

London Borough of Croydon

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

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Children’s services in Croydon are inadequate	
1. Children who need help and protection	Inadequate
2. Children looked after and achieving permanence	Inadequate
2.1 Adoption performance	Requires improvement
2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance	Inadequate

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

There are widespread and serious failures in the services provided to children and their families in Croydon that leave some children at risk of significant harm. Inspectors identified a legacy of poor practice characterised by drift and delay in the provision of key services. Weak managerial oversight at all levels has not ensured that basic social work practice is of a good enough standard. Children do not receive robust and timely responses to ensure that risk is reduced and their needs are met. The local authority was required to take immediate action in a small number of cases identified by inspectors during the inspection.

Since the local authority was inspected in 2012, there has been significant deterioration in the quality of service provision. Poor managerial oversight of cases fails to ensure that basic social work practice is of a good enough standard. This means that not all children receive help in a robust and timely manner. The workloads of social workers in some teams are high and this presents a serious barrier to providing effective services for children. The turnover of staff in many teams, coupled with the many transition points, further inhibits the building of trusting relationships between social workers and children.

When children are missing or are at risk of sexual exploitation, poor recognition and response to these concerns is not reducing risk to them effectively. Too few children looked after who go missing are spoken to when they return, therefore the understanding of associated risks is weak. While strategic partnership understanding has improved, the response to children who are at risk from sexual exploitation is underdeveloped. When circumstances for some children do not improve, the local authority is either too slow to take action or reduces the level of support without evidence of demonstrable progress. This means that some children remain in harmful situations for too long.

Too many children wait too long for a decision to be made as to whether they need to be looked after, or they return home without sufficient support. This has left them at risk of significant harm from neglectful parenting. The pre-proceedings phase of the Public Law Outline (PLO) is not used often enough or early enough to ensure that parents are aware of the potentially serious consequences of poor or harmful parenting.

The chief executive and current director of children's services (DCS) recognised the breadth and depth of this decline and they commissioned a number of detailed external service reviews on their appointments in July 2016. The local authority is at a very early stage in addressing the poor practice identified. Some improvements have been made, for example in the multi-agency safeguarding hub (MASH). However, action plans to address deficits are focused on process or structure and there is insufficient consideration of improving outcomes for children. This has created delay in addressing and targeting the areas of greatest concern.

Most children looked after live in stable foster placements where they are cared for well. However, many carers feel poorly supported and the fostering service is not compliant with all regulations. There is good consideration of most children's diverse needs in placement matches. In the majority of cases, social workers see children regularly, although evidence of purposeful direct work is more limited.

Political leaders and chief officers say that vulnerable children are a top priority for the council. Effectively supporting such a high number of unaccompanied asylum seekers is a formidable challenge that has been a priority. However, this prioritisation is not having the same impact on the rest of the frontline services. There has been political and senior leader support for increasing capacity at senior manager level and there have been some recent appointments to additional manager posts. There is evidence of some recent improvements, including a strengthening of work within the MASH. This has led to more effective management oversight of practice by a dedicated project manager who oversees all decisions within 24 hours. A specialist team of social workers and managers works closely and effectively with the Home Office to ensure a strong and caring initial response to children arriving alone in the country.

The range and coordination of early help provision for children and families are not fully established. Individual partner agencies are unclear about the early help offer and have not been involved in developing a shared approach to delivering services. Inconsistent application of thresholds and a lack of recognition of risk are commonly evident in assessments and plans, including where risks escalate. Multi-agency participation in and contribution to the support of children in need are not robust or sufficiently effective.

A lack of challenge from the Local Safeguarding Children Board (LSCB) has not assisted in raising safeguarding standards in the local authority. It is too soon to see the impact of engagement of key strategic partners in improving services for children, as services are newly commissioned or are at the planning stage and there is not yet an evaluation of improvement.

More recently, children who cannot live with their families have been increasingly considered for adoption, but delays remain. The quality of children's permanence reports (CPRs) is variable. Adopters are assessed well and report being supported. The large majority of care leavers are in education, employment or training and they report strong and consistent support from their personal advisers. However, not enough young people live with their foster carers beyond the age of 18. Too few care leavers have the opportunity to move to independent accommodation when they are ready to do so. Preparation of young people for independent living is inconsistent and not all are fully aware of their entitlements. The quality and timeliness of pathway planning are too variable.

The corporate parenting panel expresses a commitment to improving the lives of children. However, the local authority overall has not prioritised and planned sufficiently to improve outcomes for enough children.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates one children's home, which was judged good in its most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in May 2012. The local authority was judged adequate.
- The previous inspection of the local authority's services for children looked after was in May 2012. The local authority was judged adequate.

Local leadership

- The DCS has been in post since July 2016.
- The DCS is also responsible for adult services.
- The chief executive has been in post since July 2016.
- The chair of the LSCB has been in post since March 2016.
- The local authority uses a systemic model of social work.

Children living in this area

- Approximately 93,435 children and young people under the age of 18 years live in Croydon. This is 25% of the total population in the area.
- Approximately 23% of the local authority's children are living in low-income families.
- The proportion of children entitled to free school meals:
 - in primary schools is 19% (the national average is 15%)
 - in secondary schools is 17% (the national average is 13%).
- Children and young people from minority ethnic groups account for 58% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are African and Caribbean.
- The proportion of children and young people who speak English as an additional language:
 - in primary schools is 36% (the national average is 20%)
 - in secondary schools is 26% (the national average is 16%).

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- Croydon has a high number of unaccompanied asylum-seeking children (364 as at 19 June 2017), which is 48% of the total children looked after population.

Child protection in this area

- At 19 June 2017, 1,789 children had been identified through assessment (in the previous 12 months) as being formally in need of a specialist children's service. This is a decrease from 1,839 as at 19 June 2016.
- At 19 June 2017, 399 children and young people were the subject of a child protection plan. This is an increase from 360 at 31 March 2016.
- At 19 June 2017, 37 children lived in a privately arranged fostering placement. This is an increase from 18 at 31 March 2016.
- Since the last inspection, 14 serious incident notifications have been submitted to Ofsted and 11 serious case reviews (SCRs) have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At the time of inspection, at 19 June 2017, 760 children were being looked after by the local authority (a rate of 81.5 per 10,000 children). Of this number:
 - 324 (43%) lived outside the local authority area
 - 15 lived in residential care homes, outside the authority area
 - four lived in residential special schools³ and they lived out of the authority area
 - 648 lived with foster families, of whom 40% lived out of the authority area
 - seven lived with parents, of whom 43% lived out of the authority area
 - 364 children were unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 20 adoptions (June 2016 to May 2017)
 - 20 children became subject to special guardianship orders
 - 515 children ceased to be looked after, of whom 5% subsequently returned to be looked after
 - 433 young people ceased to be looked after and moved on to independent living
 - 270 young people ceased to be looked after, and are now living in houses in multiple occupation.

³ These are residential special schools that look after children for 295 days or less per year.

