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Commission



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Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in the London Borough of Croydon

Between 16 May and 20 May, Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in the London Borough of Croydon.¹ This inspection included a 'deep dive' focus on the response to child sexual exploitation and those missing from home, care or education.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in the London Borough of Croydon.

Partners are working together effectively in many areas of practice to meet the challenges of increasing demand and complexity in the local population of the London Borough of Croydon. Some aspects of multi-agency work are delivering well for children and young people but, in other service areas, multi-agency and individual agency work requires significant improvement. Croydon as a local area is unique, in some respects. There are high numbers of unaccompanied asylum-seeking children (UASC), who make up almost half of the population of children looked after, high numbers of children placed by other local authorities in the borough (550) and increasing levels of deprivation. The borough also has very high numbers of missing children. The demand for services is increasing the pressure on the police, health services, probation services and the local authority to ensure that there are sufficient resources to meet needs. To enhance the core statutory services, children missing and at risk of child sexual exploitation are supported by the local authority through

¹ This joint inspection was conducted under section 20 of the Children Act 2004.



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the commissioning of a wide range of voluntary agency specialist services. This was seen to be making a real difference to children, young people and their families. However, there remain inconsistencies in response to some children at risk of child sexual exploitation and those who are missing. Although no children were seen to be left at immediate risk of harm, insufficient levels of staffing in the school nursing service and the multi-agency safeguarding hub (MASH) mean that there is not always a timely identification and assessment of children's needs. Some children have to wait too long for a social work assessment, or for an investigation to be undertaken by the police. The local authority is leading immediate remedial action and considering what additional resources are required to address this concern in the MASH. For some vulnerable children at risk of sexual exploitation, police investigations may result in the involvement of a number of police officers, due to the way that responsibilities are shared between the Metropolitan and the borough police. This may cause confusion for the child and can sometimes result in delays in the police response to sexual exploitation. The local authority, police, health and probation services undertake analyses of the known cohort of children at risk of sexual exploitation, and this is driving the development of services to meet current needs and to prevent exploitation. However, the profiling of those who offend against children is underdeveloped. The Local Safeguarding Children Board (LSCB) recognises that much more work is needed to achieve a full understanding of the profile of perpetrators, and to understand patterns and trends in the population of children who go missing to enable a more proactive, quicker response to developing need and risk.

Key Strengths

- In meeting the level of current demand, there is a clear commitment from the council and senior leaders across all partners to work together to support some of the most vulnerable children in the community. For example, the leader of the council, the local strategic partnership and the Local Children's Safeguarding Board (LSCB) have prioritised child sexual exploitation through a programme of work to increase awareness across the local area and build capacity, to respond to and prevent child sexual exploitation.
- There is wide representation, including from the voluntary sector, on the LSCB, both at board level and across the sub-groups. The board has been instrumental in driving improvements at a strategic level in response to child sexual exploitation. For example, multi-agency sexual exploitation (MASE) meetings are resulting in sharing of information about risks to children to inform disruption activity by the police at identified locations, such as hotels and private homes. Sharing of intelligence and information at these meetings has also supported the youth offending service (YOS) to map child sexual exploitation and networks linked to gangs, to understand better the risks to some young women.



