CROYDON SAFEGUARDING CHILDREN BOARD

Annual Report 2012/13

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I Foreword

CSCB Annual Report 2012/13 – Independent Chair's Foreword

This year has been particularly challenging for the board and all of our partner agencies. It is well known that organisational and front line staff stability and continuity, manageable workloads, regular, reflective supervision and strong lines of inter-agency communication for the essential bedrock of an effective safeguarding service. Largely as a result of government policies of 'diversification', outsourcing and austerity the obverse has applied across the partnership.

As far as the safeguarding board itself is concerned the year has seen 100% turnover of its support team. Our experienced and well respected board manager, training officer and administrator all moved on and as a result the board has been without adequate support for much of the year. Despite several attempts to recruit to vacant posts we enter the new year carrying vacancies for our training and quality assurance officer posts.

We were however successful in recruiting to the posts of business manager (late in the year) and administrator and it is largely due to the stirling work of the latter (Vicky Hersey) that the board has been able to continue to make progress, albeit at a slower pace than we would have hoped.

On the positive side of the equation the health service has made good progress with regard to rectifying the shortfall in Health Visitors reported last year, children's social care have introduced a new model of evidence based family social work supported by consultant practitioners, the new Strengthening Families approach to case conferences is beginning to yield positive results and our focus on the related risks associated with children who go missing, get involved with gangs and/or

who are sexually exploited has been significantly strengthened. We have recruited 2 excellent 'lay members' who are already making a very positive contribution. Board meetings continue to be well attended, members are clearly committed to active participation in the work of the board and its sub-groups.

As we enter a new year we do not expect the pace of change and resulting fragmentation in the workforce to abate. The toxic combination of further resource reduction and increased demand due to demographic changes in the borough, increasing levels of family poverty and the associated perils of substance misuse and domestic violence mean that there is absolutely no room for complacency. The imperative for everyone to remain vigilant and report their concerns about children who they believe to be suffering harm is greater than ever.

For the Safeguarding Board our key priorities going forward are;

- **Strengthening quality assurance/performance management**
- **Improving communications across an increasingly fragmented workforce and with the public**
- **Embedding the lessons learned from Serious Case Reviews**
- **Ensuring that our adult services really do 'think family'**
- **Implementing expected new statutory guidance contained in the long awaited, revised 'Working Together to Safeguard Children'**

I commend this annual report to you.

Paul Fallon
(Independent Chair)

II Objectives

The Croydon Safeguarding Children Board (CSCB) has been created under the *Children Act 2004.*

The CHSCB holds a statutory responsibility for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

The core objectives of the CSCB as set out in Working Together to Safeguard Children 2010 are as follows:

- 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; and
- to ensure the effectiveness of what is done by each such person or body for that purpose.

The CSCB also has statutory functions relating to all child deaths in Croydon and to undertake serious case reviews in cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern as to the way in which Croydon, Croydon's Board partners or other relevant persons have worked together to safeguard a child.

III Board Membership

Board Structure & Membership

The structure of the Board was reviewed in March 2012, resulting in the creation of a small Executive Steering Group, accountable to the main Board - to monitor progress against the Business Plan, drive the work of the sub-committees and agree the agendas for Board meetings. The change was a response to the fact that the Board had grown to a level that, while representative of the vast majority of interests was bigger than desirable for the conducting of business.

The Board's current membership will be under review in during 2013/14 as part of the implementation process of the requirements in the newly released Working Together 2013. The independent Chair, Paul Fallon, is accountable to the Director of Children's Services. However as set out in the new Working Together 2013, from the next financial year 2013/14, the independent Chair will be accountable to the Chief Executive. Representatives currently sitting on the Board are at a senior level from the following agencies:

- Children and Family Court Advisory and Support Service (CAFCASS)
- Children Families and Learning – Children's Social Care
- Children Families and Learning – Early Intervention
- Children Families and Learning – Education
- Children Families and Learning – Youth Service and YOT
- Croydon Council – Community Services
- Croydon Council – Legal
- Croydon Council – Public Health
- Croydon Council – Safeguarding Adults
- Croydon Health Services NHS Trust
- Croydon Commissioning Group
- Croydon Schools and Colleges
- Housing
- London Ambulance Service
- NHS South West London Croydon Borough Team / Croydon Clinical Commissioning Group
- Metropolitan Police Service Borough
- Metropolitan Police Service CAIT
- Private Schools and Colleges
- Probation

- South London and Maudsley NHS Foundation Trust
- UKBA

Croydon's Lead Member for Children's Services, Councillor Tim Pollard, the Deputy Leader of Croydon Council and Cabinet Member for Children's Services, is a 'participant observer' on the CSCB. Councillor Pollard is also the Chair of the Children and Families Partnership Board.

The Board's membership also includes two lay members representing the local community and three voluntary sector representatives.

Supporting Structure

Sub-Groups

In order to assist the Board to undertake its objectives and functions, there are well-established multi-agency sub-groups in place. Each sub-committee has met on schedule this year. Due to large number of meetings for the sub-groups overall, with an overlap in representatives in some of the groups, a decision was taken in March 2013 to reduce the number of sub-group meetings per year in three of the seven sub-groups.

The roles of the individual sub-committee are outlined briefly below:

- Child Death Overview Panel – reviews all child deaths and ensures that learning points are acted upon
- Health sub-group – promotes and integrates best practice in relation to safeguarding children/child protection across the Health economy in Croydon
- Learning and Development sub-group – oversees the delivery and development of the multi-agency training programme and evaluates its impact
- Operational Chairs sub-group – coordinates the work of the CSCB sub-groups and ensures that safeguarding and promoting the welfare of the child is incorporated in the work of all organisations working with children and young people
- Safeguarding Practice sub-group – examines safeguarding practice across service departments, agencies and organisations; analyses complex and/or multi-agency practice issues; and develops, disseminates and promotes best practice to children and young people's workforce
- Serious Case Review sub-group – commissions serious case and other case reviews and oversees the ongoing implementation of action plans resulting from the learning that is generated
- Performance and Quality Assurance sub-group – monitors effectiveness of safeguarding arrangements across the CSCB partnership, including

monitoring of performance, development and carrying out multi-agency audits and as a result of audits, recommending short term task groups to complete additional work.

The structure chart of the Board can be found in Appendix 1.

The Board closely monitors attendance of Board and sub-committee members throughout the year.

The work of the Board and its sub-committees is supported by a small team of officers: A Development Manager, who manages the delivery of the Board's work programme and a support team, which comprises a Board Coordinator and Child Death Overview Panel Co-ordinator. The Quality Assurance Manager and the Training Manager posts have been vacant throughout the year.

IV Safeguarding Activity

This section sets out the main specific child protection data which is gathered by CSCB partners. The series of data presented in this report is for the 12 month period ending 31st March 2013.

1. Referrals to Children's Social Care

In 2012-13 there were 4818 referrals made to Children's Social Care. Compared with last year's figure of 4177, this represents an increase of 15.3 % (641) referrals. The increase in referrals has occurred at a time where funding cuts are impacting on the services' ability to grow within the Council. The continued increase of pressure on the 'front door' supports the need to develop a multi-agency safeguarding hub to ensure early information sharing and allocation of work.

The table below outlines the numbers and percentages of referrals and initial assessments completed by children's social care services during 2011-12 compared with statistical neighbours.