Recommendations

1. Ensure that managers have sufficient oversight of practice, and provide social workers with effective, clearly recorded supervision to support good social work practice.
2. Establish a stable workforce through purposeful recruitment and retention activity that includes targeted training for frontline staff and managers so that they have the skills and knowledge to better protect and care for children. Take steps to ensure that the workloads of social workers are manageable, and that they have sufficient time to complete essential work.
3. Ensure that there is appropriate and timely action with regard to understanding and reducing risk to all children, especially those at risk of sexual exploitation and those who go missing from home or care. Ensure that social workers have the necessary skills and knowledge to help children at risk of sexual exploitation.
4. Ensure that children missing from home or care have every opportunity to speak to an independent person about the reasons they go missing so that appropriate action can be taken to effectively support them, and reduce risk.
5. Ensure that all plans for children contain achievable, realistic goals and that timescales and contingency planning are specific, and include sufficient support for children who return home. Ensure that the individual needs of brothers and sisters are identified and met.
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.
7. Ensure that strategy discussions include information gathered from all partners, and result in clear planning and recording of actions and the rationale for decisions.
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.
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.

10. Ensure that child protection conference chairs and independent reviewing officers (IROs) provide appropriate challenge that prevents drift and delay in planning for children. Ensure that formal escalation systems are used to record and monitor actions raised, to make sure that purposeful work is done in order to achieve improved outcomes for children.
11. Strengthen the provision of early help support for children and families and ensure that partner agencies have a shared understanding of the early help strategy and associated thresholds.
12. Improve the quality of assessments to take account of individual children's needs, including historical information, and ensure that all information is rigorously analysed and updated when circumstances for children change.
13. Ensure that the fostering service appropriately supports foster carers, and that the work of this service meets all relevant regulations.
14. Improve permanence planning across the wider service to ensure that the planning and timeliness of adoption improve for all children. Ensure that there is focused family-finding activity for children with adoption plans, to minimise delays.
15. Review the provision and take-up of advocacy and independent visitor services to ensure that all children who would like this can access these services.
16. Ensure that appropriate assessments identify children living in private fostering arrangements.
17. Ensure timely pathway planning and ensure that plans are specific, accurate and detailed, and include contingency planning, to support good outcomes for all care leavers.
18. Ensure that staying-put arrangements are promoted to all care leavers and foster carers, so that care leavers who want to stay with their former foster carers can benefit from greater permanency and support as they move towards independent adulthood.
19. Ensure that young people move on to independent accommodation only when it is the right time for them to do so. Improve the help/assistance provided during their transition to independent living through more consistently good preparation and support. This should include accurate, comprehensive and up-to-date information about young people's rights and entitlements.
20. Ensure that elected members, as corporate parents, prioritise and focus on improving all areas of poor practice for children looked after and care leavers.
21. Strengthen training and work on complaints and embed a culture of feedback. Improve the analysis of complaints and the understanding of the reasons why children, families and foster carers complain, in order to address issues raised.

Summary for children and young people

- Too many services for children and young people in Croydon are poor. This means that not all children are kept safe from harm or are helped early enough.
- Senior leaders know that services need to be better, but they have taken too long to take action to improve them.
- When professionals tell social workers that they are worried about children and young people, not all available information is collected to help them to decide quickly what services will best support them and their families.
- Managers have not made sure that all social workers have enough time to ensure that children and young people are visited often in order to understand how they feel and what they need. This means that they do not always gather all the information they need to understand what life is like for children and young people in Croydon, and to make plans to help them improve their lives.
- Too many children and young people in Croydon have too many different social workers, which means that it is hard to trust and make positive relationships with their social workers as they change too often.
- Managers are not giving social workers the help that they need in order to make sure that they are getting things right for children and young people, and taking action that will help them quickly enough.
- When children and young people are missing, there is not always enough information gathered about the risks that they face. This means that the risks to children and young people, especially dangers from adults sexually exploiting them or from gangs, are not always known and the best help and support are not always given.
- Managers are not making decisions quickly enough when children need to come into care. It also takes too long for some children and young people to get to know where they will live until they are adults. Not enough children and young people are staying with their carers after they are 18 years of age.
- Most children and young people who live with foster carers feel settled with carers who know them well and who listen to them.
- Recently, more children have had plans to be adopted and, once this decision is made, they receive a better service.
- Most care leavers have workers who they like and trust and many young people are working, training or in further education. However, too few young people leaving care move to live independently and many are not helped enough to know how to manage money and how to look after themselves well.

<p>The experiences and progress of children who need help and protection</p>	<p>Inadequate</p>
<p>Summary</p> <p>Services for children in need of help and protection in Croydon are inadequate. Serious and widespread failings leave some children at risk of significant harm. Weak managerial oversight at all levels has not ensured that basic social work practice is of a good enough standard. Children do not receive robust and timely responses to ensure that risk is reduced and their needs are met. The local authority was required to take additional steps in some cases during the inspection to be assured that the children were not at immediate risk of harm.</p> <p>The inconsistent application of thresholds and a failure to recognise risk are common features in too many cases. When circumstances for children do not improve, the local authority is too slow to take action. This means that some children are left in harmful situations for too long.</p> <p>The workloads of some social workers, in some teams, are too high. This is a serious barrier to their providing effective services for children. There is too great a turnover of staff in many teams, which makes building trusting relationships between social workers and children difficult.</p> <p>The range and coordination of early help provision for children and families are underdeveloped. However, partner agencies are at the early stages of working together to develop a new, shared approach to delivering services.</p> <p>Most assessments do not effectively consider history or parental capacity or analyse risk. Additionally, the majority of children’s plans are not of good quality, and are too narrowly focused. Progress is often limited and actions are not achieved before plans are closed. Work with some children drifts without reassessment or analysis of change.</p> <p>Child protection chairs and partner agencies are not currently using formal systems, child protection conferences and core groups to effectively challenge drift and delay in planning for children.</p> <p>When children are missing or they are at risk of sexual exploitation, the recognition of and response to these concerns are not effectively reducing risk to them. Stronger arrangements are in place for tracking children who are missing from education.</p> <p>The local authority has undertaken awareness raising to protect children from radicalisation and to take appropriate action to support children who are at risk.</p> <p>Effective multi-agency services for girls at risk of genital mutilation are in place.</p>	

Inspection findings

22. For too many children, risk is not consistently recognised and responded to at the right level or at the right time and previous concerns about children are given insufficient consideration. When risks to children escalate, or do not reduce, the local authority fails to intervene quickly enough.
23. The workloads of some social workers and team managers, in some teams, are too demanding in both volume and complexity. Some staff told inspectors that they are overwhelmed by the amount of work, and are unable to complete essential tasks, such as visiting children regularly and completing assessments within timescales.
24. Too many changes of social worker mean that many children miss the opportunity to build trusting relationships with their social workers. Some newly allocated workers then struggle to capture a genuine understanding of children's lived experience, by routinely reading the history or taking account of, and building on, previous social work to progress children's plans. This means that social workers have to start over again for too many families.
25. Management oversight and supervision of social work practice in many teams, while regular, are not effective. Social workers do not receive sufficient support, direction or challenge to ensure that children receive effective and timely help.
26. The range and coordination of early help provision for children and families are underdeveloped. Partner agencies remain unclear about the purpose of the early help offer. However, they are at the early stages of working together to develop a new approach, building on the Best Start Programme, which is helping to further develop a shared approach to delivering services. The early help hub facilitates access to services and supports professionals in completing early help assessments. However, there is an insufficient range of evidence-based interventions to support families. The evaluation of work is not taking place, which means that it is difficult to measure impact or demonstrate that the work is sustainable and is making a difference for children.
(Recommendation)
27. The early help screening and assessment process builds delay in decision-making processes and operates separately from children's social care systems. Non social work staff can hold cases for several days without the early help screening team making a decision. For example, some cases wait too long before being allocated for a social work assessment.