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- The LSCB child sexual exploitation sub-group has undertaken a range of analyses to better understand and map the profile of known victims of child sexual exploitation. It has a good understanding of how the profile of child sexual exploitation has changed in the borough over the last year, with less use of hotels as venues to exploit young people, and increasing use of other venues and of incidents of online grooming. The sub-group produced a detailed and analytical annual report on child sexual exploitation in 2015, which evidences a range of work to engage young people and target services, some of which is based on this analysis. In recognition of the prevalence of peer on peer abuse, work is being developed to act quickly to address and try to stop harmful sexual behaviour through the YOS. The sub-group has used information to identify areas that require further work. Although 58 children were identified as victims of trafficking in 2015–16, the partnership recognises that more focused activity is needed to ensure that all those at risk of trafficking and child sexual exploitation are identified. Plans are in place to develop this activity, and work has commenced; for example, 'modern slavery champions' are being trained to work across services.
- There is a clear strategic approach in Croydon to commissioning and working with the voluntary sector to build capacity and expertise in working with children at risk of child sexual exploitation and those who are missing. This approach was seen to be making a positive difference in cases reviewed for this inspection. Safer London (a children's charity), for example, provides a range of services to children and their families. This includes direct work with over 300 young people in Croydon in 2015–16; with high rates of engagement (92% of young people remain engaged in direct work at three months after first contact). The feedback from children and young people who access this service is very positive.
- There are some good examples of effective work by the LSCB to engage with young people and respond to identified need. For example, consultation with young people resulted in the development of a pamphlet designed to support young people to identify the signs of sexual exploitation in their peers, as consultation showed that young people are more likely to recognise the signs in their friends than they are themselves. Analysis of return home interviews identified that many young people who had been missing and were not known to services did require ongoing support. Two workers from a children's charity have been commissioned by children's social care to work in the 'missing' team to provide the support needed. Their engagement with young people is resulting in a reduction in the frequency of episodes of 'missing' for some young people, and staff build trusting relationships, which means that young people have someone to turn to. For example, one young person rang her worker to tell her that she was at risk of going missing.
- In recognition that Croydon has the highest number of missing children of any local authority and the need to identify those most at risk, Operation Raptor (a



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joint investigation to develop responses to child sexual exploitation) commenced in 2014. The operation was developed by the national crime agency, the Metropolitan Police and children's social care in Croydon. As a result, 20 girls at high risk of sexual exploitation were identified and support was put in place. The profiling of the patterns of child sexual exploitation resulted in targeted work with hotels, and taxi and bus drivers, and the training of over 1,000 professionals and training of CCTV operators to identify risks to children. In recognition that a number of young people who attend pupil referral units (PRUs) were at risk of child sexual exploitation, focused work is in place with the staff of PRUs to support them to prevent child sexual exploitation.

- Further work to target the business community and specific premises, in order to deliver training through Operation Makesafe, is improving awareness and the borough police report that this has resulted in an increase in referrals of concern about child sexual exploitation, as well as a reduction in crime associated with specific hotel venues.
- The police have committed an additional officer, and children's social care has identified more resources to meet local demand. There is a commitment from senior leaders in the local borough police to review and develop a more resilient and coordinated structure. An increase in staffing and the co-location of staff working on missing', gangs, schools, licensing and child sexual exploitation are leading to better information sharing, especially in relation to the links between gang activity and risk of child sexual exploitation. Children's social care has committed funding for two new posts which will enable them to enhance performance management and develop a more detailed understanding of patterns and trends of child sexual exploitation.
- Safeguarding supervision across the main health providers is well established, giving a range of opportunities to develop practice. The clinical commissioning group (CCG) has implemented a general practitioner (GP) case reflective model to allow cases to be considered in more depth, as well as workshops on child sexual exploitation. South London and Maudsley NHS foundation trust ensures that frontline staff have good access to the named nurse, named doctor and social worker for support and consultation on safeguarding. The maternity supervisors at Croydon health services NHS trust (CHS) are on call 24 hours a day, and this means that staff who identify safeguarding concerns out of hours can obtain access to advice at any time.
- The CHS Trust, supported by the CCG, has implemented monthly multi-agency meetings as part of a new pre-birth pathway. These meetings involve the midwifery team, a perinatal mental health midwife, health visitors, children's social care, the family nurse partnership and an independent domestic violence advocate (IDVA). Although the impact has not yet been assessed, it nonetheless shows a firm commitment to information sharing and discussion aimed at safeguarding unborn children.