Local Authority	Referrals Number	Referrals Rate per 10,000 of children aged under 18 years	Initial Assessments completed Numbers	Initial Assessments completed Rate per 10,000 children aged under 18 years	All initial assessments completed as a percentage of total referrals in the year
England	**605,100**	**533.5**	**451,500**	**398.1**	**74.6**
London	**84,300**	**463.9**	**64,900**	**357.4**	**77.0**
Outer London	**50,200**	**433.6**	**37,900**	**326.9**	**75.4**
Croydon and Statistical Neighbours					
Birmingham	21,654	789.0	12,701	462.8	58.7
Luton	3,582	685.5	3,085	590.4	86.1
Croydon	4,177	468.2	3,414	382.7	81.7
Ealing	3,864	503.2	2,672	348.0	69.2
Enfield	2,660	337.2	2,387	302.6	89.7
Greenwich	4,715	767.2	3,580	582.5	75.9
Hillingdon	3,625	562.5	3,024	469.3	83.4
Merton	1,527	351.5	1,143	263.1	74.9
Redbridge	3,691	520.2	3,435	484.1	93.1
Waltham Forest	2,506	406.7	1,930	313.2	77.0
Reading	2,088	625.0	1,968	589.1	94.3

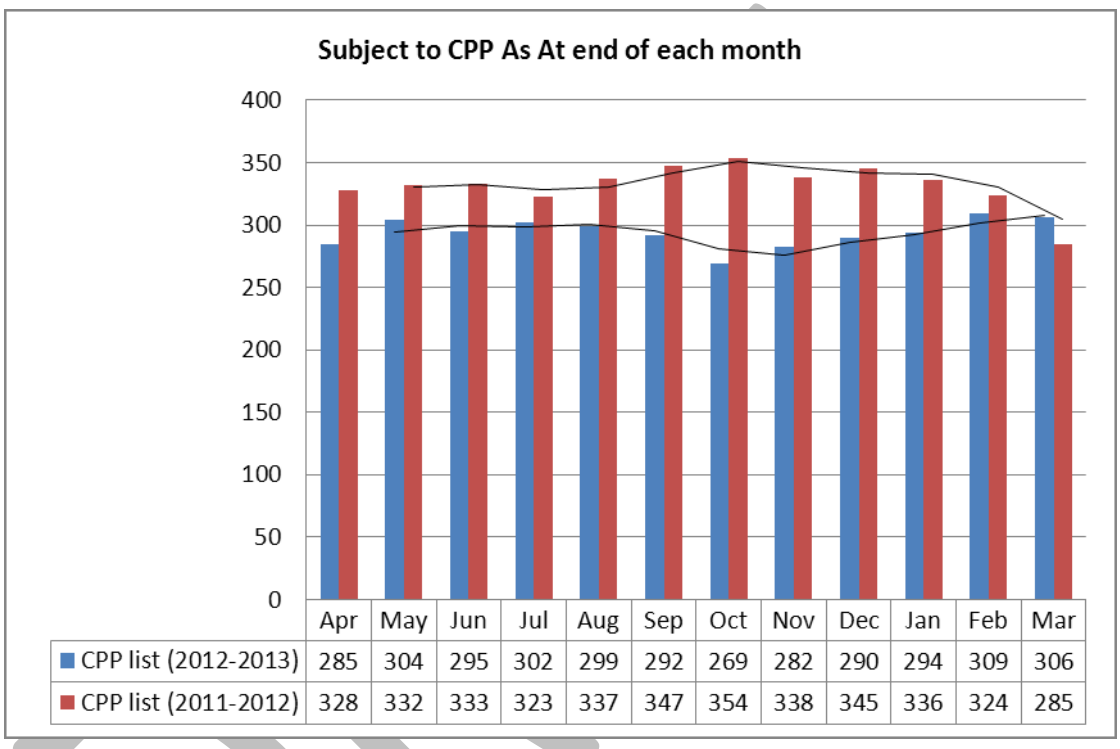
2. Number of Core Assessments Completed 2012/13

There were 1726 core assessments completed during 2012-13, this compares to 1732 core assessments completed last year. The below table highlights the percentage of core assessments completed within 35 days compared to statistical neighbours (2011/12).

England	75.50%
Birmingham	65.20%
Luton	68.10%
Croydon	73.40%
Ealing	88.50%
Enfield	84.50%
Greenwich	76.50%
Hillingdon	88.20%
Merton	57.50%
Redbridge	71.30%
Waltham Forest	67.00%
Reading	63.40%

The core assessment performance data indicates that the end of year performance in respect of timeliness of core assessments was at 73.40% (the local target is 80%). This performance measure is monitored on a weekly basis and there are management reports in place to assist in the tracking of open assessment. Despite this, there has been a decrease in the number of core assessments compared to last year where the end of year performance was at 76%.

3. Number of children becoming subject to CP Plan



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CPP list (2012-2013)	285	304	295	302	299	292	269	282	290	294	309	306
CPP list (2011-2012)	328	332	333	323	337	347	354	338	345	336	324	285

In comparison with last year's figures the general trend is that the number of children subject to a Child Protection Plan at the end of each month was lower during 2012/13 in comparison with the previous 12 month period.

In 2011/12 the rate of children who became the subject of a child protection plan per 10,000 children in Croydon was 38.8 which is lower than the national rate of 46.0 and placed Croydon as the 4th lowest borough in comparison with our statistical neighbours.

	Source: 2011-12 Children in Need census		
	Children who became the subject of a child protection plan during 2011-12	Rate of children who became the subject of a child protection plan during 2011-12 per 10,000 children	Children who ceased to be the subject of a child protection plan during 2011-12
England	**52,100**	**46.0**	**51,600**
London	**7,300**	**40.0**	**7,200**
Outer London	**4,400**	**38.2**	**4,300**
Croydon and Statistical Neighbours			
Birmingham	1,574	57.4	1,648
Luton	331	63.3	339
Croydon	346	38.8	389
Ealing	366	47.7	354
Enfield	284	36.0	251
Greenwich	388	63.1	359
Hillingdon	383	59.4	258
Merton	192	44.2	139
Redbridge	189	26.6	213
Waltham Forest	218	35.4	227
Reading	207	62.0	194

During 2012/13, 333 children and young people ceased to be the subject of a CP plan, this is less than last year's figure of 389 children and young people. A CP monitoring panel is constantly reviewing all cases where the child has been subject to a child protection plan for longer than 18 months. The aim of this panel is to address drift and ensure that the care plan continues to meet the child's needs.

V Progress against Business Plan 2012/13

1. To ensure the effectiveness of the work of local partners to safeguard and promote the welfare of children.

We said we would have in place a robust framework for evaluating the quality and effectiveness of multi-agency and single-agency safeguarding arrangements and, in particular, the impact of these arrangements on outcomes for children and their families.

We have:

- Undertaken a comprehensive audit reviewing partner agencies individual casework in selected Child in Need, Child Protection and Looked After Children cases and the impact of multi agency intervention.
- Introduced a new section 11 safeguarding profile which all partner agencies with the exception of UKBA has completed and returned to the Board. The returns are presented to the board on an ongoing basis and analysed by board members to ensure the effectiveness of safeguarding arrangements in each agency.
- Developed a commissioning brief for Independent Consultants to analyse information contained within the new section 11 safeguarding profiles and prepare a report to the CSCB and the Performance and QA subgroup as a result.
- Not being able to fully complete the planned 360° feedback exercise, to capture the experience of frontline staff and managers in main agencies in relation to safeguarding within their own agency and partnership working, due to pressures within agencies.
- Ensured that a Thresholds document was developed and signed by all key partner agencies. This should come out – we did this in the 2011-12 year.
- Developed a framework for Safeguarding Practice Reflection and partner agencies have been asked to review their own policies and arrangements for safeguarding supervision in light of this framework. Partner agencies have asked to return their finalised safeguarding supervision policy and arrangements to the Performance and Quality Assurance sub-group.
- Asked partner agencies to consider specific Quality Assurance programmes for their individual areas both through the new section 11 safeguarding profile and through completion and return of an adopted the Local Government Improvement and Development (LGID) Strategic Safeguarding

Quality Assurance Framework to the Performance and Quality Assurance sub-group.

- Provided multi agency Quality Assurance methodology training on 8th June 2012. This training was delivered by an external Professor of Social Work with a particular experience and expertise in child protection. The training focussed on the following key outcomes:
    - Enabling members of the partner agencies to develop their own Quality Assurance programs and to participate fully in the LGID programme;
    - Exploring methodologies in relation to Quality Assurance;
    - Assisting agencies in developing Quality Assurance capacity through co-auditing/ co-interviewing activities; and
    - Generating a positive approach to the processes of challenge and reflection.

2. Ensuring that Child Protection Systems are fit for purpose and working well

We said we would have processes in place to ensure that safeguarding supervision is fit for purpose.

We have:

- Developed a Framework for Safeguarding Practice Reflection which has been agreed by all Croydon partner agencies.
- Requested and received partner agencies finalised supervision policy and arrangements for safeguarding supervision.
- Developed a commissioning brief for Independent Consultants to undertake a safeguarding supervision audit, focussing on analysing the quality of supervision given and how supervision is used to improve positive outcomes for children.

We said we would raise private fostering awareness through the development of a private fostering strategy, a pilot project in a school, training and a multi-agency conference.

We have:

- Circulated a London Borough of Croydon Broadcast on Private Fostering to all internal staff and staff in educational settings.
- Reviewed a Private Fostering Report for April 2012 – January 2013 and agreed to raise further awareness of private fostering in schools.
- Developed and distributed private fostering pamphlets to key partner agencies for their distribution and display in entrances, practices and public noticeboards.