28. Action taken by the local authority to address the deficits identified during a joint targeted area inspection (JTAI) of MASH arrangements 12 months ago has resulted in better practice, with more effective management oversight of work in the MASH. There is more timely and robust management action taken by a dedicated project manager, who signs off all decisions within 24 hours. Daily MASH discussions take place to effectively share information and agree actions on individual cases.
29. The understanding and application of statutory thresholds both by the local authority and by partner agencies are inconsistent. The number of contacts that lead to no further action continues to be high at 60%, although this has reduced from 80% at the time of the JTAI. Several different referral pathways into children's services exist and this is confusing for partners, and means that some contacts are made through the wrong pathway. (Recommendation)
30. Strategy discussions, though mostly timely, generally take the form of a telephone call with the police child abuse investigation team (CAIT). Other relevant agencies are not routinely involved, which means that multi-agency sharing of comprehensive information is not available to inform decisions. A high number of child protection enquiries (63%) do not lead to an initial child protection conference. This means that there may be another missed opportunity for multi-agency discussion and a shared approach to planning for children. (Recommendation)
31. The quality of assessments overall is mostly poor. Information is not rigorously analysed and there is insufficient consideration of families' historical information. Children's identity and cultural needs are not fully explored during the assessment process. While the views of children and their parents are recorded in the majority of cases, meaningful work with children in order to really understand their lived experiences is weak. Brothers and sisters are referred to collectively in assessments and many children's individual needs are overlooked. Some children who live in families in which there is a particular focus on one child are not referred to in assessments. Assessments are not routinely updated and new information is not analysed to reflect what may be significant changes in children's circumstances. (Recommendation)
32. Clear practice standards or recognised tools to assess levels of neglect are not used to inform assessments and, in too many cases, the impact of chronic neglect on children is not fully addressed.

33. Too many child in need and child protection plans are narrowly focused and goals and timescales are not clear enough. Specific contingency planning is missing. This means that some families do not understand the consequences if progress is not made to address concerns. Social workers do not visit all children regularly enough to monitor whether plans are making a positive difference to their lives. Brothers and sisters are considered together on shared plans and in the vast majority of cases these do not consider or address their individual needs. In many cases, child protection plans are ceased too soon, before sufficient progress has been made. For example, in some cases, plans end when parents have just started to engage in work to address long-standing domestic abuse, even though their ability to make and sustain improvement has not been demonstrated. (Recommendation)
34. The quality of social work for disabled children is variable. There are some stronger examples in the specialist team of whole-family assessments and work to support brothers and sisters. However, practice is less effective when there are presenting safeguarding concerns. Workers do not recognise and take timely action to address neglect for all of these children, reflecting the poor practice found in other teams.
35. There are a very small number of cases that have good-quality assessments, plans and recordings, where social workers go the extra mile to ensure that children's thoughts and feelings are reflected in their plans and case records.
36. Core-group meetings take place regularly. However, professionals in core groups do not all ensure that plans are used to measure and promote improvement and they do not challenge each other when there is delay in progress. This leads to a lack of purposeful and effective work and too many children experience unacceptable drift and delay.
37. Child protection conference chairs do not consistently provide effective challenge or use the formal alert system to highlight poor practice. Child protection chairs often have informal conversations with social workers and managers which are not recorded. This means that it is difficult to monitor agreed actions and progress. (Recommendation)
38. Advocacy is not well promoted or well used for children and young people in Croydon. Inspectors did not see any cases where advocacy had been offered or used to support children in need of help and protection, or to support their parents, to help them understand and fully participate in the process.
39. Responses to the needs of children who go missing are weak. Return interviews are not taking place for the majority of children, which means that the opportunity to gather critical information, identify risks and take timely protective action is lost.

40. Recognition of the risks to children from sexual exploitation is poor. Most social workers do not have sufficient knowledge and understanding of sexual exploitation to enable them to help children. Recognised models and tools for assessing the risk of child sexual exploitation are not used and the majority of staff have not received training in the skills needed to support children who are exploited. (Recommendation)
41. Inspectors found that social workers lack a consistent understanding of what constitutes a private fostering arrangement. Several cases were seen where an assessment should have been completed to ensure that children were appropriately cared for, which means that some children live in circumstances where the suitability and commitment of carers are unknown. (Recommendation)
42. The designated officer arrangements for considering allegations or concerns about staff or volunteers are in place and strategy meetings are proportionate. However, there is no formal tracking system to ensure that work is completed and within timescales, which means that the implications for some children are not known and acted on.
43. There is an effective commitment to partnership working between the multi-agency public protection arrangements (MAPPAs) and multi-agency risk assessment conferences (MARACs). MARACs are well attended by relevant partner agencies and there is timely reporting on actions. However, too many children living in families affected by domestic abuse do not receive the appropriate level of help and protection to substantially reduce risk.
44. There are effective responses to girls in Croydon who are at risk of genital mutilation. A comprehensive risk assessment tool is in place and its use is leading to better identification of the risk of female genital mutilation. A dedicated health worker efficiently coordinates links across relevant agencies, and promotes the education of parents and community groups. A range of professionals from other agencies and local authorities have benefited from understanding their approach.
45. The local authority has undertaken effective awareness raising about the risks to children of extremism and radicalisation. Training has been provided to the majority of schools in the area and appropriate referrals are made to the 'Channel' panel.

46. There are effective arrangements for tracking children who are missing education. The children missing education welfare officer works closely with schools to ensure that children missing education are identified quickly. Education welfare officers work closely with schools and other partners to ensure that children return to school and improve their attendance. Alternative provision meets the needs of children and young people effectively. Children who are electively home educated (EHE) are well monitored. The EHE officer ensures that all families who are considering EHE are offered and receive home visits or face-to-face meetings. The EHE officer contacts a wide range of appropriate agencies to identify any potential risks to children whose parents do not engage.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Inadequate</p>
<p>Summary</p> <p>Services for children looked after by Croydon are inadequate. Inspectors identified too many children who have waited too long for a decision to be made as to whether they should be looked after, or who have returned home without sufficient support. The pre-proceedings phase of the PLO is not used often or early enough to ensure that parents are aware of the potentially serious consequences of poor or harmful parenting. Parallel planning is not embedded, and drift and delay adversely affect children at all stages of care planning.</p> <p>Too few children looked after who go missing are spoken to when they return, and the analysis of associated risks is weak. The response to children who are at risk from sexual exploitation is also underdeveloped, and assessments and plans to reduce future harm are rarely evident.</p> <p>Most children looked after live in stable foster placements where they are cared for well. However, many carers feel poorly supported, and the fostering service is not compliant with all regulations. In the majority of cases, social workers see children regularly. However, there is limited purposeful direct work to help them.</p> <p>Children’s health assessments and reviews are increasingly timely. Children, parents and carers engage with statutory reviews, and most meetings are a comprehensive account of children’s lives. Overall, IROs know children well, but they do not always stay in touch with all children between children’s reviews and they do not challenge delay assertively enough.</p> <p>Teachers find the involvement of the virtual school helpful, but the majority of personal education plans (PEPs) need to be improved.</p> <p>Children who cannot live with their families are increasingly considered for adoption, but delays exist. The quality of CPRs is variable. Adopters are well assessed and supported.</p> <p>Not enough young people live with their foster carers beyond the age of 18 years. Too few care leavers have the opportunity to move to independent accommodation when they are ready to do so. Preparation of young people for independent living is inconsistent and not all are fully aware of their entitlements. The quality of pathway planning is too variable. However, the large majority of care leavers are in education, employment or training, and they report strong and consistent support from their personal advisers.</p>	

