Aviation House
125 Kingsway
London WC2B 6SE

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

9 May 2018

Ms Barbara Peacock
Executive Director, People
Floor 7, Zone D
Bernard Weatherill House
8 Mint Walk
Croydon
London
CR0 1EA

Dear Barbara

Monitoring visit to the London Borough of Croydon children's services

This letter summarises the findings of the monitoring visit to Croydon children's services on 20 and 21 March 2018. The visit was the second monitoring visit since the local authority was judged to be inadequate in July 2017. The inspectors were Louise Hocking, HMI, and Anne Waterman, HMI.

Senior leaders and managers in Croydon are progressing well in implementing their improvement plan and they have quickly responded to issues identified in the first monitoring visit. The local authority has invested a significant amount of additional resources to improve the quality of children's services. This visit focused on services to vulnerable adolescents. Despite it being early in their improvement journey, senior managers showed an openness to considering their practice and the quality of services offered to this particularly complex group of children. Inspectors found that the quality of practice for vulnerable adolescents continues to be highly variable and, in some cases, remains inadequate. The extent and detail of risk and response are not always fully analysed and explored for many children who face the highest risk.

Areas covered by the visit

A range of evidence was considered during this second monitoring visit, including electronic case records, sampling casework alongside practitioners and speaking with team managers. We looked at experiences for vulnerable adolescents across the range of children's services, including child in need, child protection and children looked after. This included children who were on the high-risk missing list, those known to the youth offending service or on the gangs matrix and also known to social care, and children whose experiences had been considered at the multi-agency sexual exploitation (MASE) panel.

Additionally, we met with the head of targeted services, who will have overarching responsibility for vulnerable adolescents in a reconfigured service, and with the director of early help and children's social care. We observed the 'missing children's' panel meeting and a group supervision with nine practitioners in the adolescent team. We met with one young person.

We also reviewed follow-up actions from the first monitoring visit in December 2017, when the work on contacts, referrals and assessments had been considered.

Overview

In a relatively short period of time, senior leaders have started to put in place an effective infrastructure. There is a sound understanding of the areas that require change and an appropriate focus on the areas of priority. Senior managers recognise the scale of the improvement task and are planning effectively. The openness to advice, guidance and support is positive. This has meant that, relatively quickly, Croydon has acted on recommendations from the first monitoring visit, formed an effective and well-focused partnership with Camden and put in place a lead 'portfolio holder' for vulnerable adolescents, reflecting the significant and far-reaching risks faced by this group of children.

However, the quality of work for vulnerable adolescents remains highly variable. Too many children receive an inadequate service. The broad issue of risk is recognised for this high-risk group, but a detailed understanding of the risks and what needs to happen in response is not always evident or clear. Management oversight is not sufficiently effective and there is not a visible presence of middle management to oversee the needs and services for this group of children. Some children are now receiving an improved service with an appropriate response to reduce risk, and some stronger work was seen in a small number of highly complex cases.

Findings and evaluation of progress

Based on the evidence gathered during the visit, we identified areas of strength and areas where improvement is taking place, but the response to vulnerable adolescents continues to be inadequate in too many cases. The broad weaknesses in practice are not specific to this group of young people and they mirror the themes found in the first monitoring visit. These include lack of management direction and oversight, lack of clarity in identifying the specific risks and clearly outlining what needs to happen to reduce risk. Written plans are generally of a poor quality, and are brief and generalised without specifically identifying risks. Written records are highly variable in quality and content.

Some concerns were specific to vulnerable adolescents, including some examples of inappropriate use of language or terminology that implied that children placed themselves at risk. There was a lack of management escalation in some cases, for

example to ensure that children's circumstances were brought to the attention of the MASE panel. Given the risks faced by this group of children, oversight by team managers should have had high priority. However, although there were some exceptions, this oversight was generally insufficient. Service manager involvement was not evident in case records.