3. Promoting a multi-agency approach

We said multi-agency safeguarding hub (MASH) implementation would be commenced and evaluated.

We have:

- Had significant challenges in progressing the establishment of a local authority IT infrastructure at 69 Park Lane, the agreed initial 'collation site' for Phase 1 of MASH. These have now been resolved and the delivery date for the network (Phase 1) is July 2013. The next Phase 2 which relates to the development of a dedicated 'firewall' has a target date in September 2013 and the 'go live' Phase 3 is currently proposed to be end of October 2013. There is clearly expressed commitment across the professional partnership and the third sector to support the development of Croydon's MASH, – we have health commitment so this is overly negative

We said we would develop a shared management of risk strategy.

We have:

- We are underway with an update of the processes within Croydon's staged approach for intervention and this will set out a reviewed approach to risk.

We said we would embed the Domestic Violence Strategy through a strategic approach to domestic violence training.

We have:

- Focussed on Domestic Violence as one of our key priorities and in particular multi-agency Domestic Violence Training. Twelve full day sessions have delivered between April 2012 and March 2013 with 289 attendees. The aim of the training focussed on the following areas:
    - Understanding the definition and parameters of domestic abuse
    - Being aware of the latest messages from research, statistics and some of the lessons from serious case reviews
    - Considering the impact on victims, parents and children
    - Having knowledge of local resources and think about how to meet the needs of the all the family including the Perpetrator.
    - Exploring how to respond to DA, risk assessments and other Referral mechanisms and in particular with regards to Safeguarding children.

  A general overview of the feedback of this training highlights positive experiences of the training day as a whole with multi-agency interaction being a positive additional component. A full evaluation of this training will be undertaken by the facilitator of the training and this will be presented to the Learning and Development sub-group.

4. Ensuring that all aspects of our work are informed by the voices of children and parents

We said we would implement a Children's focus group.

We have:

- The Children and Families Partnership has led on the further development of the child and young person's voice, updating our strategy and putting in place a small team of young apprentices to support this work.

We said we would further develop the process for understanding the outcomes of those children that have been subject to a CP Plan.

We have:

- Undertaken two extensive audits in relation to Child Protection Outcomes. The first audit considered all cases where a Child Protection Plan ended between September and November 2011. This included 22 cases involving 52 children. The second audit relates to 35 families in which Child Protection Plans ended between December 2011 and March 2012. Eighty one children's plans were audited.
    - In both audits the key focus was on obtaining feedback from families to ascertain their views about the Child Protection Process.
    - The outcomes of the audit in the form of reports to the Board revealed that less than half felt that the Social Worker had explained properly what was going on in the Child Protection Process and listened to their views.
    - A positive outcome is that all of the children felt safe at school.
    - A new Children's Leaflet/Consultation Form has subsequently been developed which explains the Child Protection Process.
    - Some children really liked their Social Workers, whilst some children did not like it when social workers change.
    - Domestic Violence was an element in 94% of the families in the December 2011 and March 2012 cohort and a recommendation from the audit report notes: *'As Domestic Violence services are re-commissioned locally, it will be important for there to be a flexible range of options to meet with therapeutic needs of family members and to ensure that working mothers are not disadvantaged'.*
    - **The two audits were one of the drivers behind the introduction of the new Strengthening Families model for child protection conferences, which has been successfully implemented. This is a significant move forward in enabling children, families and partners to make better use of the opportunities offered by these conferences.**

We said we would further develop the process for understanding the experiences of those children that are looked after.

We have:

- Introduced Croydon's Quality Report to provide a detailed snapshot of how children and young people looked after by Croydon Council experience being looked after. Information is collected directly from young people about their understanding and experience of their time being looked after following their statutory LAC Review meetings. Additionally, Independent Reviewing Officers were asked to provide a professional assessment of several aspects of the quality of life experienced by children and young people. A key finding in the most recent report 88% of the young people reported that their lives had improved for the better since becoming looked after and were keen to provide examples of how this had been achieved. Several reported being "protected from abuse", "feeling safe", "being given opportunities", and "having a family".
- Made stronger links with the Youth Council, which actively affects the work of the Partnership, e.g. its identification of issues by young peoples about safe travel led to a work stream on this area in 2012.
- Arranged an away day for Board members in December 2012 which specifically focussed on parents' and children's views of the Child Protection System.

5. Vulnerable Young People

We said we would develop a Strategy for Vulnerable Young People.

We have:

- Developed an Overarching Vulnerable Young People's Strategy and a Vulnerable Adolescent Complex Case Planning Process which have been signed off by the Board. The purpose of the strategy and guidance is to assist practitioners in identifying the correct pathway for the young people concerned and to hold multi-agency meetings for the few vulnerable young people that will need to access this process. To date one Complex Case Planning Meeting has been held.
- Planned an outcomes focussed audit to evaluate the effectiveness of the multi-agency response in assessing and supporting vulnerable people across a range of issues such as children known to YOT, at risk of sexual exploitation and missing children.

We said one of our key priorities was sexual-exploitation

We have:

- Worked effectively with partner agencies to ensure there is a strong process in place to help missing children and those at risk of sexual exploitation and a track record of improved outcomes for these children can be demonstrated. Quarterly Strategic Planning Meetings have been held and a Sexual Exploitation Protocol specific to Croydon has been drafted and implemented in February 2013. Multi Agency Planning Meetings (MAP), as per the protocol, takes place on a regular basis with strong links with NSPCC and Safer London Foundation.

VI Progress against Single Agency Objectives

All partner agencies of the CSCB agreed a set of objectives for 2012-13, which have a focus on measurable improvements. The aim of gathering this information is to enable this year's annual report to be outcomes focus. Moving to an outcomes-based approach to safeguarding is not easy as it required those involved to approach things differently. It will however bring significant benefits as it will help the CSCB to promote models of good practice ('what good looks like') but also more significantly it will help us to understand what is not making a difference, and therefore to challenge areas of practice/service.

Set out in table 1 below are the returned responses from partner agencies of the CSCB. Probation has to date not returned a response.

Table 1

Children's Social Care

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Development of the Sexual Exploitation Protocol	• There are clear pathways in place to assess children at risk of or suffering harm from sexual exploitation and identify appropriate support. • Children and young people are able to access support in a timely manner.	• The procedures were updated in January 2013 in line with the key recommendations from the Inquiry into Child Sexual Exploitation in gangs and groups 2012. • Work is still underway to ensure that clear pathways are in place to assess children at risk of sexual exploitation. Referrals currently go directly to the QA manager in the Children's Quality Assurance & Safeguarding Service (CQASS), where these meetings are set up in partnership with front line social workers and partner agencies. It is hoped that once the MASH becomes fully operational, these referrals will be more effectively dealt with alongside the Common Assessment Framework (CAF) and Early Intervention (EIT) services. • The CQASS has worked hard to ensure the effective running of these meetings, some of which	• The updated procedures have directly helped to improve organisational understanding of the definitions of sexual exploitation, the assessment of risk and the plans for intervention and support. • A training event on sexual exploitation is currently being organised to raise awareness of the procedures and the support arrangements for young people. This will help to ensure that children are able to access support in a timely manner. • The timely organisation of Multi Agency Panel (MAP) meetings ensures an effective safeguarding response to vulnerable children in Croydon. • Multi agency meetings will assist efforts to develop our strategic understanding of sexual exploitation in Croydon and

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		were chaired by partner agencies. Unfortunately we experienced difficulties running these meetings with the limited chairing resources available, and in May 2013, agreement was given by senior management to secure additional funding for a ½ time IRO post to chair all MAP meetings. • The partnership with the SLF and the NSPCC continues to work well to ensure that appropriate, timely and targeted support is made available to all young people who need it as part of the MAP process. • A multi-agency strategic meeting is planned for July to bring together data on all 43 children currently subject to the MAP process to identify children who may be victims of sexual exploitation. This will take into consideration their school, home environment, local area, individuals in common and times of disappearance etc. • The role of the CSCB and the need	develop local strategies to respond to the national agenda and meet government requirements driven by the CSCB.