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- Governance arrangements for the YOS are robust, and the management board is incorporated into the youth crime group. This draws together both strategies to tackle gangs and diversionary work with young people. There is evidence of effective management oversight of practice and, in particular, a clear focus on risk of harm to others, safeguarding and child sexual exploitation, so that YOS workers have a good understanding of risk and staff record this well.
- In cases with the highest risk of child sexual exploitation, health services, the voluntary sector, police, education, children's social care and youth offending services work together to safeguard children. In most cases seen, risks were reducing as a result of joint working. Action to protect children at risk by commencing care proceedings is sufficiently swift to ensure that risk is reduced and, where there is identification of risk around missing and child sexual exploitation, agencies are referring concerns to children's social care in a timely way. In some cases, the perseverance and the skill of individual workers is engaging children and their families well, resulting in effective work to help family relationships and parenting styles to improve, and therefore to reduce risk. There were some good examples of health practitioners listening to the voices of young people that resulted in additional help, such as referral to the child and adolescent mental health service (CAMHS). In those cases where the YOS was involved, there are high levels of contact and good engagement with young people.
- There are some examples of effective assessments of children at risk of child sexual exploitation, including children's social care assessments, that are sufficiently detailed and analytical, and support planning to meet a range of needs. YOS assessments were mostly of good quality, with good access to a range of information across agencies.
- The sexual health service undertakes high-quality risk assessments for young people. Case examples demonstrated that assessments consistently capture extensive social histories and that practitioners analyse risk levels well, including consideration of the young person's presentation and demeanour. Where concerns are identified, clinicians make a referral immediately after seeing the child or young person. Cases are also discussed at the weekly multidisciplinary team meeting for further risk review, ensuring a robust and timely response to need and risk.
- The quality of the assessment of the risk of serious harm to young people at risk of child sexual exploitation, conducted by the national probation service (NPS), was seen to be of a good standard in the cases examined. There are good examples within sexual health services and Safer London of children being seen, spoken with and listened to. This is further evidenced in health assessments of the unaccompanied asylum seeking children where the 'voice of the child' is evident in most cases.



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- The MASH is co-located and there is 'buy in', across children's social care, the police, health, housing, YOS, education and probation services, to providing a multi-agency approach to information sharing. When there is an immediate high level of risk, referrals are responded to quickly and progress to the duty assessment team in a timely manner.
- Members of the public, including young people, can access and speak to a duty social worker at any time through the reception at council offices and the emergency duty team after hours. This service is particularly well used by young people with accommodation issues. In addition, the information and advice line for professionals provides an opportunity for individuals considering non-urgent referrals to discuss their concerns, and this is improving the quality of referrals.
- Age assessments of unaccompanied asylum seeking children are thorough, with the process and basis of the assessment clearly evidenced and in line with guidance and current case law. Effective joint screening between social care and the Home Office ensures that immediate need and risk are identified for young people presenting as unaccompanied asylum seekers, and this ensures that a placement that will meet their needs is provided. Issues of risk are considered in placement matching. For example, when the age of a young person is disputed, placements without younger children are sought, and when risks relating to potential trafficking are identified, the actions and directions are clear for prospective foster carers.
- The CCG is ten months into a year-long project to address female genital mutilation, to improve health outcomes for women and girls. To date, over 700 people across Croydon have received training in identifying the signs of female genital mutilation using a risk-assessment tool and responding according to a locally devised female genital mutilation pathway. This includes staff from the local authority, schools and health services. This is an encouraging initiative led by the CCG and there is evidence of the project's visibility, such as leaflets and posters at the providers visited during the inspection. However, the full impact cannot yet be assessed due to its recent implementation.



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Case study: highly effective practice

The local authority has effective joint screening arrangements in place with the Home Office, which ensure that initial needs and risks for Unaccompanied Asylum Seeking Children (UASC) who present in Croydon are identified immediately. Well-developed commissioning processes locate and access foster placements promptly, meaning that there are no unnecessary delays for this vulnerable group of young people. A duty social worker is based at the Home Office which supports the joint approach for UASC. Where potential risks are identified, such as the young person being the victim of trafficking or where the age of the young person presenting is disputed, these are appropriately considered in the placement-matching process. Following consultation with young people, this process was further amended to ensure that young people do not wait for long periods on the day for a placement to be found. In one example seen during the inspection, the process for screening, placement identification, then matching and transporting the young person to the placement was completed within two hours. A further strength is that all young people who present as under the age of 18 are placed in foster care, including 16- and 17-year-olds. This means that placements that are made at the point of presentation are more likely to offer effective support and stability. Subsequent moves to semi-independent living for this age group will only take place following a detailed assessment and agreement by the independent reviewing officer and senior managers.

