

# Education and Local Economy Scrutiny Commission

Wednesday 3 December 2025

7.00 pm

Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1  
2QH

## Supplementary Agenda No.1

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6.	<b>Southwark Safeguarding Children Partnership (SSCP)</b> To receive the SSCP Annual Report for 2024/25 from Alasdair Smith, Director of Children's Services <ul style="list-style-type: none"><li>Major Changes- Children's well-being and schools bill in parliament, scrutiny of safe-guarding work, core child protection activity and reduction of children in child protection plan</li><li>SSCP transformation and roles</li></ul>	1 - 29
7.	<b>Connect to Work programme</b> To receive an update from officers Danny Edwards, Head of Economy and Nick Wollf, Employment and Skills Manager on employment support for those facing health and disability barriers to work, delivered through the Connect to Work programme.	30 - 32

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Date: 28 November 2025



Southwark Safeguarding  
Children Partnership



# Southwark Safeguarding Children Partnership

Annual Report 2024-2025

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# 1. Purpose of the Report

Southwark Safeguarding Children Partnership (SSCP) 2024-25 annual report outlines the statutory requirement for safeguarding partners to submit an annual report to the Child Safeguarding Practice Review Panel, on how the SSCP ensures good governance and strategic oversight of multi-agency safeguarding arrangements within Southwark.

Throughout the year, the report helps the partnership improve safeguarding practices, test arrangements, and measure the impact on local families. It serves as a learning and communication tool, outlining Southwark's response to national reforms in multiagency safeguarding arrangements.

It analyses the activities of partners and their connections to operational practices through subgroups, forums, audit cycles, and training. The report also highlights how the partnership has learned from serious incidents and practice reviews, and how these insights impact ongoing work with children and families to improve outcomes.

# 2. The Southwark Local Context

Southwark is a densely populated and diverse inner-London borough situated on the south bank of the River Thames, with Lambeth to the west and Lewisham to the east. The borough is made up of a patchwork of communities: from leafy Dulwich in the south, to bustling Peckham and Camberwell, and the rapidly changing Rotherhithe peninsula. Towards the north, Borough and Bankside are thriving with high levels of private investment and development. Yet there remain areas affected by high levels of disadvantage, where outcomes fall short of what any resident should expect. Southwark's population is young, diverse and growing, with large numbers of young adults, from a wide range of ethnic and social backgrounds.

- The median age (33.4 years) is more than two years younger than London, and almost seven years younger than England.
- Around half (51%) of people living in Southwark have a White ethnic background compared to 81% nationally.
- The largest ethnic group other than White is 'Black, Black British, Caribbean or African', accounting for one-quarter (25%) of Southwark residents.
- Over 80 languages are spoken in the borough. Of the 53,700 Southwark residents whose main language is not English, 10,200 (19%) cannot speak English well or have no English proficiency.
- Over 40 distinct religions are reported by Southwark residents.
- Southwark has the fourth largest LGB+ population and the fifth largest trans population of any English local authority: 8.1% residents aged 16+ (nearly 21,000 people) identify as

non-heterosexual, and 1.2% (over 3,000 people) report a gender identity different to their birth sex registration.

Over 18,000 residents provide unpaid care, equivalent to 6% of Southwark's population. Around a quarter of unpaid carers in the borough provided more than 50 hours of care per week.

Areas of deprivation are concentrated across the central and northern parts of Southwark. Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in these neighbourhoods. In particular, communities in Faraday and Peckham wards. However, it is important to acknowledge that pockets of disadvantage also exist within areas of affluence, such as the Kingswood estate in Dulwich Wood and Downtown estate in Surrey Docks.

Data Source:

[JSNA Annual Report](#)

### 3. The Partnership



#### Our Vision

All children in Southwark have the right to be safe and protected from harm. We will work together to protect children and young people through high quality services that enable children to reach their full potential and achieve the best possible outcomes.

Southwark Safeguarding Children Partnership's primary objective is to assure itself that local safeguarding arrangements and partners act to help and protect children.

The partnership will hold agencies to account for their key safeguarding responsibilities, so that:

- All those who work with children and young people know what to do if they are concerned about possible harm.
- When concerns about a child's welfare or concerns about harm are reported, action is taken quickly and the right support is provided at the right time. This covers the spectrum

from early help when issues first arise through to emergency action needed to keep children and young people safe.

- Agencies that provide services for children and young people ensure that they are safe, and monitor service quality and impact.



## Key Strategic Questions for the SSCP

- Is the help provided effective? How do we know our interventions are making a positive difference? How do we know all agencies are doing everything they can to ensure children and young people are safe?
- Are all partner agencies meeting their statutory responsibilities as set out in Working Together 2023?
- Do all partner agencies quality assure practice and is there evidence of learning and improving practice?
- Is safeguarding training monitored and evaluated and is there evidence of training and learning impacting on practice?

### 3.1. Our Partners

Partnership work is vital to the successful delivery of safeguarding services and interventions in Southwark. We remain confident that safeguarding is at the heart of the services delivered by statutory and voluntary services in Southwark, and we also remain committed to maintaining an open dialogue with all our partners, and working jointly with partners to ensure the best, person-centred outcomes for children and young people.