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		to link sexual exploitation to an appropriate sub group to ensure its effective operation is also now being considered. • A report for the CSCB on the progress of the protocol will be provided by the end of July.	
2. Ensure outcomes focussed care plans are in place for all children (CIN, CP, LAC)	• All children receiving an ongoing service from CSC have an outcomes focused care plan. • There is evidence that plans are reviewed regularly, drift is reduced and the impact of intervention is understood.	• The CQASS has developed a LAC spread sheet for IRO's to ensure timely completion of LAC care plans and all other performance data including PEP's, Pathway Plans, Permanency Planning meetings, health assessments, immunisations etc. This data is shared with the senior management group on a monthly basis and used by IRO's on a daily basis to track outcomes for all LAC children.	• The completion of the LAC spread sheet alongside effective management oversight ensures that the CQASS plays a central role in ensuring that the department is meeting all of its statutory responsibilities to LAC children. The use of the dispute resolution protocol in the CQASS to address drift and poor practice also helps to achieve positive outcomes.
3. Improve the quality of strategy meetings (inc. multi agency attendance, recording and distribution of minutes).	• Multi agency strategy meetings are taking place and actions are clearly recorded. • Initial sharing of information is improved and assessments reflect a multi-agency approach.		

Adults

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Develop the CSAB partnership and quality assurance processes.	• The CSAB is accountable, representative and has a positive impact in promoting outcomes for adults and their families.	• The CSAB has been independently chaired since January 2012. • In June 2012 a board development day enabled partner agencies to meet to develop priorities that underpin the business plan for 2013 to 2015. This business plan is now being incorporated into the work of the board and its subgroups. A quality assurance framework has been developed. To date actions include: • board and subgroup scrutiny of the most recent SRC • strong partnership working to develop more inclusive partnership across adults and children including representation of Human Trafficking issues and training. • an action plan to address potential issues highlighted by the Winterbourne report, • an external file audit of safeguarding case work and Croydon Council is now planning to	Continuing development of a shared understanding across the partnership in how together we can be effective in safeguarding adults and in measuring outcomes. In this respect: • The business plan is now being actively developed to include improved methods of service user participation and empowerment. • The learning from recent SCR's has been disseminated through multiagency training events and training for providers through the care forums. • Increased awareness of the risks of human trafficking in Croydon and how to identify and refer people, including children, who may be victims. • A review of adults with a learning disability and challenging behaviour/ mental health needs and of processes to support them to prevent a Winterbourne type scenario with a robust multiagency

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		implement a multiagency case file audit.	action plan in place.
2. Develop a common approach across the partnership to risk assessment and risk management based on a commitment to multi-agency working and shared principles	• There is evidence that there is a consistent approach to risk assessment and management of cases across services. • Risk assessment training is effectively evaluated to monitor the impact of learning events.	A broad approach across the partnership to risk assessment is still under development. Specifics which have been achieved so far include: • A multiagency self neglect protocol has been developed which highlights the needs and risks of this group of people and provides advice/ guidance for all agencies. • The external file audit and on-going internal safeguarding audit process keeps the management of risk versus service user empowerment to the fore and will inform our partnership framework. • Independent chairing of safeguarding cases has been established and the chairs are fully sighted on identifying and working with risks across the partner agencies. • The SCR partner agency training identified common risks and their management incorporating	The partnership is developing a shared understanding of important underpinning principles and associated legislation in risk work. This will be consolidated when a partnership framework / approach is fully implemented in 2013/14. • People who self neglect receive interventions that focus on capacity and on degree of risk and the involvement of other agencies. • There is an increased focus for service users subject to safeguarding events on both risk management allied with proportionate and chosen acceptance of risk by people with capacity to make these choices. • The independent chairs actively oversee the development of the protection plan and risk management for service users at risk of abuse. • The care support team work with

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		understanding of the flexibilities of the mental capacity act and best interest decision making. • Recent SCR's have illustrated some common specific areas of risk for which we have put in place robust responses, such as pressure ulcer care, falls training and strengthened continuing care processes. • Links between vulnerability of tenants in the housing sector and safeguarding risks are being identified and addressed in partnership. Monthly meetings take place between Croydon landlord services and mental health teams to identify, refer and support tenants with mental health problems. • Training has been provided to registered housing providers on safeguarding issues includes risk of harm with further training planned.	providers of care to improve the management of risks from falls, tissue viability, infection control and dementia awareness and management strategies. • Joint training programmes for GP's and other health staff support them in identifying risks and knowing how to respond. • Housing staff are being engaged as significant partners in supporting vulnerable people. • People with a learning disability and challenging behaviours are being actively reviewed to manage risks.
3. Develop a workforce strategy and action plan	• Processes are consistent and promote positive outcomes for	We are putting together guidance across the whole partnership to	• In order to measure the impact of the revised supervision policy, we

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
(focusing on common standards in supervision; recruitment; performance management and learning).	vulnerable adults.	support best practice in this context and progress has been made as follows: • A revised supervision policy has been implemented for Croydon Council social care staff which incorporates reflective practice and HCPC competencies. This will be developed across the partnership. • Training on safer recruitment for partner agencies including information about the revised DBS process is being developed and will shortly be rolled out. • A wide range of training is available to social work, health, partner agency staff and providers on a range of issues including safeguarding, MCA and DOLS, dementia awareness, human trafficking, falls, infection control etc	are about to carry out a survey of staff to assess the impact of the revised policy on reflective practice and workload management. This is intended to improve social work services for vulnerable adults and the identification of risks to any associated children. • Social care staff and provider staff are knowledgeable about referrals to the DBS following a presentation at the board and further training is planned on this and safer recruitment to consolidate learning. • Multiagency staff and providers have access to a range of training on workforce issues to improve practice and service user experience and further training/ information dissemination is planned.

SLAM/CAMHS

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Increased learning through training and dissemination of lessons learned.	• SCR recommendations are effectively implemented to improve child safety. • Training is effectively evaluated to monitor the impact of learning events.	The recommendations for the recent Child X SCR included the dissemination of learning to the team involved which will be carried out by the Trust Safeguarding Leads. All Trust Safeguarding Children training is evaluated by participants and the impact of learning events is reviewed in the annual Trust Practice Audits. Following the revised Intercollegiate Document the Trust devised a new training strategy which aims to meet mandatory national requirements and responds to staff requests for increased access to safeguarding leads, case discussion and updating regarding lessons from Serious Case Reviews. The new training strategy also strengthens the sharing of learning from specific SCRs across the Trust. The proposal is in conjunction with all Trust safeguarding children arrangements as part of a "systems" approach attempting to consistently embed safeguarding children principles	Previous SCR recommendations are highlighted in the current Safeguarding Children Training eg. Private fostering / LADO along with a focus on embedding these into practice. Current Safeguarding Children training is well evaluated and staff are able to identify changes to their practice as a result. Evidence is sought to support this through the annual audits and there is good evidence that good safeguarding practice is embedded across teams.

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		in practice. SLaM has also responded to recommendations not made directly to the Trust but that may affect safeguarding practice ie. sharing the lessons learned in Child E SCR and improving practice through the recommendations made.	
2. Improve access to CAMHS	• Children and families experience improved timeliness in respect of access and capacity to manage risk is increased through appropriate caseload allocation.	The service has appointed a dedicated referrals co-ordinator to ensure appropriate cases are prioritised. If we are not able to offer a service we signpost to other agencies and e.g. on line resources. There is a traffic light system for managing caseloads. The Children's IAPT services are increasing skills of the Voluntary sector and capacity to manage cases that don't meet CAMHS thresholds. We have ensured that newly funded staff have prioritised waiting list cases. SLAM has also managed some referrals of significant cases by use of tier 4 resources funded via increased funding	Staff are clear about priorities and patients are clear about waiting times

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		in year We are planning increased DAWBA completion to improve efficiency and patient choice. The service is planning to re-shape teams to match increased demand	
3. Further development of 'Think Family' approach	• Families experiencing parental mental illness experience a more consistent approach. • A joint approach to families is promoted across services	The Trust Child Need and Risk Screen, which identifies which service users have contact with children and supports staff to assess the needs of and potential risks to the child has been revised to ensure it is a more effective tool which support best safeguarding practice. Completion of Child Need and Risk Screens is overseen within each service's bi-monthly Performance Management meeting with a mandatory minimum completion rate of 95%. Completion rates are also reviewed at the Trust Safeguarding Children Committee, the local Borough Safeguarding Children Committee, the CEO Performance Management Meeting and by the Board of Directors.	The revised Child Need & Risk Screen now prompts staff to; 1. list any child a service user has any contact with 2. identify if a service user is pregnant and consider any risks to the unborn child and the possible need for a pre-birth CP conference 3. identify risks to children in the wider public including through any work or employment of the service user 4. consider the impact of mental illness, substance misuse and learning disability on capacity to meet the needs of children with a link to the Trust Safeguarding Children Intranet site and clear prompts to seek supervision and further specialist safeguarding