Inspection findings

47. Too many children wait too long for a decision to be made as to whether they should be looked after and this means that they continue to live in neglectful or harmful situations for longer than is necessary. If they return home from care, plans and packages of support are not always sufficiently robust to avoid problems recurring.
48. Senior managers have been very slow to adopt the pre-proceedings phase of the PLO, which is a legal requirement. This means that an important step in engaging with families and planning for children's legal permanence is bypassed and parents do not always have the opportunity to change their behaviour, or have a clear understanding of the consequences of not doing so. Although the number of children in pre-proceedings is increasing, it is still too low. Child protection plans that are not effective continue for too long when more decisive action is needed and when the care threshold is likely to be met. This leaves children at risk of further harm.
49. Until recently, the tracking and oversight of pre-proceedings, court work and permanence planning were significantly underdeveloped. This created delays for children at all stages, from the decision that the legal threshold for care proceedings is met, through to a permanent placement match being decided. Inspectors saw a number of cases where children have experienced drift and delay due to assessments not being commissioned or completed on time, or statements and applications submitted to court late. This slows children's journeys towards secure and permanent homes. (Recommendation)
50. The determined work of the care proceedings manager, appointed in September 2016, and the recent increased attention of senior managers are beginning to have a positive effect on services, from a low base. Inspectors noted some improvements in the oversight of care proceedings and pre-proceedings from April this year. Targeted training and mentoring of staff are increasing their skills. These early signs of change are also reported by the Child and Family Court Advisory and Support Service (Cafcass), which has noted that, although practice remains inconsistent, the timeliness and quality of court assessments and care plans are improving.
51. A permanence policy, introduced in January 2017, ensures that staff increasingly understand what is expected of them. However, senior leaders have been much too slow to establish minimum standards and these are not embedded in practice. Permanency planning meetings are not always ambitious or assertive enough to ensure that a range of permanence options are considered and pursued for children of all ages. This demonstrates a lack of ambition to achieve the best positive permanence option for all children. Contingency and parallel planning are often not evident and this leads to avoidable delays for children when a preferred care plan, such as a family care arrangement, proves to be unviable. (Recommendation)

52. Children are thoroughly matched with long-term permanent carers, but delays are evident. Some children wait for up to a year to know where they will live for the remainder of their childhood and beyond. Foster carers told inspectors that this is difficult and unsettling for children. Once decisions have been made, it is positive that social workers and managers mark these important events with certificates and celebratory activities.
53. Although case supervision is regular in most cases, and there are some detailed updates and actions, close attention to overall care plans for children and purposeful challenge of delay are rarely evident. In a number of cases important risk factors are not sufficiently explored and in a few cases they are not mentioned at all. Clarity about accountability for important decisions for children looked after is not established or evident in recording.
54. When children go missing from care, they are rarely spoken to about their experiences. When a conversation is offered, children often refuse to engage. A lack of persistence and creativity in considering why children run away, whom they are with, where they go and the risks they face, is a key weakness. This is because it limits professionals' understanding of children's lives and reduces opportunities to make them safer. Leaders and partners have put in place appropriate strategic arrangements, including a commissioned service that provides high-quality support. However, practice is highly inconsistent; comprehensive risk assessments and assertive planning to safeguard children are rare, leaving them vulnerable to harm. (Recommendation)
55. Most social workers who spoke with inspectors demonstrated an understanding of children's lives and histories. Better performance information is enabling managers to monitor some important aspects of support for children looked after, including the frequency of social work visits. Visits are regular for the majority of children, including those who live out of the authority area, although records do not always evidence purposeful direct work with children. Some children wait too long for important direct work, such as life story work, but inspectors also saw some good examples of creative time spent with children, including singing, using pictures to help them to understand their country of birth and playing make-believe games. Children told us that they see their social workers often and most find them friendly and helpful.
56. In the first quarter of 2017–18, only 13 children looked after were supported by an advocate and this means that very few children have the benefit of an independent supporter who can help them to express their views, challenge their plans, or raise something that they are worried about. There is a waiting list for children who have asked for an independent visitor. When children do spend time with independent visitors, they value this support and friendship. (Recommendation)

57. It is positive that a high proportion (85%) of children looked after live with a foster family. Placement stability is good. Less than one in 10 children moved placements more than twice in the 12 months preceding the inspection. There is sufficient choice for children with regard to in-house foster carers and independent fostering agencies. Almost half of Croydon's 760 children looked after cohort are unaccompanied asylum-seeking children. Inspectors saw detailed age assessments and some positive matches of children with carers who understand and celebrate their culture and faith. However, a small minority of less well-matched children are losing touch with their culture or language.
58. Croydon has some highly committed and skilled foster carers who are providing good-quality care to children. The foster carers who spoke with inspectors talked warmly and protectively about the children they are caring for. A strong commitment to children looked after as much-loved members of families is commonplace among these carers. One foster carer said, 'We are very lucky to have him in our family.' Children told us that they are happy and settled with their carers: 'They are like my mum and dad'; 'We do fun things together like other families'; 'They sort out injustice at school'; and, 'If I'm feeling down she always asks me about it.'
59. However, most carers expressed dissatisfaction with the support provided by the fostering service. A recent independent review identified similar concerns, including a lack of out-of-hours support, irregular supervision, poor communication, lack of delegated authority, insufficient consideration of matching for children and carers not being listened to when they try to challenge poor care planning. The fostering service is not consistently compliant with regulatory standards; unannounced visits are irregular, annual reviews are delayed and delegated authority is not consistently in place. Inspectors also identified children living in unregulated placements where emergency and viability assessments are delayed or not completed within timescales, so that potential risks relating to these households are not fully understood.
(Recommendation)
60. The headteachers and designated teachers who spoke with inspectors said that the virtual school team provides helpful support and challenge. They reported that this has improved during the last year. Although the virtual school team has provided training for social workers and designated teachers, the quality of the majority of PEPs requires improvement. Key areas for improvement included the quality of target setting and recording the use of pupil premium funding and the voice of the child. Some children told inspectors that within their PEP meetings they are not praised enough for the things they have achieved. At the time of the inspection, the introduction of e-PEPs, to support quality improvement, was imminent.

61. Most children looked after attend good or outstanding schools and none attends schools judged as inadequate. The virtual school team works closely with the small number of schools that require improvement, to ensure that they receive the support that they need. Children looked after in Croydon achieve less well than their peers in neighbouring authorities and nationally at each key stage of education. Results at key stage 4 are improving, but remain just below the national rates. This improvement is a significant achievement due to the high proportion of children looked after who are unaccompanied asylum-seeking children, many of whom have minimal previous experience of education and speak little English on their arrival. The virtual school team has ensured that good arrangements are in place for unaccompanied asylum-seeking children to enrol in schools quickly. Courses for speakers of other languages are quickly sourced for those who need to improve their English. In addition, a short course is provided for those children who have had very little or no formal education prior to their arrival in the United Kingdom.
62. Local authority officers monitor and support schools well to ensure that all children are aware of the dangers of extremism and radicalisation as well as what to do if they experience bullying or the inappropriate use of social media. Survey responses indicate that the number of children who report experiencing bullying is falling. Children looked after told inspectors that their foster carers and teachers have acted quickly to stop bullying when children have experienced this at school.
63. The local authority ensures that all alternative education provision takes place with registered providers. All children who attend these providers receive full-time timetables. In addition, a registered tuition service, 'Springboard', provides bespoke support to children, most of whom have medical or complex special educational needs. A small number of children looked after are supported through the tuition service and have part-time timetables.
64. Senior managers and partners have worked together to improve the timeliness of initial health assessments from a low base. However, children looked after nurses are not always notified quickly enough when children come into care, leading to delays in some children's health needs being understood. Children looked after nurses acknowledge that greater specificity in health-related actions would improve consistency of follow-up and oversight of children's health needs. Children looked after nurses increasingly engage creatively with hard-to-reach young people, but they have insufficient capacity to be closely involved in children's day-to-day care plans, for example by attending statutory reviews.