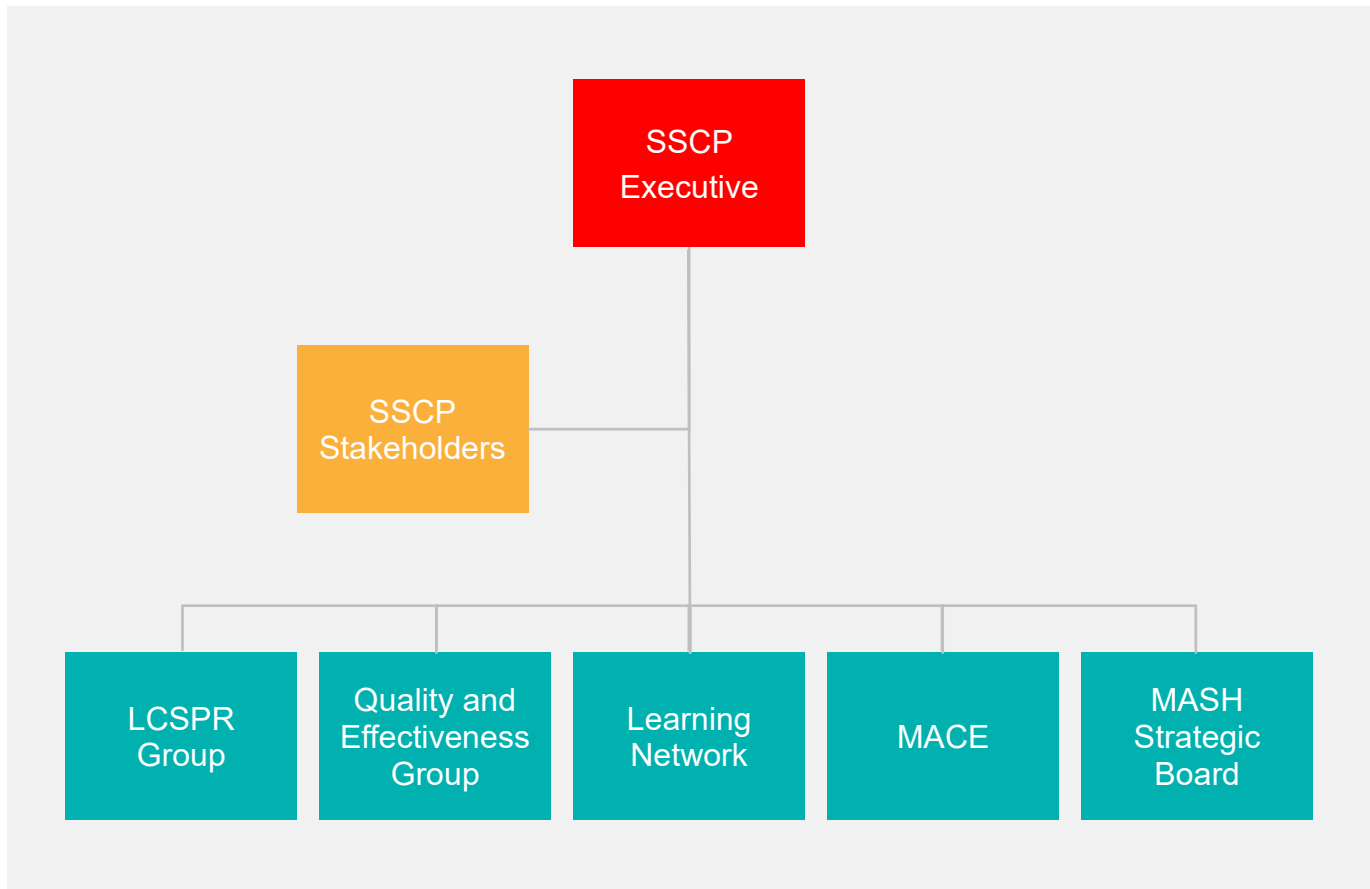
Following on from the publication of Working Together 2023 (Dec 2023) the partnership has reviewed the current arrangements which were put in place after Sir Alan Wood's review of local arrangements for safeguarding children.

Southwark Council	ICB/NHS	Police	Other Organisations
Cabinet Member for Children, Schools and Adult Care	Place Based Director Southwark – NHS SEL ICB	Borough Commander	Borough Commander, London Fire Brigade
Cabinet Member for Community Safety and Public Protection	Designated Nurse, Safeguarding Children, NHS SEL ICB	Superintendent in charge of	Head of Service Lewisham and Southwark Probation



Southwark Council	ICB/NHS	Police	Other Organisations
		public protection	
Strategic Director of Children's and Adults Services	Named GP for Safeguarding Children, NHS, SEL ICB		CEO Community Southwark
Director of Children's Services	Designated Doctor for Looked After Children, NHS, SEL ICB		Primary and Secondary School Heads
Director of Commissioning	Head of Safeguarding (GSTT)		Safeguarding Lead CAFCASS
Director of Public Health	Head of Safeguarding (KCH)		Provider representatives
Assistant Directors: Early Help, Safeguarding, Commissioning	Named Nurse Safeguarding Children (SLaM)		
Assistant Directors: Community Safety and Quality Assurance	AMH Safeguarding Lead (SLaM)		

## 3.2. SSCP Subgroups



### 3.2.1. Learning Network

The Learning Network subgroup was reviewed and relaunched. It was agreed that there would be a joint chairing arrangement between children’s social care and public health.

The SSCP is committed to promoting a culture which values and facilitates learning and in which the lesson learned are used to improve future practice and partnership working. This approach has facilitated robust mechanisms to review, analyse and develop practice. We are confident that our approach to learning and development drives improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

Traditionally there has been an emphasis on “training” and although uptake of training programmes can be measured, we require further assurance as to the impact this has on practice. As a result, during the latter part of the year we reviewed our current model and as we move into 2025-26 we will transition to a strengthened approach where learning is embedded in the culture of all safeguarding practice.



### **3.2.2. Child Safeguarding Practice Review (CSPR) Subgroup:**

Responsibility for how lessons are learned locally from serious child safeguarding incidents lies with the safeguarding partners, via the Child Safeguarding Practice Review Subgroup. The terms of reference for this group have been revised to take into account the new statutory guidance.

The subgroup is responsible for identifying cases which meet the criteria for a Child Safeguarding Practice Review. For cases that fall below the threshold the group determines if there is relevant possible learning from the case, and recommends the process and methodology for understanding the learning.

The group also identifies any themes or trends within local referrals and national reviews that may further improve the quality and impact of safeguarding in Southwark.

Once a review has been completed, the implementation and impact of any multi-agency lessons to be learned are monitored to ensure that the learning from all case reviewing activity is embedded in practice.

The CSPR subgroup also reviews Youth Offending Service Community Safety and Public Protection Incident reports (CSPPIs). Work is ongoing to establish best practice for quality assuring these reviews and sharing any learning across the partnership.

### **3.2.3. Quality and Effectiveness Subgroup:**

The purpose of the Quality and Effectiveness subgroup is to build and maintain an accurate picture across the SSCP of:

- the quality and effectiveness of safeguarding arrangements
- areas of strength and good practice
- areas of risk and vulnerability
- actions related to improve outcomes for children

The subgroup works to strengthen the partnership's assurance process by:

- Developing and ratifying borough- wide strategies, policies and guidance.
- Monitoring and analysing safeguarding indicators across the partnership to identify whether safeguarding practice and arrangements have led to improved outcomes for children and young people.
- Providing challenge and monitoring action plans identified through section 11 audits.
- Identifying and commissioning multi-agency audits to evaluate safeguarding practice and its impact on children, young people and families.
- Monitoring the progress of action plans arising from any local or national reviews.

- Demonstrating that the voice of the child has been heard and using this information to improve services and the effectiveness of professional practice.