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		The Lead CP Nurse and local Borough Safeguarding Children Committee has further developed a monitoring system for CP referrals made. The Lead CP nurse is advised of all invites to CP conferences and those that relate to any Croydon SLaM service user are shared with the care coordinator for follow up as per the Trust CP Policy. The Trust expectation is that SLaM staff will fully participate in multi-agency child protection conferences by attending to share and hear information about concerns relating to a child(ren). In this way mental health services can actively promote the safety and welfare of children alongside partner agencies.	support where the impact may be unclear or practitioners are unsure 5. consider the impact of Domestic Violence on the family situation 6. consider if a private fostering arrangement has been identified 7. identify the professional network involved with the family 8. identify if a service user is an inpatient and the impact of this for the child 9. record and track if a children social care referral has been made and what follow up was needed 10. seek support, management oversight and consider the need for escalation All these aspects fit with the "Think Family" model and offer a framework that consistently enables professional judgement. All referrals to Children Social Care along with the outcomes are monitored within CAMHS. This ensures that there

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
			is a multi-disciplinary team discussion about the outcome which ensures that safeguarding decisions are timely and can be challenged or escalated when appropriate. This also prompts staff to seek the advice / support of the Lead CP Nurse when needed. The Trust is currently working to roll this out across adult mental health services. In Croydon the Lead CP Nurse and local Borough Safeguarding Children Committee have regularly reviewed this and local teams are increasingly implementing the system. All SLaM staff working with a Croydon family that is subject to a CP conference are informed of the conference and reminded ot the expectation to actively participate in the multiagency process to safeguard the child(ren) irrespective of who is the service user within the family. This has increased the awareness of mental health teams across the borough of the

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
			Trust expectation of them in relation to Child Protection Conferences. The Trust has started positive discussions regarding how it will work with Croydon's Family Engagement Partnership and plans to collaboratively grow the network through increased awareness and contact between the different organisations and parts of the system.

Police

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Serious Sexual Offences: Identify, apprehend, prosecute perpetrators, ensuring victims are appropriately cared for.	• Young people who are victims of sexual abuse are appropriately supported through criminal hearings. • Adults posing a risk are identified and strategies are put in place to ensure the wellbeing of children.	1. Dedicated child abuse investigation teams, enable specialist trained officers to support YP throughout criminal hearings into sexual offences. The use of ABE, intermediaries and VLOs in court proceedings. This changes, that have been brought in over time have helped create far better systems to support YP who are victims/ witnesses in the judicial process.	The routine use of special measures and ABE have had dramatic impact on the ability of YP to give better evidence at court that also has a less detrimental effect on their wellbeing than traditional court proceedings.

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		2. Dedicated borough "Jigsaw" units to manage registration requirements and sexual offences Prevention orders in relation to Registered sex offenders- also feed into Mappa to ensure effective management of offenders.	2. Croydon Jigsaw unit is fully staffed, with specifically recruited for staff. The unit has identified and successfully identified and detected several breaches of registration conditions, thus ensuring those who do fail to comply with their registration orders are brought to justice, and reducing the risk from offenders.
2. Missing Persons: Maintain reduction of 60%	• There is a continued reduction in the number of children going missing. • Improved outcomes are reported for those children monitored through the Croydon Missing Children Panel (i.e. no longer missing, in appropriate placements).	1. There were 127 fewer missing person reports year on year 2012/13 compared to 2011/12. 2. Missing Children's panel has assisted with ensuring a directed multi agency problem solving approach to monitoring missing children	Missing Children's panel has assisted with ensuring a directed multi agency problem solving approach to monitoring missing children. Although we do have a number of frequent missing children, there has been some success where the panel has identified a need for a specific placement for a YP, which has reduced the number of missing instances.
3. Sexual Exploitation: Identify, apprehend, prosecute perpetrators for the offences, including use of sec 2 abduction notices, ensuring victims are appropriately cared for.	• There are clear pathways in place to assess children at risk of or suffering harm from sexual exploitation and identify appropriate support. • Children and young people are able to access support in a timely	The MPS is currently implementing a sexual exploitation pilot in Lewisham to assist in identifying children at risk of sexual exploitation, and support accordingly. This will be subject to review later in the year and recommendations made accordingly re	The establishment of the Sexual exploitation and missing persons unit in Croydon has assisted the MPS in drawing up and trialling a Sexual exploitation in Lewisham borough. This will be subject to review and potential implementation in line with the local

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
	manner.	roll out across the MPS dependant on project findings. Emily Wareham, Op Connect gangs and girls worker , working alongside Missing persons unit, enabling effective referral and intervention where YPs require support	policing model with specialist child abuse and sexual offence investigation units leading on this project.

Education

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. All educational settings are aware of their responsibility regarding safeguarding practice conforms	• The framework for safeguarding practice reflection is implemented and supports staff in managing the pastoral area of their work. • Training is effectively evaluated to monitor the impact of learning events.	• Three training sessions have been held centrally for Senior Designated Professionals in schools and colleges and further sessions have been delivered in individual settings in both the maintained and independent sectors and at Croydon College. • All schools and colleges have an appropriately trained Senior Designated Professional. • Whole School Safeguarding training has been provided to primary and secondary settings in both the	• Increased levels of awareness and training • Increase in the number of referrals to the LADO • Increased engagement with the non-maintained sector • Increased pastoral care support and awareness

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		maintained and independent sectors. • All training has been consistently evaluated as good or outstanding. • All Croydon schools have adopted Safeguarding Policies and all that have been inspected have been judged by OFSTED to have the necessary policies and procedures in place to meet statutory requirements. • The Teaching and Learning Adviser (Safeguarding) has established relationships with 19 non-maintained and independent schools in Croydon, from a baseline of 0 at the beginning of September 2011. All 19 have undertaken training for Senior Designated Professionals and/or Whole Staff Safeguarding Training • Training has been provided for whole governing bodies and for Designated Governors to ensure they are aware of their statutory responsibilities. • Croydon College has updated its	

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		Internal procedures • Croydon College has increased Divisional training and Cross College planned training has been booked	
2. Maintain and develop further communication systems to ensure that schools and other settings are kept updated i.e. DV, Sexual Exploitation etc	• Schools feel confident that they have the knowledge and skills to support young people. • Staff have attended training to support them to identify children and young people who are vulnerable and potentially at risk of sexual exploitation/gangs/missing episodes. • Where appropriate children and young people are referred onto targeted service provision.	• A termly Safeguarding Forum has been established in order to ensure schools and colleges are kept up to date with latest developments and best practice guidance. Sukriti Sen (Head of Children in Need) and Gareth Flemyng (Multi-Agency Safeguarding Hub Project Manager) are regular contributors. • Every maintained school has a named contact within the School Improvement Team, their Link Adviser, and all schools are aware of their named person. • All schools, academies and colleges have an updated list of relevant contacts within the LA, including the LADO, the Improvement Adviser for Safeguarding and Multi-Agency	• More awareness for front line staff • Support and work with students has increased • Individual Learner needs and support in place • Increased staff Awareness • Increased safeguarding referrals • Gangs awareness and referrals

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		working and the Teaching and Learning Adviser (Safeguarding). • Regular updates and guidance for schools are provided via Fronter (the Local Authorities electronic communications system with schools) and via the weekly bulletin sent to schools. Independent schools have been provided with free access to the Fronter safeguarding room. • Croydon schools are participating in the Growing Against Gang Violence • Front line staff are trained on Sexual Exploitation and DV • Croydon College has a link with the Family Justice Centre • Croydon College conducts risk assessments for Youth Offenders and support plans are in place Croydon College has links with YOT, council and Met police unit, missing persons are monitored and receive support when they return. Staff at the College have undertaken	

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		additional levels of training • Missing persons monitoring and support when they return • Increased staff training- raising key issues	
3. To ensure that thresholds and 'step up, step down' processes are fully understood by all school settings.	• CAF is employed by schools in line with the staged intervention protocol.	• Training in place and up to date • Regular support and guidance is provided to schools and the Head of Children in Need and the MASH manager have contributed to termly safeguarding forum meetings.	• Used when appropriate to ensure effective systems are in place