65. Although over 80% of children looked after are allocated within the permanence service, the remainder are allocated to social workers in over 25 teams and units. This presents a significant challenge for senior managers in achieving consistency of practice across the service. It has also made it more difficult for the child and adolescent mental health service (CAMHS) to ensure that all social workers know about the children looked after CAMHS provision and associated consultation offer. Although some positive work is taking place, inspectors reviewed a number of cases where children or carers who need therapeutic support have waited too long for advice about children's behaviour or direct support, such as play therapy.
66. Assessments are not regularly updated and care plans and reports for statutory reviews do not outline and analyse children's life experiences alongside recent events comprehensively enough to compensate for this deficit. Care plans are brief and rarely include any detail about children's day-to-day lives, aspirations or overall plans for permanence. This reduces the ability of social workers, carers and professionals to ensure that they are working together purposefully to improve children's outcomes.
67. Statutory reviews are increasingly timely, although too many are still late, due to an inefficient system for arranging meetings. In most cases, children, carers and parents engage with or contribute to these meetings and the majority of records are comprehensive accounts of children's lives and achievements. In most cases, contact arrangements with friends and family members are considered well. Some children told inspectors that reviews are too long and that they sometimes feel that adults are talking about them, not with them. IROs have established long-term relationships with some children, but they acknowledge that they have insufficient time to stay in close touch with children to progress their plans. Inspectors saw some evidence of IROs providing challenge regarding children's care plans, but high-level intervention was not evident enough in those cases where children have experienced most delay.

The graded judgement for adoption performance is that it requires improvement

68. The number of children leaving care through adoption in Croydon is slowly rising. Since June 2016, 32 children who have a wide range of needs, ethnic backgrounds and ages, and groups of brothers and sisters, have been placed for adoption, of whom 22 children have been successfully adopted, including three children placed under foster to adopt arrangements. This performance has improved from 2015–16 as a result of continued focus on making earlier decisions and an increased number of decisions with regard to children to be placed for adoption: 19 in 2015–16, rising to 44 in 2016–17, and this trend is likely to continue into 2017–18.

69. The local authority has recently identified that permanency planning for children across the wider service is weak and needs improvement. Inspectors saw that the impact and legacy of this are that children are waiting longer for adoption, for example, where decisions to progress pre-proceedings within the PLO and care proceedings are delayed, and where care planning is poor once children are looked after.
70. While a recent permanence panel and a permanence tracker monitor children's plans for permanence more robustly, these have not provided sufficient scrutiny and oversight to ensure that plans for adoption are strong and timely for all children. Inspectors observed avoidable delays, for example when decisions to achieve permanence are not quick enough, and some delays in family finding that impact on the timeliness of matching for a few children with adoptive families. The local authority acknowledges that improvements in permanence planning are very recent and that this area requires continued focus and robust oversight to improve performance further. (Recommendation)
71. The timeliness of adoptions is improving, but it does not meet the latest published national thresholds on key indicators. This performance links to the legacy of poor permanence planning across the service. It takes too long for a child in Croydon, from becoming looked after, to be living with an adoptive family. However, the recently improved focus on practice with regard to placing children for adoption is resulting in more timely matches to permanent homes for some children.
72. Similarly, on average, most children are still waiting too long to be legally adopted. A systematic focus on and tighter management of permanence planning are needed across the wider service to ensure the timeliness of adoption for all children, once the agency decision-maker (ADM) makes the appropriate decision that this is the best plan.
73. The recruitment and preparation of adopters are thorough, and there is appropriate use of the South London Adoption Consortium for the provision of preparation groups. Adopters met during the inspection reported that their preparation and assessment were well managed and they commented favourably on the professionalism and support provided by the adoption staff. One adopter had specifically chosen Croydon due to a positive recommendation.
74. Prospective adopters' reports (PARs) seen during the inspection showed that comprehensive checks and references are progressed appropriately, and that prospective adopters are visited regularly and seen alone. This enables their strengths, motivation and ability to parent adopted children to be well considered. However, assessments are not all completed within the six-month timescales, although some delay is appropriate, for example adopters requesting to have a break between stage one and stage two of the process.

75. CPRs are of variable quality. This is acknowledged by managers, the adoption panel chair and the ADM. In the better reports, children's and birth family's details are thorough and include all aspects of the child's life, including relevant decisions and details that may be required in later life. Weaker reports are not clear. They lack important information and do not provide the rationale for decision-making or up-to-date information, which are extremely important in helping children to understand their early experiences. Recent workshops for social workers to improve practice have addressed the quality of reports, but it is too early to see their impact.
76. The local authority works well with the South London Adoption Consortium and other relevant adoption services to match children with adoptive families that meet their needs. Some delay in the family finding process for children waiting was identified during the inspection and tighter monitoring is required in order to improve this in future.
77. The quality of matching reflects a thorough approach once adopters are identified. Adoption placement reports successfully identify children's needs and the ways in which adopters will meet them. Minutes of the adoption panel reflect appropriate scrutiny and challenge, and recorded decisions by the ADM are comprehensive. The adopters met during the inspection who have been matched with children reported that the process was timely and that they were well supported.
78. The adoption panel is appropriately constituted and effective, and has an experienced panel chair. Panel minutes and recommendations for children and adopters are clear, evidencing a well-balanced rationale. ADM decisions are timely and well considered. Issues identified at adoption panel regarding the work and performance of the adoption agency are highlighted in a six-monthly reporting cycle. These are progressed in order to improve learning and practice, for example the provision of workshops for social workers to improve the quality of CPRs.
79. Life story books seen during the inspection are well constructed and appropriate, evidencing a child-centred approach. Later life letters sampled were sensitively written, with attention to the likely emotional response of the child when older.
80. The adoption service provides a range of support services post adoption, including facilitation of direct contact between birth family members, letterbox arrangements, birth records counselling and intermediary support. Experienced staff provide support to adopters and children, including therapeutic services and interventions, and they liaise and commission relevant additional post-adoptive support services if needed. Applications to the adoption support fund result in appropriate support for families and plans are in place to extend this more fully in the future.