This year the group have focused on Neglect, domestic abuse, child sexual abuse, response to National Panel reports, audits and website development.

### **3.2.4. MACE**

The strategic MACE has been running in Southwark since 2021. When the safeguarding arrangements were reviewed in 2023-24, it was agreed that the strategic MACE group would formally come under the governance of the SSCP.

The MACE is chaired by Children's Services and the Police. The MACE runs every 2 months and is well attended by multiagency partners. The terms of reference for the group are well articulated and this allows for robust discussions. The group focuses on the following:

- Providing oversight of exploitation, information, intelligence and activity across the Local Authority in relation to instances, cohorts and contexts presenting extra-familial risk to children and young people
- identify, discuss and deliver a partnership response to short-, medium- and longer-term themes trends and patterns emerging from exploitation
- Review thematic problem profiles arising from discussions at the operational Extra-Familial Risk Panel, using the VOLT approach. Victim, Offender, Location, Theme

### **3.2.5. MASH Strategic Board**

As part of the review of arrangements the SSCP agreed that the MASH Strategic Board would formally come under the governance of the SSCP. The purpose of the Board is to provide strategic level oversight of the operations and performance of the MASH Partnership

The group is chaired by an assistant director in Children's Services with Probation holding the deputy chair role. The terms of reference for the group are well articulated and this allows for robust discussions. The group focuses on the following:

- monitoring key performance indicators and developing analysis of the impact of the MASH Partnership.
- directing quality assurance activity (including audit) associated with MASH operations and associated partnership activity, including the collation and dissemination of learning.
- agreeing and directing sufficient operational resources within the MASH, and for associated developmental activity.
- responding to local and national policy and legislative change to ensure partnership practice is aligned.

- resolution of issues unable to be resolved through the Operational Steering Group
- ensuring the formal Partnership Agreement remains fit for purpose through regular review and monitoring.

## 4. Partnership Workstreams 2024-2025 – Response to Scrutiny 2023-24

As part of the 2023-24 Annual report the Independent Scrutineer for the partnership laid out some key areas for development for the year 2024-2025, the progress on these areas can be seen below

### 4.1. Full implementation of Working Together 2023

The key areas of focus for the SSCP were for the executive to agree with lines of communication and functionality of the LSP and DSP roles. Discussions took place via the executive and in liaison with senior colleagues across London to fully establish the expectations for the DSP role particularly in ensuring that the LSPs for the partnership are kept informed of all significant actions or obstacles to the progress of the partnership's objectives. This is now established.

The second key element was the engagement of schools across the partnership. There has been significant improvement in this area. Schools are present at all sub-groups of the partnership and also now sit on the executive. In addition, the safeguarding in schools team based within Southwark Council has further enhanced communications with schools and enabled them to contribute to review and audit activity across the partnership.

### 4.2. Review the business support model, capacity and resource

A review of staffing within the SCP business support unit was undertaken. The unit supports the SSCP and SSAB functions. The executive agreed that there was not sufficient resource to adequately service both partnerships. A decision was made to establish three fixed term roles to support the unit. They will focus on progressing against work plans including coordination of multiagency learning and training linked to the findings from reviews and audits.

#### 4.2.1. Priority work

Neglect and Adolescent Harm- there had been a significant amount of work led by Children's Services to develop a Neglect Strategy, work has continued in this area and is reported below as is the area of adolescent harm.

#### 4.2.2. Website platform

As part of the above strategy, the website project was progressed during 2024-25 with a new platform launched in September Southwark Safeguarding Partnership

#### 4.2.3. The multiagency dataset

remains a recognised areas for development which has not gained traction due to a lack of business support capacity and resource. Data is however being shared on key areas e.g. MACE and MASH groups to enhance understanding and decision making for partners.

#### 4.2.4. The Learning Network model

This was reviewed in and a decision made to split children and adults groups to ensure that each had significant priority.

## 5. Scrutiny – 2024-25

The Independent Scrutineer for the Southwark Safeguarding Children Partnership (SSCP) presented quarterly, thematic style, and end of year scrutiny reports to the Delegated Safeguarding Partners in the reporting period of this annual report. These reports outlined the key developments of the partnership over the year and made some recommendations for the year ahead.

The role of the scrutineer is to ask questions about how well services are safeguarding and promoting the welfare of children and young people in Southwark. Whilst there is no set list of things for a scrutineer to do or how to do them, activity was agreed with the SCP Executive throughout the year in alignment with their arrangements. This included participating in the review of their arrangements under WT23 implementation, a scrutiny appraisal on the effectiveness of arrangement culminating in recommendations, reports on progress against areas of focus, and overall participation within the subgroups. This activity was supplemented by regular participation in strategic meetings, review of relevant SCP documents, engagement with partner agencies, business manager, chairs of the subgroups, information obtained from the Executive meeting, observations of the work of some of the subgroups, review of meeting minutes and action logs, and ongoing observations of overall SCP processes and systems.

Overall, there is observation of good partner engagement, positive relationships and an appetite for the success of joint children's arrangements. The amount of work undertaken within SSCP to develop and strengthen provides a strong foundation for the SSCP, in particular and not exhaustive:

- Under the neglect priority, the revision of the Neglect Strategy and associated actions to disseminate and embed into practice (ongoing).
- A review of the capacity and resources within the business unit, and recruitment to support this function.
- To test out the effectiveness of domestic abuse responses, the SCP has undertaken an audit process aligned with JTAI thematics and made recommendations which sit across the partnership.
- Development of a Child Sexual Abuse steering group

- Inclusion of the MASH Strategic Board within the MASA arrangements.
- Recognition and planning for an adolescent strategy and a review of the strategic arrangements for adolescents.

The independent scrutineer has worked closely with the business manager and the Executive meeting in its work throughout the year, and the scrutiny work plan is intended to add value and run alongside the functions and mechanisms of the SCP. There are a number of key points identified through scrutiny activity as areas for development and further scrutiny which can be broadly summarised into the thematic areas of measuring impact and outcomes, strengthening engagement and learning functions and further developing the areas of focus within the SCP priorities. This will influence the scrutiny workplan for 2025/2026.