Early Intervention and Family Support

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Domestic Violence: Improve children and adult safeguarding arrangements in the Family Justice Centre.	• There are clear pathways in place to ensure that risk is managed at the appropriate threshold. • Services are accessible for all and recognise the diversity within our community • Families are able to access support in a timely manner.	Systems are in place within FJC to ensure pathways have been secured and risk managed. Clients at FJC do represent diverse groups in Croydon. Work with agencies such as children's centres is progressing but this will be the focus of 2013-14 work.	Feedback from clients indicates they are able to make decisions about their situation. The client has effective support to enable them to leave violent situations. Referrals to MARAC are increasing indicating that there are improvements in assessing risk both at FJC and other partners.
2. Early Years Settings: Continue to be supported to	• The framework for safeguarding practice reflection is implemented	All children's centres have robust supervision arrangements in place.	Evidence in Ofsted reports for centres inspected show the effectiveness of the

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
have in place strong safeguarding procedures	and staff receive regular good quality supervision. • Staff have a good understanding of the staged intervention document and cases are managed at appropriate threshold levels. • There are appropriate escalation processes in place.	Safeguarding training is provided for all early years' settings that includes the threshold document. CrISS provides advice and support telephone support and 1:1 input is offered through the Early Intervention Consultants.	arrangements. Although we have had a low rate of safeguarding issues in Croydon, we have seen an increase in the number referred to Ofsted for safeguarding concerns – we are reviewing our training for 2013-14.
3. Family Resilience Service and Key Worker teams to have in place robust safeguarding procedures.	• The framework for safeguarding practice reflection is implemented and staff receive regular good quality supervision. • Staff have a good understanding of the staged intervention document and cases are managed at appropriate threshold levels. • There are appropriate escalation processes in place.	Robust supervision and case management processes are in place and are regularly reviewed. All staff have a clear understanding of Croydon thresholds and staged intervention. Clear processes for escalation in place.	The work with clients is effective and where necessary escalation to social care is used appropriately.

Health

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
1. Embed safeguarding supervision across the organisation	• All practitioners receive regular and good quality supervision that focuses on improved outcomes for children.	Develop and ratified a safeguarding policy, which includes specific competencies for supervisor and supervisee.(January 2013).	Rolling programme of supervision training delivered. Safeguarding supervision is well embedded in CUS, CHAH team and

What we intend to do	Desired Outcome	What did we do? How well did we do it?	What difference did we make?
		Safeguarding team currently collating trust wide data base of staff requiring child protection supervision and supervisees.	FNP. Action plans with clear timescales developed to embed supervision across wider organisation.
2. Increase Health Visitor numbers and develop long term recruitment strategy.	• Improved capacity will result in better quality provision of service and enhance early intervention strategies. • A recruitment strategy will ensure that the projected pressures (relating to an older workforce) are	Recruited to existing establishment of HV's. Funding agreed for a further 9.3 HV's. Developing pathways for HV recruitment including microsite and timelines for recruitment process.	99% attendance at initial case conferences Commenced 1 and 2 year developmental reviews.
3. Review of the referrals made to CSC in respect of children under the age of one.	• The CSCB is confident that there are no barriers to referrals being made. • Risk is being managed at the appropriate threshold.	Action plan devised and implemented – monitored quarterly, Reviewed training presentations to embed referral process into practice.	Consistent rate of referral for under one's , as evidenced in quarterly monitoring report.

VII Quality Assurance

As discussed in section V (Progress against Business Plan 2012/13) we undertook a multi-agency audit during the months of February and March 2013 on ten selected cases including children in need cases, child protection cases and looked after child cases. An audit tool was completed for each case by children social care managers and partner agency representatives. A 2 day multi agency meeting was then convened to enable group discussion and challenge in respect of each case. The audits were given a sub grading in respect of the Children's Social Care intervention and overall multi agency gradings were then agreed. The gradings were based on the following: 1 = Good; 2 = Adequate; 3 = Inadequate.

Any audits that identified areas of concern were referred to managers for action.

The multi-agency audit highlighted a drift in partnership working; lack of management oversight; lack of purposeless and the lack of business plans. All 10 cases reviewed revealed failings in partnership working. There was evidence of good outcomes for children in respect of education and health outcomes. There was also positive evidence of multi agency working taking place despite the lack of a formal care plan being in place.

Many of the issues arising from the audit were the same as those identified other audits undertaken by Children's Social Care in 2012-13 and in recent Serious Case Reviews. As is further discussed in section X (Overall Analysis) of this report, in order to facilitate learning, the Board will commission a two phase programme: Phase 1 will be for operational managers across the partnership and Phase 2 will be for front line staff. The aim of the event is to focus on reflection on interagency safeguarding issues and key messages from SCRs and the multi-agency audit.

As well as the Board's main focus on Domestic Violence during the year, the Board has also prioritised Safeguarding Training and Safeguarding Policy implementation for faith groups. One of the Board's lay members has been instrumental in taking this work forward within the community. A task and finish faith group was set up in 2012, a Safeguarding Children Policy and Protocol template has been developed for organisations in Croydon to use as the basis for adopting and implementing their own policy, and a special two day training programme to help support Mosque leaders, Imams, and more specifically Madrassah teachers understand safeguarding within their respective organisations was arranged.

Given capacity issues both within individual agency and at Board level, particularly with the vacant Quality Assurance Manager Post for over a year, there is an acute need to commission the Board's Quality Assurance work to address and strengthen this key driver of the Board' work. This is planned as a three year project.

In addition, we reviewed our processes for Section 11 returns and began to implement our revised approach to reporting the outcomes of Section 11 audits to the Board. Currently the analysis and evaluation of the section 11 returns is being commissioned out for completion by external consultants as well as the analysis of individual agencies supervision policies and the audit of safeguarding supervision. The Quality Assurance framework for 2013/14 therefore includes the following major pieces of work:

- Analysis of individual agencies supervision policies
- An audit of safeguarding supervision (including reviewing case files and gathering the qualitative experience of front line practitioners and managers)
- Analysis of section 11 safeguarding profile returns
- An audit of vulnerable adolescents
- An audit of local procedures to meet the needs of deaf children and children with special needs
- Analysis of case conferences with a particular focus on the experiences of children and young people, parents, carers and professionals.

Part of the Board's work on communication includes newsletters; the development of a new external website and the dissemination of lessons learnt from local Serious Case Reviews. The Board's external website once launched will play a key feature in the dissemination and communication to Board members, professionals, parents and carers and children and young people.

VIII Serious Case Reviews

Serious case reviews are undertaken when children die or a serious injured, and abuse and/or neglect are suspected or known to be a factor, and/or there are concerns about how local agencies worked together. The purpose of such reviews is to learn lessons and improve practice.

During the period from 1st April 2012 – 31st March 2013, the CSCB completed one serious case review. The CSCB commenced work on three further serious case reviews which will be discussed in the 2013/14 Annual Report. The CSCB was also involved in a SCR process in a neighbouring borough and an overview report using the SCIE model in another borough.

The key areas identified through the completed serious case review by the CSCB were:

- The need for all agencies to be aware of and adhere to agreed procedures in relation to sexually active children and children subject to sexual exploitation.
- The need to ensure that child protection concerns are considered in all children who are sexually active below the age of 16 years, including the possibility of sexual exploitation.
- The need to develop a strategy for children and young people who are vulnerable and at risk of exploitation.
- The need for ongoing single agency and multi-agency training for staff on recognition of the sexual exploitation of children and young people, child development, maturity and vulnerability.
- The need to develop information leaflets aimed at helping parents whose children are victims of child sexual exploitation.
- The need for better recordkeeping; completion of core assessments; completion of all the required checks in a section 47 investigation; and sharing of vital information between agencies and staff working closely so that they can form a better understanding of any change of behavior, protect the child from harm and promote the welfare of the child.
- For criteria to be developed by the safeguarding children team in Health on cases that must to be discussed at supervision. One of the criterion to be included is children subject to sexual exploitation.
- To ensure that all key messages of this review are contained within the training packages for Independent Contractor Services.

- The need for Walk in Clinics to have robust safeguarding processes in place.
- The need for staff likely to undertake the authoring of Internal Management Reviews in any future Serious Case Review to be provided not only with written guidance (as is currently the case) but also with training.

The Multi Agency Action Plan is subject to ongoing review and implementation by the Serious Case Review Sub Group.

In order to promote ongoing learning from both local and national Serious Case Reviews, the CSCB intends to commission an external agency to develop a comprehensive summary of our Serious Case Review messages and realign these with national messages and learning from local Domestic Homicide Reviews. The aim of this piece of work is to enable learning, capture each Serious Case Review in a memorable way and complement the findings with national research in a comprehensive summary format, which can be used as a resource for all partner agencies.