The graded judgement about the experience and progress of care leavers is that it requires improvement

81. The care leaving team was working with a high number of care leavers at the time of the inspection (705), half of whom were unaccompanied asylum-seeking young people who had become looked after in Croydon. Social workers and personal advisers are in touch with a very large majority of their care leavers (92%) and most personal advisers and social workers are tenacious in their efforts to re-establish contact with those not in touch. Most care leavers receive appropriate help with progressing smoothly to independent living. However, a minority do not receive sufficient support to meet their needs, and are less well prepared for the transition to adulthood.
82. The quality of pathway planning with care leavers is too variable and planning starts too late. Workers begin pathway plans just before the care leaver becomes 18 years of age, rather than in the three months before they reach their 16th birthday. This delay affects their transition to adulthood because establishing relationships with personal advisers does not begin early enough. Not all plans contain sufficient detail or consideration of contingencies and they do not all reflect the views of young people well. (Recommendation)
83. Care leavers benefit from up-to-date health assessments, which are completed by the children looked after nurse before they reach 18 years of age. They receive key information about their health histories. However, while most care leavers receive appropriate healthcare, there are insufficient specific health services available to care leavers to promote and support them after the age of 18, for example specific drop-in clinics for sexual health.
84. Social workers and personal advisers do not ensure that all care leavers are sufficiently prepared for living independently. Care leavers told inspectors of their different experiences of how well they are supported after leaving care. While some talked about very good preparation and support from their personal advisers, including help with learning how to budget and to cook, others said that they were not helped to prepare themselves well. For example, a minority of care leavers got into financial difficulty because no one had told them that they needed to pay council tax when moving to private accommodation.

85. Not enough care leavers benefit from staying-put arrangements. A much lower proportion of Croydon care leavers benefit from living with their former foster carers beyond the age of 18 years than in neighbouring authorities or nationally. Some care leavers and foster carers reported that they believed that staying-put arrangements are only available until the age of 18 if they remain in full-time education. In addition, care plans often say that children will remain in placement until 18 years of age. Both of these factors undermine efforts to ensure that more care leavers benefit from the security and stability of continuing to live with their foster carers as they transition to independent adulthood. (Recommendation)
86. The large majority (78%) of care leavers are in education, employment or training, which is better than rates achieved by neighbouring authorities or nationally. Senior leaders are working to improve opportunities for care leavers in a borough with strong economic growth, for example by expanding existing contracts to ensure that commissioned partners and the authority itself offer apprenticeship opportunities specifically aimed at care leavers.
87. A high number of care leavers have achieved a place in higher education. At the time of the inspection, there were 100 young people taking degree courses and a small but increasing number on higher apprenticeships. These young people continue to benefit from good support provided by their social workers or personal advisers. This support extends to the provision of accommodation for those who want to return to Croydon during university breaks.
88. Not all care leavers are aware of their entitlements, despite this information being included in a well-written care leavers' handbook. Inconsistent support for individual care leavers and a lack of focus in pathway plans mean that not all care leavers have a good understanding of, and access to, their entitlements.
89. The majority of care leavers live in suitable accommodation. However, care leavers have limited options for moving on to independent living when they are ready to do so. More care leavers are living in shared accommodation, following a decision by senior managers to reduce the number of commissioned self-contained housing options. Although care leavers interviewed said that their shared accommodation arrangements were working well, some felt ready, and would prefer, to live independently. The fact that care leavers are not given any priority to help them to secure social housing reduces their options further. A very small number of care leavers are homeless or in emergency accommodation. At the time of the inspection, one care leaver was in short-term bed and breakfast accommodation and, although his circumstances were well assessed and supported, this is not acceptable practice. (Recommendation)

90. Care leavers who met with inspectors held the care leaving team workers in very high regard. They said that their workers were proud of them and their achievements. One said that she regarded her personal adviser and the broader care leaving team as her 'family'. There are also some examples of creative and innovative ideas that are supporting care leavers to be as fully informed as possible about available support. For example, a personal adviser has developed a range of very high-quality YouTube guides under the banner 'former-relevant TV' to help care leavers learn a range of useful skills, including how to select, and use, good-quality private rental websites.

Leadership, management and governance	Inadequate
<p>Summary</p> <p>Services for vulnerable children in Croydon are inadequate. There are widespread and serious failures in the services provided to children and their families in Croydon that leave some children at risk of significant harm. Senior leaders identified a legacy of poor practice and weak managerial oversight at all levels. However, they have not ensured that basic social work practice is of a good enough standard. The serious and widespread issues across the service had not been fully understood by elected members or senior managers until this inspection and this corporate failure has led to a lack of prioritisation and timely action. This has resulted in too many children remaining at risk of escalating or actual harm characterised by drift and delay.</p> <p>Work in strengthening partnership working and understanding local need has been more successful. Work has taken place with partners since the JTAI to strengthen the effectiveness of work in the MASH and improve performance management information. This now includes a comprehensive monthly dashboard, performance clinics and performance meetings, including a monthly safeguarding meeting chaired by the leader of the council. However, this monitoring does not translate into commensurate action that improves practice.</p> <p>Managers, in particular, do not provide enough guidance or direction to social workers to ensure improved outcomes for children. Conference chairs and IROs do not routinely or effectively challenge poorer practice.</p> <p>The corporate parenting panel has been effective in championing some issues that have led to better outcomes for children looked after, for example improved placement stability and access to education, employment and training. The corporate parenting panel expresses a commitment to improving the lives of children. However, the local authority overall has not prioritised and planned sufficiently to improve outcomes for enough children.</p> <p>More recent commissioning partnerships demonstrate improvement in some services, but more work is required to ensure that contracts and resources reflect the level of need for children.</p> <p>The local authority has begun to implement a new recruitment and retention strategy, but work to date has been ineffective in addressing vacancy rates and staff turnover, and in ensuring that there is appropriate support for newly qualified social workers.</p> <p>Work is taking place to give children a greater strategic voice, but this is yet to translate into practice. The lived experience of a high number of children is unknown or not clearly understood and advocacy to support children is limited.</p>	

Inspection findings

91. Work has taken place over the last year to strengthen strategic oversight, management information and structures in Croydon. However, these measures have failed to result in the improvements that are required to ensure that children are safe and well cared for. The serious and widespread issues across the service had not been fully understood by elected members or senior managers until this inspection and this corporate failure has led to a lack of prioritisation and timely action. This has resulted in too many children remaining at risk of escalating or actual harm.
92. Inspectors identified a high number of children for whom a failure to follow procedures has resulted in a lack of care and protection. Inspectors also referred a number of children, for whom there were significant concerns, to the local authority. All of these cases were accepted by Croydon's senior managers and almost all required immediate action to ensure the safety of the children. The local authority has referred one case to the Croydon Safeguarding Children Board (CSCB) for a 'learning lessons' review.
93. Not long after their appointments in July 2016, and in response to growing concerns, senior leaders commissioned a number of detailed external service reviews and undertook two practice weeks, which included all managers across the service auditing and observing practice. Leaders therefore became aware of the serious deficits in frontline practice, but they failed to correctly prioritise the areas of greatest concern. The local authority is at a very early stage in addressing the poor practice identified. However, some improvements have been made, for example in the MASH. Senior managers have put in place an improvement board, an improvement plan, service plans and a range of action plans that are currently focused on improving processes and structures; there is an insufficient focus on the experience of children. This has created delay in addressing the serious and widespread practice issues.
94. There is a dedicated children's and young people's scrutiny committee and regular meetings between officers and elected members, with clear lines of accountability and governance arrangements between political, strategic and operational roles. However, a significant number of meetings and discussions take place informally and there is a lack of formal minutes to demonstrate and evidence accountability and agreed actions. This means that there is no formal record to demonstrate a clear line of sight from elected members and senior managers to frontline practice.
95. Governance arrangements between key strategic bodies are not clear enough. Senior leaders recognise that these require strengthening, and have therefore begun a review of these arrangements. This review includes the Children's Partnership Group, the Health and Wellbeing Board, the CSCB and the local strategic partnership.