## 6. SSCP accountability

### 6.1. Core child protection activity

Category	Southwark 24-25		Southwark 23-24		Statistical Neighbour Rate	England Rate	London Rate	Southwark Change
	Number	Rate*	Number	Rate*				
Referrals	3414	604	3368	596	640	518	505	+1%
Re-Referrals	594	17%	757	22%	17%	21%	18%	-29%
Completed Assessments	3208	568	3056	541	608	536	543	+5%
Section 47 Enquiries Starting	1479	262	1222	216	225	187	172	+18%
ICPCs Held	413	73	499	88	64	60	59	-21%

Category	Southwark 24-25		Southwark 23-24		Statistical Neighbour Rate	England Rate	London Rate	Southwark Change
	Number	Rate*	Number	Rate*				
CPP (31/03/2025)	216	38	269	48	46	42	41	-26%
CPP 2+ Years (31/03/2025)	5	2%	4	1%	5%	3%	3%	+50%
CPP Starts in Year	344	61	393	70	52	52	48	-15%
CPP Ceased in Year	397	70	365	65	52	52	48	+7%
CLA (31/03/2025)	387	68.5	397	69.6	67.4	70.0	51.0	-2%
CLA Starts in Year	192	34.0	177	31.0	30.9	28.0	25.0	+9%
CLA Ceased in Year	198	35.0	208	37.0	32.1	28.0	25.0	-6%

- Rate per 10,000 0-17 population (ONS mid-year estimate) unless given as a percentage
- The rate and number of referrals to Children's Social Care decreased by just 1% between 2023/24 to 2024/25. The rate remains below statistical neighbours but above the London and National outturns for 2023/24.
- Re-referrals (the proportion of new Referrals in the year within 12 months of a previous Referral) decreased during 2024/25, and is now again in line with statistical neighbours, and below the London and national outturn.
- Despite the reduction in referrals, Southwark has seen a 5% increase in the number of completed assessments. Southwark's rate per 10,000 under 18 population is above all comparator groups.

- Section 47 enquiries continue to be high, again with the rate per 10,000 under 18 population being above all comparators.
- This upward trend in safeguarding activity has a knock-on effect on the number and rate of Initial Child Protection Conferences, although it is noted that a reduction can be seen in the number of ICPCs being held suggesting reduction in the conversion from Section 47 to ICPC. Despite the reduction for Southwark between 2023/24 and 24/25 the rate remains above all comparators.
- The lowest number of children and young people on a Child Protection Plan was noted at the end of 2024/25 with number this low not seen since 2009. Southwark's rate is now below all comparators.
- The number and percentage of children and young people on a Child Protection Plan over two years remains an area of strength, with performance better than all comparators suggesting less drift in CPPs.
- Linked to the year on year reduction in the number of ICPCs taking place, the rate of new child protection plans has also reduced. Southwark's rate per 10,000 under 18 population does however remain above all comparators.
- The rate of CPPs ending has increased for Southwark this year. This linked with the decreased in new plans has led to the overall reduction in CPP numbers. Southwark's rate per 10,000 under 18 population means that more children are ceasing to be on a plan than all comparators.
- Despite the reducing number of children and young people in care, Southwark's rate remains just above our statistical neighbours, and significantly above London but below that of the national picture.

## 6.2. Local Authority Designated Officer (LADO)

This summary provides an overview of the role and statutory responsibilities of the Local Authority Designated Officer (LADO), referencing key national guidance and local procedures. It presents some analysis of the 2024/25 LADO contact data, highlighting an increase in total contacts, a reduction in referrals, and a rise in consultations. These trends are attributed to heightened awareness and proactive safeguarding approaches among schools, nurseries, and social workers. The summary underscores the importance of consultations, even when they do not meet referral thresholds, and examines the workload implications for the LADO. The pivotal contributions of Early Years Service Development Teams, Schools HR and Safeguarding in Schools Team are also acknowledged for their role in strengthening safeguarding practices.

### Statutory Context

Working Together to Safeguard Children (2023): Outlines the statutory duty of local authorities to manage allegations against adults working with children, specifying the LADO's coordinating role.



London Child Protection Procedures: Provide a regional framework for responding to allegations and concerns, detailing referral and consultation processes with the LADO. Keeping Children Safe in Education (KCSIE, 2024): Mandates all education settings to have robust procedures for managing allegations, including engagement with the LADO.

## **LADO Responsibilities**

The LADO is responsible for overseeing the management of allegations and concerns about adults who work and volunteering with children, ensuring that safeguarding procedures are followed consistently and fairly. Key statutory duties include:

- Providing advice and guidance to employers and voluntary organisations on responding to concerns and allegations regarding staff behaviour.
- Coordinating information-sharing and risk assessments with relevant agencies.
- Monitoring the progress of cases to ensure timely and appropriate resolutions.
- Ensuring that allegations are managed in accordance with statutory guidance and local procedures.
- Maintaining accurate records and reporting on trends to inform local safeguarding strategies.

## **2024/25 Contact Data Analysis/Trends and Analysis**

### **Increased Total Contacts**

The rise in total LADO contacts in 2024/25 reflects improved safeguarding awareness and a culture of proactive engagement among professionals. Schools, nurseries, and social workers are more frequently seeking support and guidance, demonstrating a commitment to early identification and intervention.

### **Decrease in Referrals**

Despite higher overall contact, the number of formal referrals—cases meeting the statutory threshold for LADO intervention—has decreased. This suggests that professionals are better equipped to distinguish between situations that require formal LADO involvement and those that can be managed through advice and support. It also indicates that organisations have effective safeguarding procedures and safer recruitment practices.

### **Rise in Consultations**

Consultations have increased, indicating that staff are seeking advice at the earliest opportunity. While these cases may not meet the referral threshold, they are vital in preventing escalation and ensuring appropriate safeguarding measures are taken. This trend highlights the value of the LADO as a source of expertise and reassurance for frontline professionals.

## Reasons for Trends

- **Greater Awareness:** Training and communication have increased understanding of the LADO's role and thresholds for referral.
- **Proactive Approaches:** Schools, nurseries, and social workers are engaging with the LADO at an early stage, often before concerns reach the threshold for referral.
- **Accessible advice** has empowered professionals to seek timely consultation and act confidently.