Areas for improvement

Identifying and managing risk of harm at the 'front door'

- The Multi Agency Safeguarding Hub (MASH) is experiencing high and increasing levels of demand. In addition to the MASH, a specialist duty service has been developed to meet the needs of the high numbers of Unaccompanied Asylum Seeking Children in Croydon. Contacts from across the partnership to the MASH are currently around 1,200 each month, and systems and capacity issues in the MASH mean that not all contacts receive a timely response.
- Agencies are required to have a thorough understanding of thresholds for referral to children's social care. However, a number of partner agencies, including some health services and some schools, do not have a clear understanding of thresholds for intervention and the application of thresholds across partners is inconsistent. For example, the emergency department at Croydon University



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Hospital is not aware of the threshold document and it is not being used to inform referrals.

- The quality of contacts received from all agencies is too variable. This is recognised by managers and the LSCB as an area for improvement, but data held by the MASH does not identify the source of all contacts, making it difficult to target the agencies or individuals that need to improve. As a consequence of poor quality contacts, too much time is taken in the MASH in establishing the key issues of concern that need to be addressed. This is not an effective use of resources in the MASH, particularly given the volume of work to be completed, and it can delay the timeliness of response to children's needs.
- At the time of the inspection, there was a backlog of 185 police incidents awaiting research and checks in police systems. Initial risk assessments had been completed to identify any children at high risk, and these cases were progressed to children's social care for further assessment. The remainder had been categorised as low or medium risk, but had not been the subject of full research and checks, which means that additional information that may inform decisions is delayed. The oldest case dated back four weeks. The police have responded to this by providing additional staff to address the backlog and deal with the unknown risk.
- When there are immediate child protection concerns identified at the point of contact, cases progress in a timely way. There are delays however in progressing a small number of other cases from the point of contact. The local authority has acknowledged that when cases are assessed as not urgent, there are sometimes delays in decision making about the next steps. During the inspection, this was seen to be due in part to limited capacity to manage the volume of work. The situation is exacerbated by partner agencies' failure to respond in a timely manner to MASH requests for information. There have been delays in receiving information on non-urgent cases from the police, GPs and the national probation service. This means that children are not always seen and their needs met in a timely manner. No children were identified as at immediate risk of harm during the inspection, and the partnership is taking immediate remedial action to address this concern.
- Strategy discussions do take place within timescales, but they are mostly individual telephone calls between police and children's social care. Health services, schools and others are not routinely involved, and strategy meetings are only called in complex cases. Therefore, there are missed opportunities to gather a full range of valuable information to inform decisions.
- There is a lack of clarity within the MASH on the process for establishing whether adults in families referred to the MASH are known to the national probation service and community rehabilitation company (CRC). The MASH probation officer is based at the Croydon NPS office and this reduces the officer's ability to have



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informal contact with and provide advice to, professionals in the MASH. The 24-hour target for responding to MASH requests for information is not always achieved by the probation service, and neither is it routinely monitored.

- At the adult emergency department of Croydon University Hospital, there is limited consideration given to identifying children at risk of hidden harm from their parents' risky behaviours resulting from drug and alcohol misuse, domestic violence and mental ill health. The risk assessment template, which would assure operational managers that the potential for hidden harm to children is being considered, is not routinely completed.
- In the CRC, in the cases seen, appropriate checks were made with the police and children's social care to identify whether adults are known to these services. Performance management monitoring of compliance with child safeguarding procedures is not yet in place, following the implementation of a major new IT system. This means that that CRC cannot be assured that offender managers are making appropriate checks with children's services in all cases. Risk assessments of offenders within CRC do not take sufficient account of risk of harm to children. The planning for offenders does not routinely include how to manage and reduce any identified risk of harm to children.
- Ethnicity is captured in assessments, but wider diversity issues such as sexual orientation, are not always recorded. This was particularly noted in assessments undertaken by social workers. This limits children's social cares ability to use this information when planning services.