96. Croydon is a unique area with very specific challenges, particularly in relation to unaccompanied asylum-seeking children. A specialist team of social workers and managers works closely and effectively with the Home Office to ensure a strong and caring initial response to children arriving alone in the country. This work extends well beyond the borough, liaising with other areas across the country as part of the national dispersal scheme and including involvement in crisis work, such as the Calais camps.
97. The council has sought to strengthen strategic understanding of all children in the borough by building a detailed and relevant picture of the community. This has included the development of strategic partnership arrangements for children at risk of radicalisation and extremism, child sexual exploitation, going missing, trafficking, female genital mutilation and gangs. Together with the police and other partners, 'Operation Raptor' and 'Operation Rosario' have helped Croydon to develop a profile of concerns and increase disruption activity. The borough has also entered into new partnerships and research projects to broaden knowledge about child sexual exploitation and female genital mutilation, and has created a new senior level group to share information about the highest-risk children.
98. Despite this improved cooperation and collaboration at a strategic level, this work insufficiently informs and improves operational frontline practice. Too many frontline practitioners do not follow child sexual exploitation and missing procedures to protect children. Inspectors saw several cases where workers and frontline managers had failed to identify, assess or respond appropriately to children at risk of sexual exploitation. Despite Croydon having one of the highest numbers of missing children nationally, procedures and protocols for children missing from home and care are not fully established or routinely followed. Not enough children receive return home interviews and risk assessments are rarely completed. As a result, vital information that would inform the partnership about these children is lost, which impedes preventative action to avoid further harm.
99. In the last 12 months, senior managers have commissioned an external review of the CSCB. This report found serious failings that resulted in 10 key areas for improvement for the board. The chief executive also challenged the partnership representatives of the board about the lack of senior level engagement. Despite these actions, the board has not improved its effectiveness in understanding the quality of help and support provided to children and families in Croydon.
100. There are improved strategic partnership arrangements, leading to better shared understanding and joint work. However, partnership working in frontline services needs strengthening. This is very apparent in the lack of multi-agency understanding of thresholds across the child's journey. Meaningful engagement and challenge from partners in key discussions and meetings aimed at protecting children, such as strategy discussions and core group meetings, are lacking. This means that children's plans do not benefit from full multi-agency involvement.

101. For children on the edge of care, the implementation of the PLO has been late in Croydon, but it is now beginning to have some impact. Similarly, the appointment of a new case progression manager is beginning to ensure more consistent court practice. However, while the local authority demonstrates an effective relationship with Cafcass, the relationship with the judiciary is poor. Despite very recent improvements, the judiciary expressed considerable concern about the quality and timeliness of legal representation in court. It highlighted a number of practice concerns, which included poor recognition of neglect, poor planning for children, resulting in significant delays, and a culture of crisis management in Croydon.
102. Croydon has taken action following the JTAI to strengthen performance information and this has resulted in improved performance management data. This includes a monthly dashboard, performance clinics and performance meetings, including a monthly safeguarding meeting chaired by the leader of the council. However, data is not collected in all areas to inform practice improvements, for example complaints from children and families. Despite weekly and daily monitoring of some priority areas of child protection processes, this monitoring does not translate into commensurate action that improves practice in key areas. Some managers do not understand performance data and, as a result, there are gaps in key areas of performance oversight, such as missing children. Performance management is therefore not informing practice improvement sufficiently.
103. The annual quality assurance framework covers a range of relevant activities. However, information is not routinely collated and analysed to aid understanding of inconsistent practice and outcomes. Auditing activity takes place regularly and inspectors noted that audit findings were accurate in 75% of cases seen. However, managers do not systematically follow up on agreed actions, and escalation processes are not routinely utilised by child protection chairs and IROs to alert senior managers to the impact of deficits in practice, for example delays in planning for permanence or insufficient progress in plans.
104. Improved commissioning arrangements at a strategic level ensure that commissioned services are informed by the needs of children in most cases. Commissioned services, underpinned by dedicated needs analysis, build on the information contained in the joint strategic needs assessment (JSNA). Partners recognise that further work is required to strengthen the JSNA and the Health and Wellbeing Board is considering this. The local authority has developed joint commissioning with the clinical commissioning group and together they have successfully commissioned a number of services that include a new CAMHS contract. However, not all contracts meet the needs of children. The advocacy contract, which began in January 2017, provides an issue-based service only and precludes children who are looked after and care leavers.

105. The joint approach to commissioning is demonstrated in framework contracts for placements. Placement stability for children looked after in foster care is strong and a high proportion of children live in family placements. However, a group of foster carers told inspectors that they do not feel valued and do not all receive the support that they need.
106. The lead member for children and young people, as the chair of the corporate parenting panel, actively engages with children and advocates on their behalf. Changes to the corporate parenting panel mean that all children across the borough can become involved in topic-based discussions. As a result, the panel has been effective in championing some issues for children and young people. For example, last year young people were part of a 'takeover' of the scrutiny committee, during which they explored housing issues for young people.
107. However, the panel is not sufficiently focused on poor performance and the practice priorities in the improvement plan. More work is also required to engage the Children in Care Council. A new draft engagement strategy is currently being debated and refined, which will begin to take these issues forward and further develop children's involvement in scrutiny and the cabinet. At the time of the inspection, Croydon was hosting a youth congress to debate young people's engagement, at which there were over 200 delegates.
(Recommendation)
108. Strengthening the voice of the child is a stated key priority for all leaders in Croydon. However, this desire is not evident in most cases seen on this inspection. Inspectors consistently saw a lack of understanding of the lived experience of children, a lack of involvement of children in their plans and limited access to advocacy and independent visitors for children.
109. Dealing with complaints from children and families is an area that requires further development. A new corporate team has been set up and the first children and families quarterly report was recently presented to children's services senior managers. It contains only basic information; it lacks analysis and does not identify the sources of complaints. There is also no routine monitoring of complaints from children looked after. As a result, managers do not know how many children make complaints, nor their reasons for doing so. Further work is required to ensure that practitioners and managers have received training, and that a culture of feedback is embedded.
(Recommendation)
110. Management oversight at all levels is weak. Supervision is ineffective in the majority of cases seen by inspectors. For some, there were long gaps in the frequency of supervision, and records show a lack of reflection and clarity about actions required in a significant number of cases. This leads to a lack of direction and purposeful work with children, and contributes to unnecessary drift and delay. Senior managers have not created good conditions in which social workers can flourish. A number of social workers told inspectors that they are not clear about what they need to do. (Recommendation)

111. Some social workers, in some teams, have high caseloads and very low morale. This is particularly true for social workers in the care planning units and for new social workers undertaking their assessed and supported year in employment (ASYE). The vast majority of ASYEs who spoke to inspectors said that they feel overwhelmed. They do not all have protected caseloads and therefore do not receive the support and supervision that they require to work effectively with children.

112. While workforce development is a priority for Croydon, this work is underdeveloped and, consequently, it has not affected turnover and vacancy rates. More work is therefore required to ensure that there is a more stable workforce, particularly for children in need and those on child protection plans. Work has been slow to target training and learning opportunities to those who need them, following findings from external reviews and practice weeks. As a result, action is required to ensure that social workers and managers have the skills they require to properly protect and care for children. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The CSCB is inadequate. It has not fully established effective arrangements for discharging 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.