## Consultations and Workload Implications

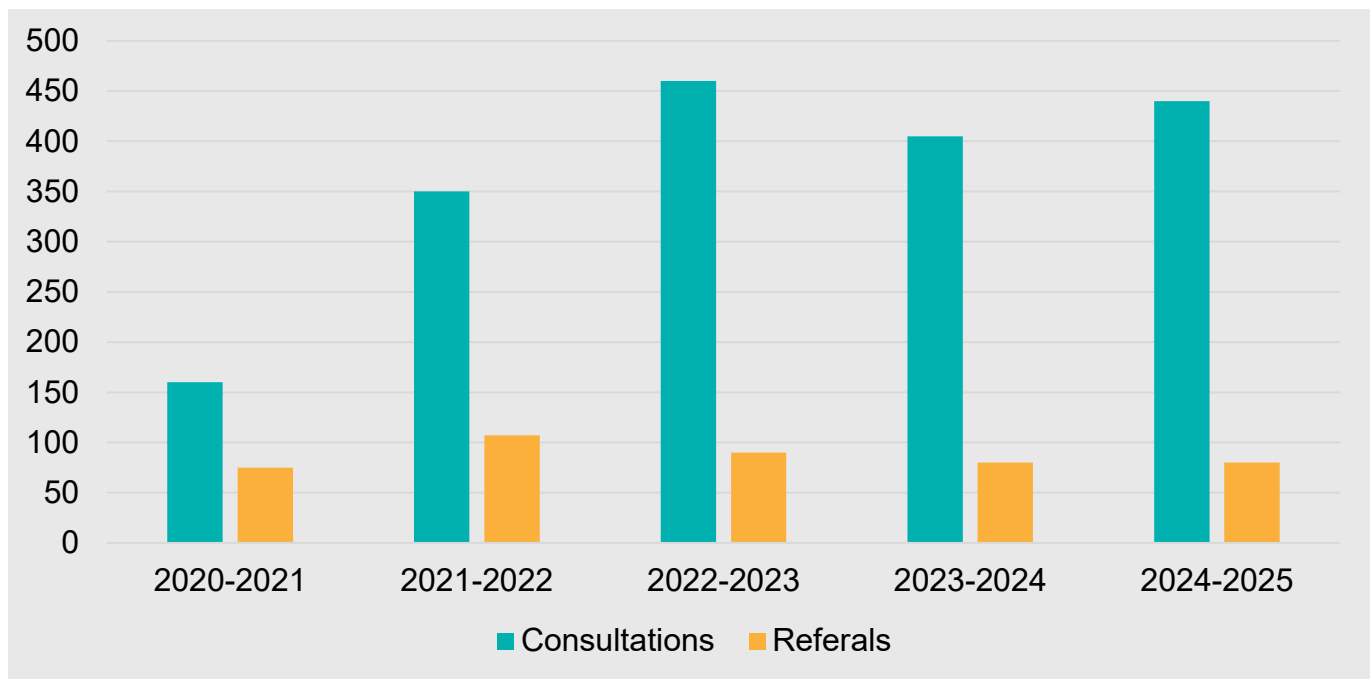
While not all consultations result in formal referrals, they represent a significant and growing aspect of the LADO's workload. Each consultation requires careful consideration, record-keeping, and often follow-up advice. The increased volume of consultations has implications for resource allocation, necessitating ongoing support for the LADO function to maintain high standards of safeguarding oversight.

## Conclusion

The 2024/25 data demonstrate a positive shift towards early intervention and partnership working in safeguarding children. The increase in LADO contacts, coupled with a reduction in formal referrals, indicates that professionals are more confident in seeking advice and acting preventively. The contributions of Early Years Service Development Teams, Schools HR, Safeguarding in Schools Team, and DSL training have been instrumental in fostering this proactive culture. To sustain these improvements, continued investment in training, guidance, and LADO capacity is recommended.

There were 446 consultations recorded in 2024/25, the majority of which were made by and about staff in education which correlates with what we see in the data for referrals.

## LADO Referrals and Consultations since 2020



## 7. Financial arrangements

The SSCP receives financial contributions from a number of agencies and other forms of in-kind support. Contribution received in 2023-24 include:

Southwark Council	£ 72,500
ICB	£55,000
MOPAC (Police)	£5,000
Total	£132,500

## 8. Areas of Focus

### 8.1. Neglect

Following on from the work in 2023-24 to draw together a neglect strategy and associated tools the partnership put together documentation and launched it formally in 2025. We see neglect as both a public health issue, and an Early Help issue. We are already doing a lot to address some of the issues that surround or result in neglect, such as the impact that housing, poverty, and wellbeing has on our population. This strategy is therefore not a stand alone document. It should instead be read in conjunction with the Public Health document, 'State of the borough report (2022)' and the Southwark Joint Health and Wellbeing Strategy (2022). It should also be read in line with the Continuum of Need documents which reflect our multiagency responses to various forms of maltreatment.

The task and finish group had agreed a **Vision** for the partnership work on neglect as follows:



'Listen, believe and hear me'.

Placing Children at the heart of our response to neglect.

This vision stems from what young people told us when we consulted them. The strategy will allow all partners to be curious about children's lived experiences, and to **listen, believe and hear** what children have to say, so that we provide highly responsive services.

The Task and finish group agreed a **set of principles** for our response to neglect. These are as follows:

- Children and young people are at the heart of what we do.
- We will support families, so that children are brought up thriving and strong.
- We will work as a joined up partnership to support families and also support each other.
- We will listen and intervene early to prevent problems from getting worse.
- We will support our workforce with the skills and tools they need to respond early and on time.
- We will work together to understand the needs of Southwark's families, the impact of neglect and to understand the impact we are making

- We will work to recognise and respond to challenges in the environment that increase stress in families

A large group of partners came together to attend the launch and in addition to this session people across the partnership were offered learning sessions on the neglect toolkit where they could join online to learn how to use the toolkit and apply it in practice. Both the strategy and toolkit are available on the SSCP website and colleagues across the partnership have shared this within their own organisations – The Neglect Hub can be found on this page of the SSCP Website: [Southwark Safeguarding Partnership - Children Policies & Procedures](#)

The partnership continues to have neglect as a priority for 2025-26 and through the process of audit will review it's impact and will also review the outcomes framework that the strategy established to understand it's impact. These measures include:

<b>Overarching</b>	<ul style="list-style-type: none"> <li>• Increasing the percentage of families who have made positive progress as a result of early help support</li> <li>• Reducing the percentage of families who are closed to early help and subsequently referred to either early help or children's social care within 24 months</li> </ul>
<b>Children and young people are safe from harm</b>	<ul style="list-style-type: none"> <li>• Fewer new child protection plans starting in the year per 10,000 population</li> <li>• Reducing the involvement of young people as victims and perpetrators of serious youth crime and/or exploitation</li> <li>• Fewer incidences of domestic violence or abuse involving children</li> </ul>
<b>Children and young people lead healthy lives</b>	<ul style="list-style-type: none"> <li>• Reduce hospital admissions for children and young people as a result of mental health conditions or self-harm</li> <li>• Reduce the rate of obesity among 10 to 11 year olds</li> <li>• Increase percentage of young people who report that they are in good health</li> </ul>
<b>Children and young people are confident, resilient and thrive in their learning</b>	<ul style="list-style-type: none"> <li>• Increasing progress at Key Stage 2 and Key Stage 4 for children supported by early help</li> <li>• Reducing rate of exclusions, both fixed and permanent, in schools</li> <li>• Increasing overall rates of attendance in school for children supported by early help</li> <li>• Reducing proportion of 16 and 17 year olds who are NEET</li> </ul>
<b>Children and young people engage positively and actively in their communities</b>	<ul style="list-style-type: none"> <li>• Reducing the number of first-time entrants to and reoffending in the youth justice system</li> <li>• Increasing numbers of young people reporting positive engagement in activities</li> <li>• Reducing numbers of young people reporting they have experienced bullying of any kind</li> <li>• Reducing involvement of young people in Anti-Social Behaviour</li> </ul>

The partnership will continue to have neglect as a priority area of focus for 2025-26, with a plan to offer further learning sessions for practitioners and linking with Lambeth to provide opportunities for partners across both boroughs in the form of shared resources, events and will also work closely with the NSPCC to develop a public facing campaign with input from young people.

## 8.2. Child Sexual Abuse within Family

As part of the remit of the SSCP Quality and Effectiveness Sub-group and in response to the National Child Safeguarding Panel's report. In order to review and gain assurance against the national recommendations the group was established with a work plan.

The report found that children who are sexually abused by someone in their family are frequently not being identified by practitioners, nor are they receiving the response needed for their ongoing safety and recovery. Child sexual abuse in the family environment has been allowed to thrive in secrecy and silence for far too long. This review aims to break this silence and drive whole-system change that empowers practitioners to identify and respond to concerns of child sexual abuse, putting the needs of children first, confident in the support of senior leaders at local and national level.

The SSCP has established an effective steering group which:

- provides focused leadership and coordination for developing and delivering a strategic response to child sexual abuse
- brings together key stakeholders from across the safeguarding partnership, ensuring that each partner agency/organisation has sufficient representation (in terms of breadth of roles and seniority) to contribute effectively to overseeing progress, aligning activity and resolving barriers.
- ensures accountability, enables shared ownership of priorities, and supports a consistent approach across the partner agencies/organisations
- provides a dedicated space to interpret national guidance, review local/regional data, monitor implementation, and ensure that the strategic response is evidence-based, informed by victims/survivors, and responsive to emerging risks.

The group started by reviewing the current response to sexual abuse and drawing up an action for progress, which highlighted the following areas and actions:

1. Review of training across partnership – outcome training levels varied, no multi-agency offers currently available. Actions for learning network to progress
2. Understanding wider partner's needs – questionnaire distributed to schools and early years providers

3. Assurance around enquiries and investigations – agreed a multi-agency audit would be commissioned for 25-26
4. Review of local health pathways for appropriate forensic medical and other health assessments, for both recent and non-recent sexual abuse, and that safeguarding practitioners understand them – agreed to be undertaken
5. Understanding of practitioner's confidence – questionnaire will be es

It is planned that the responses to these quality assurance activities will provide the building blocks for the partnership to develop a strategic response with associated tools during the next year.

## 8.3. Adolescent Safeguarding

Adolescent safeguarding has remained a priority for the SSCP in 2024-25, with the MACE arrangements becoming part of the formal governance structure of the partnership. Over the past couple of years MACE has struggled with structure, attendance and intelligence. However, there have been some significant improvements over the past year. There is now consistent attendance from key partners and education are also included in this with a substantive school's rep on the group. In addition, another challenge has been ensuring that MACE have a Problem Profile shared at each meeting that considers the VOLT profile.

This situation has improved significantly, with the introduction of the Pre – MACE and also police colleagues sharing aggregated data very well from their own systems (crime data) and analysed data on the involvement of the Child Sexual

Exploitation Team. There is now work being done to compile a data set that can be presented to MACE and to Executive centred on the Problem Profile. A request will be made at the next Executive meeting for the release of data on specific indicators from each agency.

Another element of adolescent safeguarding has been the development of a strategy for the partnership. A task group was established to undertake this work, the strategy will combine workstreams across the spectrum of adolescent safeguarding including:

- Missing from home and school
- Transitional safeguarding
- Mental health and wellbeing
- Neglect
- Exploitation/Harm outside the home



## 8.4. Learnings from Reviews

Under [Working Together 2023](#), local safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area.

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed (serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health

All Child Safeguarding Practice Reviews will result in a report, which is published and readily accessible on the SSCP website for a minimum of 12 months, unless there are overwhelming reasons why the report should not be published.

During 2024/25 SSCP conducted the following:

### 8.4.1. Rapid Reviews

A rapid review for a teenage girl in the care of the local authority. Concerns were raised around sexual assault by a person in a position of trust. Learnings included the following:

- Being aware of soft intelligence and looking not just at formal missing episodes but at a pattern of behaviours should inform practitioners thinking and decision making
- Awareness for practitioners for how young people access sexual and mental health services post 18 is important so that there can be consistency in support offered.
- Usage of CCTV within residential settings needs to balance safety and privacy, providers need to evidence this and placing authorities need to assure themselves this is adhered to
- The current system of DBS checks is subjective, and soft intelligence is not always shared with employers making risk assessments incomplete and increasing the risks to the safety of our children and young people.

A second rapid review took place for an eight-year-old girl with severe disabilities. Concerns were raised around medical diagnosis for unexplained wounds, role of the father, information sharing and working across boundaries. A national finding was also highlighted to the national child safeguarding panel for consideration. Learnings included:

- Working with children who have complex medical disabilities is a challenging area of practice, working closely with parents and family members is key to success however practitioners should always consider the child's lived experience and question at an early stage any unexplainable wound/injury by seeking a medical diagnosis

- Knowing and understanding the role of a father or male carer in a household is critical to understanding the lived experience of a child. It is important that professionals understand the role significant men play in the lives of the children they work with.
- Working with children who have complex medical needs where there is cross boundary services requires all professionals to share any concerns or the support provided to the family, the plan and outcomes being expected. It is important to be actively curious and seek clarity from other agencies about any information shared which suggests a change in a family's circumstances that could pose new risks
- GP Triage process: Standard triage protocols need to be adapted for children with learning disabilities so that there is a lower threshold for the child to be seen in person rather than the triage decision being based on an electronic form filled by parent. This is both a local and a national issue

#### 8.4.2. Local Child Safeguarding Practice Review

A Local Child Safeguarding Practice Review (Child H [Southwark Child Safeguarding Practice Review](#)) was concluded in 2024-25, there were some delays in publication due to family consultations, however the findings are now available on the SSCP website.