Response to child sexual exploitation and missing children

- The quality of frontline practice with children and their families to respond to and prevent child sexual exploitation is too variable. This means that responses to children are inconsistent and this is especially evident in those cases where the risk is less immediate. In some cases, health services have not been invited to key meetings, such as children looked after reviews and child protection case conferences, to share information and make joint decisions. There is no evidence that this is escalated by health services as a concern when this happens. The voluntary sector undertakes a wide range of work with children at risk of child sexual exploitation and of going missing. Details of this work, such as the progress made, are not always recorded on the child's file and, in a small number of cases; social workers were not clear as to the nature and progress of this work.
- Health services are not routinely using systems and processes available to them to identify children at risk of child sexual exploitation. Health professionals are inconsistent in their use of the 'Spotting the signs' checklist for the identification of children at risk of child sexual exploitation. Moreover, they do not always place



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flags on the record of young people at risk of child sexual exploitation to ensure that all health professionals are alert to the risks.

- The electronic recording system used in children's social care does not always support a coherent overview of children's experiences and the interventions by agencies. This means that it is sometimes difficult to understand whether earlier events have been properly considered in assessments and plans. In addition, when children have been missing it is not always clear from the child's record whether there has been a return home interview, or whether the child has received the appropriate level of support to reduce the likelihood of them going missing again. Children's social care records need to show a clear account of risks to children as well as protective factors, and to record how these change over time. This applies to the recording of single and multi-agency meetings as, in a small number of case records; different meetings had recorded differing conflicting levels of risk for the same child.
- A specialist service provided by the NSPCC offers return home interviews to Croydon children who are assessed as high risk and who have been missing. However, the local authority does not collate data on the number of return interviews offered and taken up by other children who have been missing and are offered interviews by professionals known to them. Information gathered from NSPCC interviews is analysed and used to inform practice, but no such work is completed on all return home interviews. This severely limits the partnership's understanding of the cohort of missing children.
- Not all multi-agency assessments led by social care are sufficiently up to date to ensure that plans are appropriate to meet young people's needs. In addition, some assessments do not consider the wider circumstances and holistic needs of young people, or include robust analysis of known risks. This means that decision making is too often reactive rather than proactive, as agencies respond to the most recent or evident concern. Children often have complex and changing needs. The lack of a comprehensive holistic assessment that is dynamic and updated as circumstances change means that plans do not always address all areas of children's needs, nor support sustained change. The partnership, and in particular children's social care, need to learn from the better examples of assessment identified by inspectors during the inspection in order to drive consistent practice across services and promote the reduction of risk over the longer term.
- Management oversight by children's social care of plans and reviews is not always sufficiently robust to ensure that progress is being made in all cases. For example, not all children have up-to-date plans and, in some cases, successive reviews in social care records contain the same action, with little evidence of progress. The recording of planning and review meetings needs to improve so



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that professionals understand their respective responsibilities, so progress can be monitored and delays challenged by managers.

- Parents and family members are not always considered sufficiently to ensure that their potential to contribute to protecting children is understood. Parental views may be recorded by children's social care, but some lack an in-depth analysis. This is a lost opportunity to engage with families, and to build protective family environments for children and young people.
- When cases are reviewed at the Multi Agency Sexual Exploitation (MASE) meetings, it is not always clear that actions that have been agreed are shared with partners in a timely way. The MASE initiative launched across London in 2014 by the Metropolitan Police is a partnership between the police, health services, public protection and Croydon's children's services. The current administration of this meeting is not operating effectively, as there are sometimes delays in distributing MASE minutes. Individual partner agencies should feedback information on decisions to their agency following the meetings. However, this does not always happen, and in these cases it is unclear how all partners can utilise the MASE discussions and actions to support plans and interventions. This has been a particular issue for health services, as frontline staff have not been consistently well informed about risks and vulnerabilities to children, nor have health services always had the opportunity to share reports at MASE meetings. This limits the effectiveness of partnership work to identify and reduce risk.
- Some children who have been missing and/or are at risk of child sexual exploitation may have a number of police teams working with them at a time when they are particularly vulnerable. For example, the child abuse investigation team (CAIT, Metropolitan Police) manages inter-familial offences and Sapphire (Metropolitan Police) investigates serious sexual assaults, while the exploitation team (Metropolitan Police) or borough child sexual exploitation officer and the missing persons unit of the borough police manage children who are missing and at risk of child sexual exploitation. The impact is that a number of different officers may interview a child. This can inhibit disclosures, and these interventions are not always managed through a shared plan of engagement. This is limiting the ability of the police to engage effectively with children and their families, and to routinely share intelligence and information about offences.