Following the implementation of the new Working Together 2013, Croydon has decided to pilot a more humanistic approach to learning and respecting families when tragic occurs. As a result, Croydon is conducting its most recent Serious Case Review using the Significant Incident Learning Process (SILP).

The SILP is a collaborative and analytical process. The key principle of the approach is the engagement of frontline staff and first line managers in conjunction with members of the Serious Case Review Sub-Group and Designated and Specialist Safeguarding Staff. The involvement of front line staff and line managers gives a much greater degree of ownership and therefore much greater commitment to learning and dissemination. The main focus is to extract learning from the detailed study of a set of circumstances. From a worker's point of view it takes account of:

- your view of what was going on in and around this case
- how you understood your role or the part you were playing
- your thinking and your context at the time
- your perspective on what aspects of the whole system influenced you as a worker
- the tools you were using.

By taking account of these things, the process focuses on understanding why someone acted in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. This process is NOT about blame or any potential disciplinary action, but about an open and transparent learning from practice, in order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

IX Child Death Overview Panel

Local Safeguarding children Boards have a responsibility, through the establishment of a Child Death Overview Panel, for reviewing the deaths of all children resident in their area. The aim is to determine whether the deaths were preventable and whether there are any lessons to be learnt or issues of concern. This section summarises the developments in respect of the Croydon's CDOP.

The panel met on 5 occasions this year, a lower number of meetings than usual, due to reduced capacity for coordination and administration of the deaths. There were 35 deaths reported to resident children of Croydon between 1st April 2012 and 31st March 2013 compared with 28 in the same period 2011/12.

There are 25 outstanding deaths of babies and children who died between April 2011 and March 2013, which are awaiting information to enable a fully informed review. Some of these are neonatal deaths of extremely premature babies. The panel have agreed these deaths should be assessed by the CDOP chair and paediatrician for safeguarding. Where it is agreed there are no safeguarding issues the cases are brought to the CDOP for sign off and agreement of findings in Form C (CDOP findings and recommendations form).

The arrangements for rapid response to the death of a child and review are well established in the area and are fed into the reviews of child deaths where relevant. There were ten deaths between 1st April 2012 and 31st March 2013 for which a rapid response meeting was held.

The use of Form B is the formal mechanism by which information is gathered from across the partnership to inform the review carried out by the Child Death Overview Panel whenever a child dies. Previously the Croydon CDOP had difficulty in obtaining completed Form Bs from many agencies. In light of this we have reviewed the sources available and now obtain information from a number of existing forms and sources e.g. neonatal unit summary/ discharge summary, hospital death summary, police forms, post mortems and rapid response meeting minutes.
This has improved the quality and detail available to the panel whilst alleviating those agencies from submitting duplicated information via a specific CDOP form.

There were 24 deaths reviewed during 2012/13:
1 died in 2010/11

12 died in 2011/12
11 died in 2012/13
9 (38%) were neonates (babies less than 28 days of age)
7 (29%) were babies aged 28 days to <1 year
14 deaths (58%) were expected and 10 (42%) were unexpected

The majority of deaths in children aged over 28 days were due to congenital abnormalities or life limiting illness; either following birth trauma or childhood events. As in the previous year the panel reviewed two sudden unexpected deaths in infancy.

Again there were no deaths related to non-accidental injury, however there was one teenager whose death was from suicide.

Two children died at home, one in a hospice and the remaining 21 died in hospital.

There were no specific recommendations for the CSCB from the reviews during this period, however the following comments and learning points will be shared to agencies directly and via the CDOP annual report to the CSCB:

- Croydon CDOP has requested and received confirmation from the Trust that the recommendations in three serious incident reports of neonatal deaths have been fully implemented.

- A learning point was noted regarding supervision of young children using private swimming pools following the death of a young child from drowning.

- The Croydon CDOP felt reassured that the serious case review, carried out following the death of a girl by suicide, had covered all aspects of recommendations and learning to minimise the risk of death from a similar situation occurring.

- Reinforcement to midwives and health visitors of the importance of giving safe sleeping advice. This should be provided to both parents, including those who do not live together and to additional family members caring for the baby, to ensure it is not just mum who is given the advice.

The CDOP have agreed that good practice should be acknowledged at each review (2013/14) and summarised in the annual report to ensure positive sharing and learning within Croydon's agencies.

Of note; the National Perinatal Epidemiology Unit (NPU) are currently conducting work to determine how to enable national sharing and learning of local CDOP recommendations.

X Overall Analysis

This has been a challenging year for the CSCB for reasons given by the Independent Chair, in his foreword at the front of this report.

Changes and restructuring in both Social Care and Health has provided a challenging context for taking forward the Business Plan from last year. The London Borough of Croydon's Children's Social Care service has undergone significant re-structuring and continues to embed significant remodelling. This has impacted on progressing multi-agency working and has involved staffing changes which has meant the need to looking inward to ensure improvement in practices. Croydon is on a transformation journey of systemic change. The Council's current implementation of the post-Munro remodelling of our Children's Social Care service demonstrates high aspirations for continuing to secure significant improvement. As well as having taken significant steps to improve the Croydon Social Care system, the Council approach safeguarding as a whole system and there is a strong link between the early help offer and Children's Social Care through our 'step up' and 'step down' processes.

Following the NHS reforms in April 2003 Health services have also undergone restructuring. This has resulting in the development of different commissioning arrangements which need to be considered in a safeguarding children context. Agencies across the Croydon health economy have worked to ensure that responding to the safeguarding needs of children have not been compromised during the period of transition.

Cuts in Probation budgets and subsequent job losses have meant that Probation is no longer as active in CSCB matters as it has been in the past years.

The Metropolitan Police service has also undergone service wide recent re-structuring, under the local policing model, which seeks to standardise policing to ensure consistency across all London Boroughs. In line with this the Croydon Sexual Exploitation and Missing Person Unit (SEMPU) now focuses on Missing Person investigations. The unit continue to work closely with Children's Services Missing Children and Sexual Exploitation panels, and advocates who work alongside police in respect of identifying children at risk of sexual violence through gang involvement and/or sexual exploitation. However, investigations of a sexual exploitation nature are now being dealt with by other parts of the Criminal Investigation Department. The MPS are currently participating in a CSE pilot project with Lewisham and Camden as pilot sites. Pending the result of this project a specific CSE unit within the

Child Abuse Investigation Command will be set up later in the year to deal with investigations where there is evidence of CSE.

Progress

In terms of partnership working and how service developments have taken place in response to identified need of Croydon's population, the following can be highlighted:

- as mentioned in section V (Progress against Business Plan 2012/13) as a response to our growing understanding of the extent and impact of DV in the borough the CSCB rolled out Partnership-wide of domestic violence training.
- the introduction of a pilot initiative between Children's Social Care and Probation to deliver the Caring Dads programme of working with fathers on the impact of children exposed to domestic violence in family life is beginning to yield very positive outcomes.
- the establishment in 2013 of a pilot housing social worker post (jointly with DASH) to respond to the growing housing-related need. The new children's social care model includes a specialist social worker for adult mental health / substance misuse, and one for domestic violence. As well as carrying complex caseloads, these posts will develop improved operational relationships – again, in response to our growing understanding of these areas of need.
- feedback from families involved in the child protection process, which has been gathered in two major exercises and reports to the CSCB, was one of the drivers behind the introduction of the new Strengthening Families model for child protection conferences (see section V, Progress against Business Plan 2012/13).
- the new outcomes focussed assessment and care planning processes and tools are designed to help individual needs and the voices of individual children to be more systematically recognised and recorded.

The areas in the business plan 2012/13 that were implemented by the Board have been referred to in this report.

Areas for further work

More work is being undertaken in evaluating and analysing agencies performance and the impact of multi-agency working on safer outcomes for children and young people. These areas are addressed in the 2013/14 business plan.

Safeguarding agencies in Croydon, both individually and as a group are acutely aware of the need to progress the Government's safeguarding agenda and the CSCB's weaknesses and our business plan for 2013/14 reflects this. Particularly, communication and public awareness of safeguarding issues and the need to further strengthen our quality assurance programme.

Despite significant attempts at recruitment, the Board currently does not have a Training Manager in post and no current training plan. The Training Manager post is planned to have a wider remit and responsibility. It is being joined with a restructuring of training functions to bring a more coherent approach to manage the work of training provided by the Children's Social Care Academy, Children and Families Partnership and the CSCB. This post will be commissioned from either a University or Independent Consultants with finance attached for three years. This will enable planning and good quality training across all safeguarding agencies.