The key elements of this review were:

H spent her early years living with both parents and was close to her extended family. Her heritage was a mix of White British and Turkish Cypriot, which she was proud of. Assigned male sex at birth, H was known by a male name for her first 12 years. H's parents separated when she was 10, and her mother's mental health deteriorated, leading to multiple hospital admissions. At age 12, H revealed she identified as female.

H struggled socially and academically at both primary and secondary school, facing teasing, exclusion, and homophobic bullying. Relationships at home became strained when H was 12 and her family and school became worried about her behaviour which led to her moving between family members due to difficulties in managing and responding to her needs. At age 13, H took an overdose and continued to experience low mood and suicidal thoughts.

H first went missing at age 15. Her family became increasingly concerned about her going out, exploitative contacts with adult men, and her drinking and drug use. Eventually, they felt unable to care for her safely and requested local authority accommodation when she was 16. The risks to H escalated once she was in care. She frequently went missing and was involved in multiple exploitative encounters. Over seven months, she lived in four semi-independent homes. In the period prior to H's death, she had been living in a semi-independent home for five months but often stayed away, spending time with a 27-year-old man whom she described as her boyfriend but who was considered by her network to be exploiting her. On the day of her death, she met the man by whom she had been exploited, who assaulted her and took her phone.

The review explored key lines of enquiry including:

- Safeguarding transgender young people
- The impact of technology
- H's mental health and well-being
- H's adverse childhood experiences

The SSCP executive accepted the findings of the report and the subsequent recommendations:

**Recommendation 1:** SCSP to develop an overarching adolescent strategy. This should include:

An up-dated multi-agency strategy to safeguard adolescents, including children and young people who go missing. This should involve a review of current systems, including systems capacity to ensure that practitioners have the necessary knowledge and skills in working with children and young people at risk of and experiencing exploitation.

SCSP guidance on children who are missing should be updated and SCSP guidance developed for children experiencing extra familial harm.

An overview of support and services available for children experiencing Gender Incongruence.

The Children and Young People's Mental Steering Group develop a plan to support the mental health needs of young people, particularly those with complex needs or are vulnerable, during times of transitions so that they are accessing mental health support and services as needed.

Addresses the integration of all existing strategies in relation to mental health and safeguarding to ensure coherence and address intersectionality.

**Recommendation 2:** The SCSP should develop a multi-agency response to safeguarding children and young people online to ensure improved awareness of the risks, supporting assessments which include consideration of online activity, sign posting to resources and training to support this.

**Recommendation 3:** SCSP to seek assurance that children missing education are effectively responded to and are adequately supported in gaining improved access to education.

**Recommendation 4:** SCSP should develop a multi-agency response to support vulnerable children and young people with Children's Social Care involvement who are awaiting gender identity services, to bridge the gap in service and support whilst awaiting GIDS.

**Recommendation 5:** The SCSP should review the work with children and young people whose parents / carers have mental health difficulties to:

- Ensure that the joint protocol between CSC and Adult mental health is updated and that the processes for communication and sharing information are working effectively.

- The SCSP should also seek assurance that impact of parental mental health on children is well responded to and that there are effective systems in place to support this.

### 8.4.3. Response to National Panel Reviews

During 2024-2025 the SSCP sub-groups have reviewed the findings from the following National Panel reports as part of their workplans and received assurances from various partners around the recommendations. This will remain a key part of the workplan for the sub-groups over the coming year.

Out of Routine – taken forward by CDOP (SUDI and ICON)

Myths of Invisible Men – through all areas of partnership/learning network/audit

Arthur and Star – MASH – planned scrutiny via independent JTAI type audit

Elective Home Education – scheduled for assurance report 2025-26

Child Sexual Abuse – Response managed via QE sub-group

Race, Racism and Safeguarding Children

As a response to the report tabled on race and racism, the partnership reviewed the way this theme is discussed and prioritised during the rapid review process. This led to a change in the way rapid review questions are asked and brought the discussion of race and racism to the fore when holding a review.

## 8.5. Audit Activity

### 8.5.1. Domestic Abuse

SSCP wanted to undertake a review of practice and multi-agency working arrangements with a specific focus on responses to Domestic Abuse (DA) issues across the partnership.

In September 2024, the UK government introduced a new Joint Targeted Area Inspection (JTAI) focused on Domestic Abuse (DA). DA is an issue within Southwark, the 2023 Joint Strategic Needs Assessment notes that DA was the top recorded factor identified in 2022 as part of social work assessments. Southwark is committed to addressing DA and has a 5-year VAWG strategy.

The SSCP agreed that a multi-agency audit should draw on the JTAI framework to evaluate safeguarding practices across partnerships for children, young people, families, and communities affected by DA. The Domestic Abuse Act 2021 defines DA between individuals aged 16+ who are personally connected and engage in abusive behaviours, including physical, sexual, psychological, emotional, and economic abuse. The Act recognises children as victims if they witness or experience the effects of abuse. The audit focused on children from unborn to age 7 due to their heightened vulnerabilities, as set out in the JTAI guidance.

Upon considering the JTAI evaluation criteria, the SSCP wanted to understand both the multiagency collaboration between partner agencies in relation to specific children and complete some auditing on the specific work of MAPPA and MARAC within the borough, two quality assurance approaches were completed.

A multi-agency audit of twenty children open to Southwark CSC, to assess the multi-agency collaboration between police, CSC, probation services, and health services, as well as their cooperation with education, early years providers, and community organisations to support victims, reduce risk and increase safety. The audit aimed to understand how children in Southwark affected by DA are identified, how agencies assess risk, and how partnerships work together to safety plan and achieve positive outcomes.

A targeted audit and quality conversation in respect of seventeen children who have been discussed at MAPPA and MARAC over the last 4 months.

This audit has found that children who are victims of DA receive a timely response across the multi-agency partnership. They are supported by professional network that has a good understand of how DA can present, associated risk factors and the impact on children. Professional network demonstrates curiosity around DA, including health partners asking during routine appointments, and children's services staff using professional curiosity to explore the lived experience of children. There was good evidence of routine enquiries being made to other Local Authorities to ensure there was an accurate understanding of the history in relation for families. Police partners are routinely using DARA risk assessments to inform their decision making and considering Right to Know legislation in their work with families.