Inspectors found some strengths. Children facing the highest risks in Croydon are known and thresholds are understood. All cases seen during this visit showed that children were receiving a service appropriate to their level of need, including escalation to child protection plans and becoming looked after. Practitioners appropriately saw adolescents, including much older adolescents, as children in need of protection. Inspectors saw some positive examples of joint working, including work with the youth offending service and a good example of practice in a joint visit with a police child sexual exploitation officer.

The quality of practice is highly variable, with some work not fully focusing on the key risks. Even in stronger work, some key meetings did not take place. Dedicated strategy meetings are held regarding children who are at risk of child sexual exploitation or for children who are missing, but this practice is not consistent, regardless of the overall quality of the casework. Evidence of written risk assessments on files was variable. Senior managers need to ensure that they have a systematic process in place to consistently oversee and monitor the key meetings at which risk is considered for this group of children. The experience for some children had been negatively impacted by lack of suitable placement choice. Drift and delay were seen for some children, particularly in pathway planning.

Staff turnover and the high number of agency staff, currently at 41%, mean that some children have too many changes of social worker. This impacts on the development of a secure social work relationship, a potentially protective factor for this vulnerable group, although it is noted that continuity of social workers for children looked after is more stable. Newer staff, who were working hard to meet the needs of children and bring casework back on track, were being hampered at times by a legacy of previous poor practice. However, inspectors were consistently impressed with the quality of frontline practitioners. They displayed a good awareness of the needs of the children they worked with and a real commitment to ensuring that they engaged well with children. The adolescent team, which is growing in size, has a clear focus on considering history and being compassionate, while also being clear and firm about expectations, particularly when working with young people involved in criminal activity.

Services for children who go missing from home or care or those at risk of being sexually exploited are highly variable in quality. The MASE panel is not functioning effectively and examples were seen of actions not followed up and confusion among practitioners about the role of the panel and how it fits with other forums to consider similar risks. The local authority is aware of these concerns and the purpose of the

MASE panel is under review. Senior managers need to ensure that services for children do not deteriorate while the new process is being embedded.

The local authority now has a dedicated senior lead manager for targeted services, in response to the significant risks that exist for adolescents. In addition to this, services are being restructured to provide a coherent specialism and align support to youth offending, 'missing', child sexual exploitation, two specialised adolescent services and other aspects of high-risk, including female genital mutilation and radicalisation. This is underway, but not yet fully in place. It has enabled a closer focus on children who go missing, with a daily 'missing' meeting and a change to the process for offering return home interviews. There is an improving take-up of return home interviews, with a completion rate of 62% in February, but timeliness is poor, with only 36% of interviews undertaken within 72 hours. The local authority is currently instigating a process for conducting return home interviews for children who go missing and are placed at a distance, but this is not yet embedded. At this time, senior managers cannot be confident that each child is receiving an appropriate response when they go missing and work needs to continue in line with their improvement plan. However, we did see some good practice examples of return home interviews undertaken by social workers that were detailed, analytical, and clear on risks and actions.

Services are benefiting from the additional investment, with higher staff numbers and smaller teams of six practitioners. Caseloads generally are at a reasonable level within the services looked at during this monitoring visit, with social workers holding an average of 19 cases, although some workers did have slightly higher caseloads than this or felt that their workload was high due to the complex needs of the children.

In summary, senior leaders and managers have acted promptly to put in place effective means for improvement. They have progressed actions since the first monitoring visit and have a clear understanding of what they need to do to continue to improve. Positive steps include:

- the engagement with their improvement partner, with an agreed set of initial priorities
- significantly improved auditing processes that show an understanding of what good practice looks like
- an improved line of sight from senior managers, including direct involvement in auditing
- a number of home visits to children by the director of early help and children's social care
- commissioning an independent external review of assessment cases closed as 'no further action', and recommissioning further work following the first monitoring visit
- gaining a clear understanding of the weakest aspects of their service.

However, the impact on children still remains too variable and this is particularly relevant for vulnerable adolescents, where the risks are highest. The service for these children remains weak at this point of transition and development, with an urgent need for improved management oversight.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Louise Hocking
Her Majesty's Inspector