While board members are aware of inadequate practice identified in previous multi-agency audits, SCRs and the findings from practice weeks, they do not provide effective challenge, or take sufficient timely action to address the poor practice and serious and widespread risks to vulnerable children in Croydon. There has been too great a focus on process that has led to insufficient understanding and prioritisation of required actions.

The board lacks direction and purpose, despite undertaking considerable activity, and it is unclear what difference this is making for children. The annual report and business plan are overly optimistic about progress, lack rigour and are not evidence based.

The early help strategy is insufficiently coordinated and implemented and the board has not ensured that pathways to early help services are well understood and applied. Ineffective action to address this fundamental deficit means that the board cannot be assured that children are receiving the right level of help at the right time.

The board leads the overall strategic approach to child sexual exploitation and children missing from home and care. While it is successfully raising awareness across a range of settings, poor scrutiny by the board means that it is not aware that basic child protection procedures for children at risk of sexual exploitation and those missing from home or care are not being followed.

Agreement for SCRs is in line with statutory guidance; learning is disseminated, but is not embedded in frontline practice. The board receives an appropriate range of reports about private fostering, the work of the designated officer and IROs. However, more rigour is required from board members to ensure that the information in these self-reports is triangulated.

There is national and international recognition for work in protecting children from female genital mutilation and for work in supporting unaccompanied asylum-seeking children in Croydon. There is significant engagement with the community and faith groups to raise awareness of specific issues facing children.

Recommendations

113. Ensure that the revised membership, remit and priorities of the board include effective processes that monitor and evaluate actions for their impact on outcomes for children.
114. Include the work of the previous child sexual exploitation and 'missing' subgroup in the Vulnerable Adolescent Committee to ensure effective connection between children at risk of child sexual exploitation, those who go missing, gang affiliation and 'county lines', and to achieve a consistent application of the board's procedures for these children.
115. Ensure that the multi-agency dataset contains sufficient information to improve quality assurance activity and to judge the effectiveness of services, particularly in relation to early help, children in need of help and protection and those in care.
116. Ensure full implementation of the early help strategy, including appropriate action to ensure shared understanding and consistent application of thresholds across the partnership.
117. Develop robust processes to routinely scrutinise, monitor and evaluate the effectiveness of frontline practice. This is to provide evidence of the board's focus on outcomes, demonstrating that it is making a difference to vulnerable local children.

Inspection findings – the Local Safeguarding Children Board

118. The CSCB is inadequate, as it has not fully established effective arrangements for discharging 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.
119. Formal arrangements are in place for the chair of the CSCB to have regular monthly meetings with the chief executive, the executive director of people and the lead member for children. However, these have not led to senior leaders fully understanding the serious and widespread risks to children identified during this inspection.
120. While the chair is a member of a number of strategic boards, in practice there is little evidence to demonstrate that strategic bodies hold each other to account, and that these arrangements are effective in safeguarding children in Croydon. Consequently, the partnership's response to safeguarding children is not assured.

121. The early help strategy is insufficiently coordinated and implemented and the board has not ensured that pathways to early help services are well understood or applied. Over a year ago, the JTAI identified that partners have insufficient understanding of thresholds and ineffective action taken by the partnership to address this fundamental deficit means that there are still no assurances that children are receiving the right level of help at the right time.
(Recommendation)
122. Systems in place for monitoring and evaluating frontline practice are ineffective. Board members noted recurring themes in findings from their multi-agency audits, practice week and learning reviews. Minutes of meetings recorded comments by board members that partners were not working together as a 'collective' and that relationships were 'fractured'. The CSCB failed to recognise, monitor and systematically evaluate the seriousness of these findings. Insufficient challenge by the board in holding partners to account for these failures has resulted in too many children being left unprotected at the time of this review. (Recommendation)
123. Child sexual exploitation arrangements are coordinated and monitored through the child sexual exploitation and 'missing' sub-group and there are plans to extend the work of the group to include all exploited and vulnerable children. This group has successfully raised awareness across a range of settings that includes direct work in schools leading to earlier identification of children at risk and collaborative work with voluntary sector projects based in sexual health clinics. Despite this, inspectors found that too many practitioners do not follow the safeguarding board's basic procedures for assessing the needs of children at risk of sexual exploitation or those who go missing from home and care. Return home interviews and risk assessments are not routinely undertaken and, as a result, these children are not adequately protected from ongoing harm.
(Recommendation)
124. Innovative projects led by the police, for example 'Operation Raptor', provide reliable analysis showing that the profile of children at risk in Croydon is largely one of small groups of peer-to-peer risk and gang-associated incidents. While data indicates that children at risk of sexual exploitation are not linked with 'county lines', the report shows that 'missing' children are. The analysis from 'Operation Raptor' shows that 60 children are involved in cross-county drug activity. This includes nine children looked after in Croydon and 15 from other local authorities. The partnership has not done enough to understand and address the poor practice in this area.

125. A review of the membership of the board took place in November 2016. However, there is too much focus on process, which has affected the ability of the board to know if outcomes for children have improved. The board still lacks direction and purpose and, while there is considerable activity, it is unclear what difference it is making for children. The board does not ask the right questions and board members are too accepting of self-reporting. The annual report states that the board achieved eight of the 10 priorities set out in its business plan. This analysis is overly optimistic and lacks rigour. It is not evidence based and does not accurately reflect the failure to safeguard children and young people in Croydon. (Recommendation)
126. An externally commissioned review of the board in January 2017 recommended that the voice of the child should underpin the work of the board. The chair has persistently requested that partners evidence the impact of their agency's work in protecting children; they have not complied with this request. This questions the authority of the chair and whether agencies fully understand and know if children who have contact with their individual agencies receive help proportionate to their presenting risks and needs. Recent changes to the section 11 audit are aimed at making this more robust.
127. Recent action has strengthened the multi-agency performance management information. This is a positive development as it includes the new monthly dashboard and shared database. More work is essential in order to align the top-line data with qualitative information, as currently there is insufficient impact on the persistent shortfalls that inspectors found in services for children who need help and protection and for those in care. (Recommendation)
128. SCRs are agreed in line with statutory guidance and there have been four commissioned in 2016–17; the associated recommendations are appropriately monitored and reported to the board. Learning from SCRs, while disseminated to all agencies, is not embedded in frontline practice. While there is a comprehensive learning and development programme that provides opportunities to engage effectively with partners, more work is needed to evaluate and evidence the impact of training in all agencies.
129. The board has received an appropriate range of reports regarding private fostering and the work of the designated officer and IROs. There is more rigour required by board members to ensure that the information in these self-reports is triangulated.
130. The child death overview panel (CDOP) identifies the learning arising from child deaths effectively. The annual report is thorough and analytical and all deaths are reviewed within a year of the death. The CDOP has taken action at local and regional levels to drive changes. The chair participates in pan-London workshops coordinated by the Healthy London Partnership CDOP, during which good practice is shared and learning opportunities are maximised in an effort to reduce the risk of child deaths in the future. Rapid response meetings are appropriately prioritised and effective.

131. All partner agencies have worked well together to achieve better outcomes for specific groups of children. For example, there is national and international recognition for work in protecting children from female genital mutilation and for work in supporting unaccompanied asylum-seeking children in Croydon. In addition, meaningful engagement with the community and faith groups has raised awareness of specific issues facing children who are sexually exploited or affected by gangs, or who go missing from home and care. Improved collaboration and joint work with social housing providers and a recent initiative with a local premier league football club ensure understanding and prioritisation of children and their families.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted.

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