young People Sub-Committee 28 November 2017</b>
<b>SUBJECT:</b>	<b>WORK PROGRAMME</b>
<b>LEAD OFFICER:</b>	<b>Stephen Rowan, Head of Democratic Services &amp; Scrutiny</b>
<b>PERSON LEADING AT SCRUTINY COMMITTEE MEETING:</b>	<b>Councillor Jan Buttinger, Chair of the Sub-Committee</b>

<b>ORIGIN OF ITEM:</b>	The Sub-Committee agreed at its previous meeting to amend its work programme in light of the recent Ofsted Inspection findings.
<b>BRIEF FOR THE COMMITTEE:</b>	To consider a revised work programme for the Sub-Committee and agree any amendments considered necessary.

## 1. EXECUTIVE SUMMARY

- 1.1 At its meeting on 5 September 2017, the Scrutiny and Overview Committee resolved that Children and Young People’s Scrutiny Meetings would have items on key themes in the Improvement Plan following the recent Ofsted inspection of Children’s Social Care in Croydon.
- 1.2 This was further considered at the meeting of this Sub-Committee, held on 19 September 2017, where it was agreed that the work programme be amended to reflect the programme of ‘deep dive’ reviews planned as part of the improvement journey being managed by the Children’s Service Improvement Board.

## 2. PLANNED DEEP DIVES & PROPOSED CHANGES TO THE WORK PROGRAMME

- 2.1 The Improvement Board is continuing to identify and prioritise the areas that it considers most suitable for deep dive reviews. At its most recent meeting on 3 October, it agreed that the following deep dives be undertaken:
  - 7 November 2017 - Early Permanence, parallel planning, Pre-birth assessments & Public Law Outline
- 2.2 The Sub-Committee has also indicated its wish to include an agenda item on children’s safeguarding in a future meeting, which is to include an examination

of the effectiveness of partnership work and the questioning of key partners in this work e.g. the police and health services.

2.3 The current planned work programme for the Sub-Committee for the remainder of this municipal year is as follows:

28 November 17	6 February 18	13 March 18
Children’s Safeguarding Board Annual Report	Education Budget	<b>Children, Young People &amp; Learning Q &amp; A</b>
Missing children statistics	Education Standards	Update on missing children statistics
Deep Dives: Public Law Outline and Early Permanence		Children’s Social Care Annual Report

2.4 As the Improvement Board continues to develop its deep dive programme, this will continue to be reported to this Sub-Committee to allow further consideration of any further potential changes to the work programme.

---

**CONTACT OFFICER:** Stephen Rowan, Head of Democratic Services & Scrutiny

**BACKGROUND DOCUMENTS:** None