It is recognised that this is a London-wide challenge for the Metropolitan Police service, and is not confined to Croydon.

Leadership and Management

- Senior managers across the partnership, children's services, police, and health and probation services do not currently collate and use a full and appropriate range of management information across all areas to help them understand the



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services they provide, to enable them to set targets and monitor performance. For example, for those partners who work within the MASH, a suite of performance management indicators would promote a better understanding of where there is delay in the system to respond to children's needs. This would help them to identify key areas of practice that require improvement. Without this information, it is a challenge for the partnership to develop strategic approaches to manage demand, or to set and monitor targets for performance. For example, 21% of contacts coming into the MASH are recorded as from 'another source'. Without a full understanding of the source of contacts, it is difficult to see how the partnership can work to reduce demand.

- Further work is needed by the CCG and NHS England to promote better engagement of GPs with MASH arrangements, to ensure that information is shared. Currently, there is no mechanism in place by which the named GP and CCG gather data on where to target actions to promote improvement. For example, there is no data available to show which GPs have not responded to MASH intelligence requests, although it is known that currently very few GPs respond to MASH requests for information.
- Despite the delivery of Operation Raptor, the partnership has more to do to understand the extent and nature of child sexual exploitation across Croydon, as at present this is underdeveloped in relation to perpetrators. There is currently individual profiling, and an informed analysis of the identified cohort of those at risk being managed by the police and partners. A wider partnership problem profile would support more proactive analysis of networks (both victims and perpetrators). This would further promote the development of protective and disruptive plans ('hot spot' identification, crime and incident series, and trend identification), and support strategic resource planning, as well as providing a clearer focus on intelligence collection requirements across the partnership. Access to analytical capability within Croydon borough police is limited. Children's services has recognised the need for more detailed analysis of trends and patterns of child sexual exploitation, and has secured funding to recruit a data analyst to undertake this work.
- The high number of children placed in Croydon by other boroughs present a challenge in terms of oversight, monitoring and analysis of patterns, and trends of all children missing. Although these children are included in daily reports that are sent to a range of key agencies, analysis of this specific cohort of missing children is limited. Return home interviews for children placed from other boroughs are undertaken by those local authorities responsible for the children, and information from these interviews is not routinely shared. The local authority has taken steps to share intelligence and review movement of children across boroughs through the establishment of regular meetings of child sexual exploitation and missing coordinators across five London boroughs. The local authority accepts that the quality and reliability of information shared at these



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meetings is variable, and that there is further work required to ensure a more robust information-sharing system.