Despite significant attempts at recruitment, the Board does not, at the time of writing, have a QA Manager in post. A short term appointment of somebody to fill the Development Manager (maternity leave), Training Manager and QA Manager was put into effect in late July. There is a plan to commission independent consultants to undertake the QA responsibilities of the CSCB for planning and delivering QA work. This plan may run into 2013/14.

The messages from SCRs are similar to the February/March 2013 audit findings and it is important that we still facilitate learning for the Board. Taking this into account and considering what is going to be realistic to achieve during 2013/14 due to capacity issues, the Board will commission a two phase programme: Phase 1 will be for operational managers across the partnership and Phase 2 will be for front line staff during the autumn of 2013. The aim of the events is to focus on reflection on interagency safeguarding issues and key messages from SCRs and the multi-agency audit.

In addition, as already discussed in section XIII (Serious Case Reviews) the Board intends to develop comprehensive summaries of our Serious Case Review messages and learning and share these with all partner agencies.

In summary, the CSCB's understanding of key current strengths and weaknesses is as follows:

Strengths	**Areas for development**
• Elements of the early help offer, including Family Engagement Partnerships (for 0-5s), Family Nurse Partnership and the Family Resilience Service • Work with young people on the edge of offending and who are attracted to gangs • The 'Strengthening Families' approach to children with child	• Further strengthening the early help system and capacity building to support its functioning • Continuing improvements to the quality of social care practice, including the consistency of quality of assessment, care planning and supervision, and using the relationship as the medium for the work and

protection plans • Improvements in joint work with children who are missing or who are at risk of child sexual exploitation • A culture of challenge and support across the partnership • A new evidence-based model of social care practice, being introduced in 2013	recording • Strengthening the whole family approach, e.g. children whose parents have substance misuse and mental health issues • Communications and public awareness of safeguarding issues, e.g. private fostering • Further strengthening our quality assurance work • Further strengthening the planning and delivery of training across all safeguarding agencies

XI Income & Expenditure 2012/13

Income 2012/13

Croydon Safeguarding Children Board Contributions 2012/13

Core Budget

Agency	Contribution
Local Authority	£300,241
Health	£27,000
Mental Health Trust	£7,500
Police (CAIT)	£5,000
Probation	£2,000
CAFCASS	£550
Grand Total for Core Budget	**£342,291**

Expenditure 2012/13

Narrative	Expenditure
Staffing: Board Manager; Administrator; Training Officer; 1 QA Officer; 0.5 CDOP	141,689
TOTAL STAFFING	**141,689**
Independent Chair & Lay Members	19,200
Children & Parents Participation	30
TOTAL INDEPENDENT CHAIR ETC	**19,230**
Training:	
• E Learning	5,000
• DV Training	10,000
• Board training – 2 away days	3,957
• Missing children	800
• Safeguarding Health check & training for Mosques and Madrassah	4,500
TOTAL TRAINING	**24,257**
SCRs	29,250
TOTAL SCRs	**29,250**
General Service and Supply Costs: Printing; Stationary; Equipment; Mobile 'Phones; meeting venues; website	20,473
TOTAL RUNNING COST	**93,210**
TOTAL COSTS	**234,899**

XII Business Plan 2013/14

CSCB Business Plan 2013-14

The Board's Vision: 'Children and young people's journeys are at the heart of our measurement of successes

Work Stream and Strategic Objective 2013-14	
1. To strengthen our architecture to deliver early help	
Milestone	**Action**
1.1 The Board sees evidence of strengthening of processes around supporting our lead professionals and increased awareness amongst agencies of resources available and the impact of this work.	1.1 Lead: Dwynwen Stepien. Performance on early help will be included in Quality Assurance reports presented to CSCB and reflect the progress made through agreed performance indicators. E-CAF will go live in the near future and this will provide more accurate performance data which will contribute to reporting processes. Information collated will be included in reports to the CSCB. Once live more accurate performance information can be collected, including the number of CAFs received, lead

	professional and agencies involved. There will be one focal point for all CAFs.
2. Ensuring that thresholds, referrals, assessments are understood and that frontline practitioners are involved	
Milestone	**Action**
2.1 Member agencies have a shared understanding of the local thresholds and processes for early help and children's social care in relation to risk and safeguarding. . 2.2 The continued development of processes, of tracking, and safeguarding young people at risk of sexual exploitation.	2.1 Lead: Head of Service for QA. All member agencies. Member agencies to reaffirm the importance of the threshold document and its use by professionals. Multi agency partners to contribute to the review and update of the Croydon Early Intervention document in order to have shared understanding of thresholds and provide additional guidance on available resources and processes. 2.2 A new CSCB sub-group will be established to ensure a strategic overview in respect of children at risk of sexual exploitation. This will include the identification of links between children/young people and possible perpetrators.
3. Ensuring that we have a strong Learning Improvement Plan and Practice	
Milestone	**Action**
3.1 By March 2014 a new integrated learning and development unit will have been established bringing together three existing roles: • Social Work Academy Manager	3.1 Lead HOS for QA. A learning and development plan will set out our future approach to Learning and Development. 3.2 Lead HOS for QA. Multi-agency training for managers and

• CSCB Learning and Development Manager • Partnership Training Resource The aim is to develop a more integrated approach to Learning and Development.	front-line staff based on messages from national and local Serious Case Reviews and audits to be rolled out in autumn 2013. A key aim focus will be the partnership dimensions. 3.3 One-day familiarisation workshops on systemic family therapy to be rolled out for key front line staff and managers across the partnership.
4. Ensuring that the QA process is robust	
Milestone	**Action**
4.1 Support and expertise for the CSCB's quality assurance functions will be procured externally in 2013 for a three year period.	4.1 Lead: Head of Safeguarding. A number of QA themed audits will be commissioned and independent consultants will be asked to carry these out. Audits will include: • An annual multi agency audit • Evaluation of CP Case Conference - 'Strengthening Families' model • Analysis of section 11 safeguarding profiles • Analysis of single agencies' safeguarding supervision policies; and an audit of practitioners' experience of supervision • Vulnerable Adolescent Audit 4.2 The completion time for the audits will be by April 2014.
5. Embed the whole family into practice	

Milestone	Action
5.1 The role of the Board in relation to other strategic partnership Boards, including the Adult Safeguarding Board, CCG, is reviewed, refined and established to enable a coordinated multi agency response to the 'Think Family' agenda. 5.2 Approaches to early help take a whole family approach where appropriate.	5.1 Lead: All CSCB members. Cross attendance at other strategic meetings by CSCB members, this will include close consultation with the Adult Safeguarding Board and other strategic partnership boards. 5.2 Lead: Head of Early Intervention and Family Support: Information of the early help offer to be further developed in order to reflect the whole family approach. 5.3 One-day familiarisation workshops on systemic family therapy to be rolled out for key front line staff and managers across the partnership.
6. Ensure strong communication strategy	
Milestone	**Action**
6.1 Key partner agencies are represented on the Multi-agency Child Protection Panel which meets monthly.  Multi-agency Scrutiny Panel of CP p 6.2 The interagency case review panel has key representatives from each partner agency.  Interagency Case Review Panel Terms c	6.1 Lead: Head of Safeguarding. Representatives from key partner agencies are able to scrutinise CP cases where a plan has been in place for longer than 12 months and any necessary actions are planned and reviewed. 6.2 Lead: Head of Safeguarding. This group will have responsibility for developing positive multi-agency work through reflective "think space". 6.2.1 Report to be completed which includes emerging themes, actions taken and evidence of improved outcomes. Report to be

6.3 Agency representatives on the Board ensure all appropriate agency members take an active role in the Board's sub-committees.	presented to Quality Assurance and Performance Sub Group and CSCB. 6.3 Lead: CSCB Development Manager. The CSCB Development Manager will monitor attendance and participation and raise any concerns with the Independent Chair.
7. Children's engagement	
Milestone	**Action**
7.1 Agencies wherever possible use opportunities to discuss with children and young people their views of services offered to them by individual and multi-agencies.	7.1 Lead Head of Safeguarding: Quality Assurance and Performance Sub Group to review all agency approaches to children and young people, including their views of their experiences. This will be included in Section 11 Safeguarding Profile Reports. 7.2 Consideration to be given at the QA and Performance Sub Group as to how these approaches can be developed and actioned.

APPENDIX 1

CSCB Board Structure