- In some agencies, for example the MASH, the police and school nursing capacity issues are limiting the effectiveness of responses to children. When a report of an incident of child sexual exploitation is made to Croydon borough police, they are proactive in undertaking initial assessments. However, in a small number of cases there have been significant delays between the date of a report of child sexual exploitation and the first contact with the child by the dedicated police officer. In half of the cases reviewed there was some delay, and in two cases there were significant delays. This clearly undermines the ability of the police to build rapport with the child, ensure timely disclosure and review risk. Despite the clear commitment to children that is demonstrated by the two dedicated police officers responsible for this work, there is currently insufficient capacity in the team to meet the demand.
- Social work managers in the MASH do not currently have the capacity to ensure systematic oversight of decisions by social workers to close contacts, and not all social workers in the MASH receive regular supervision. This means that decisions to close contacts are not routinely reviewed and agreed by managers. For example, in one case seen during this inspection, the decision to close a contact was inappropriate and resulted in a further referral when concerns increased. In this case, the child did not receive the help that they needed early enough.
- A large backlog of initial health assessments for unaccompanied asylum seeking children was managed through the implementation of a bespoke Saturday service, for this purpose. The CCG provided training to a small group of GPs to undertake these assessments. It is acknowledged that this reduced the backlog significantly over a relatively short time. However, the initial delays in undertaking these health assessments for this vulnerable cohort of children has led to delays in some young people's health needs being met in a timely way. Furthermore, there is no formal quality assurance process for the health assessment of both unaccompanied asylum seeking children and local children looked after. This means that the CCG or the commissioners of the service cannot be assured that health assessments are successfully or accurately meeting the needs of children looked after. There is no robust mechanism in place to check and advise on the quality of safeguarding referrals from the emergency department at Croydon University Hospital at the time that they are made. There is an over-reliance on the paediatric liaison health visitor to provide management oversight of referrals, and on the health practitioner within the MASH to act as a secondary checking mechanism. However, recent technical issues have meant that the paediatric liaison health visitor cannot currently provide this oversight in a timely way, and the capacity of the MASH health professional is limited due to insufficient resources within the trust's safeguarding team. The absence of any management



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oversight at the point of referral has led to a generally poor standard of referral being received in the MASH.

Local Children's Safeguarding Board

- The quality of performance data received by the LSCB is neither sufficiently comprehensive nor robust. This means that the partnership does not have effective oversight of all areas of practice, in particular the 'front door' of services. Consequently, the quality of the work, outcomes for children and demands for service is not sufficiently well understood by all senior leaders. The development of a more effective performance and quality assurance framework, to support improved understanding and decision making across the partnership in relation to initial responses to all forms of child abuse at the point of identification, will aid development and improvement of service delivery. The LSCB began working on a new performance management framework in February 2016 and this has been recognised by the newly appointed LSCB chair as a key area that requires development.
- The MASH sub-group of the LSCB is not demonstrating the levels of leadership that are required to effectively monitor and challenge the performance of the MASH. The sub-group lacks SMART action plans that are informed by robust data which is specific and tailored to the requirements of Croydon.
- Partnership meeting structures and engagement between professionals in forums such as MASE are in place. However, this does not always result in an overall documented multi-agency plan to ensure a coordinated response to children's needs.

Case study: Area for improvement

The MASH team has a system for gathering information from across the agencies on non-urgent cases. This process, known as MASH Intelligence, involves emailing partner agencies to check if families are known, and to request any information which could help to better inform decision making at the MASH.

In principle, this process is a positive step in gaining as full a picture as possible before making decisions about contacts, however in most cases seen, there were delays by partner agencies in responding to these requests. Staff reported that it can take several days or, in some cases, weeks for agencies to respond. This is causing delays in children and families being seen, and offered help and support.

Work across the partnership to agree protocols and practice standards, in relation to response times for MASH intelligence requests, would promote better practice and reduce delays for children.



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There is currently no data collected on individual agency performance on returning requests. The regular measuring and reporting of this performance indicator to the LSCB would enable monitoring, training and challenge to be targeted where it is needed most across the partnership.

Additionally, the process needs further work to ensure that there is no delay to children being seen, and offered help and support while MASH is waiting for information requests to be returned.

Next steps

The local authority should coordinate the preparation of a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving LSCB partnership, specifically health services, the police, probation, children’s social care and the Youth Offending Service. The response should set out the actions for the partnership and, where appropriate, individual agencies.²

The local authority should send the written statement of action to protectionofchildren@ofsted.gov.uk by 6 October 2016. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	Care Quality Commission
Eleanor Schooling National Director Social Care	Sue McMillan Deputy Chief Inspector
HMI Constabulary	HMI Probation
Wendy Williams Her Majesty’s Inspector of Constabulary	Helen Davies Assistant Chief Inspector

² The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted’s chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.