Audits found that the use of risk assessments including DASH and CAARDA-DASH amongst children's services and health partners was significantly lower, and this is an area of improvement, to ensure that risk in relation to DA are accurately considered in assessments and decision making. Furthermore, more training could be provided around familial DA. Whilst police charged seven perpetrators, 65% of victims chose not to support ongoing investigations, consideration should be given by police on how to provide more support to v/s particularly in the first few hours and days after the perpetrators arrest, in order to increase engagement of victims in investigations.

Overall, children and their families are provided with extensive support, which considered their needs, risks, background, and identity, referrals were made across the multi-agency network, and was varied and tailored to families' various needs, and considering each family member separately. Schools were instrumental in providing tailored support to children particularly in relation to emotional and therapeutic support and supporting families to obtain EHC plans. Schools participated in monitoring and collaborating with multi-agency partners around CIN and CP processes. However, the change in police reporting requirements in relation to schools' children attend, has directly impacted on MASH being able to provide information to schools under Operation Encompass, and thus the support that children receive from schools in a timely manner.

Sixty percent of victims were referred to IDVA services, the majority of these were provided a timely response and with clear safety planning and support. Sixty-five percent of the families had been referred to MARAC and thirty percent to the PAC panel, although this has now ended. There was also evidence of children's services exploring the support of the wider family network via Family Group Conference's and alternative care arrangements when required, to offer wider support and keep children within their family networks.

There was good evidence of direct work and recording the voice of children within records and some evidence of exploring DA with victims and the impact on children. This audit was able to get the views of twenty-five percent of victims, of which twenty percent reported a positive experience. However engaging fathers in work around DA was a significant area of weakness with seventy-eight percent of fathers denying or refusing to engage with social work assessments and plans, this is further compounded by a lack of programmes for perpetrators within the borough. It is recommended that clearer guidance is considered in relation to engaging with fathers within children's services assessments and work in considered. Furthermore, only fifteen percent of audits found there to be clear, SMART safety plans on the children's services records.

Extensive steps were taken to prevent children from becoming victims of DA, including support in relation to moving, and where families chose to stay, support to make their housing safer, including changing locks, alarms, and notifications on addresses for emergency services. However, for three children, support had not prevented them from becoming repeat victims of DA, and they had experienced multiple rounds of CP plans and care proceedings. A key issue within this was practitioners not considering within the family's ability to make and sustain changes and analysing the history.

Disproportionality in relation to Black and Mixed broad ethnic categories remains an outstanding issue for children's services, however in relation to DA representation of these groups was less disproportionate than present within children's services more widely.

Arrangements within MAPPA and MARAC are safe and adequate, overall there was good attendance of multi-agencies at MAPPA and MARAC and where specific agency attendance was lower, steps have been taken to improve attendance.

## **Learnings and Conclusions from Domestic Abuse Audit**

Overall practice in relation to DA within the partnership is good. Children and their families receive a timely response, professionals are knowledgeable about DA, how it can present, the impact of other factors such as ACES, NRPF and mental health / substance misuse, the risks for v/s around pregnancy and choosing to separate. There is evidence that children receive a timely response from all agencies and professionals are actively asking about DA and considering histories of DA in their assessments. Police are using DARA risk assessments consistently and considering right to know procedures, alongside charging offenders. However, changes to police reporting requirements has directly impacted on the number of Operation Encompass referrals which are completed, and thus the number of children that are support.



Children's voices, views and wishes are actively sought and recorded in case files, and wider families are explored as sources of support in assessments, family group conferences and as alternative carers in court proceedings. Family's needs and backgrounds are being considered when considering relevant referrals for support. Safe housing is considered as a key part of keeping children and their families safe, and families are supported to move if they want, or safety features are being placed in the home to keep children and their families safe.

A significant area of development is the engagement of fathers, seventy-eight percent of fathers denied or declined to work with children's services, and this is a significant barrier to achieving safety for children in the long term, this is compounded by a lack of specific programmes for perpetrators of DA within the borough currently. Police should also consider what more can be done to support v/s to continue to support police investigations around incidents of DA.

Equally there was limited evidence of health and children's services professionals using risk assessments such as the DASH and CAARDA-DASH risk assessment in their work with families, this is important to ensure that assessments of risk are based on evidence and is used to inform analysis and decision making. Children's services also need to improve the recording of safety plans, ensuring that plans are SMART, families know their plan and consider it to be helpful and achievable, and for these to be evidenced on the case file.

### **8.5.2. Audit Plans 2025-2026**

As part of the development of a range of quality assurance activities the partnership is going to be undertaking two key pieces of scrutiny via independent audit during 2025-2026.

Firstly, a review of practice around response to child sexual abuse. This supports the thematic work that has been identified through a review of the findings of the National Safeguarding Panel report into child sexual abuse and will involve case file auditing, meeting with frontline staff in the MASH and some appreciative enquiries with members of the wider partnership including schools.

Secondarily the MASH strategic board has planned to commission a review of practice in MASH and will use a JTAI type methodology to undertake this work. Again, case files and documents will be provided to the auditors, who will then review and talk to practitioners involved in certain cases, sit in the MASH and follow up on any emerging key lines of enquiry.

The SSCP executive feels these are two very important areas of practice they would require assurance on.

In addition to this some audit work will be identified to support the priority around neglect and the impact/usage of the toolkits and associated resources for partners.

## **9. Looking Ahead**

The SSCP will focus on the following areas for 2025-2026:



- (a) Focus on development of an adolescent strategy for the SSCP
- (b) Develop the SSCP learning Offer via the re-established learning network
- (c) Develop a holistic quality assurance approach – including multi-agency audit, data, learning reviews and independent scrutiny
- (d) Continue to strengthen the role of **education partners** within the partnership structure
- (e) Safeguarding partners should **review funding arrangements** to ensure that agencies are contributing enough to support the decision-making infrastructure and statutory requirements of local arrangements.
- (f) **Review current ways of working** to support effective practice as set out in the multi-agency expectations, principles for **working with parents** and carers and the **multi-agency child protection standards**.

During 2025-2026 the partnership will continue to focus on the key priorities of neglect and adolescent safeguarding and respond to any emerging themes nationally. The partnership will also support the implementation of the social care reforms. Southwark SSCP will concentrate on learning and embedding changes into practice with a focus on outcomes.



### Contact information

- If you have any questions about the content of this report, or thoughts about what we should include in future reports, please contact [sscp@southwark.gov.uk](mailto:sscp@southwark.gov.uk).
- If you are concerned about a child at risk in the borough of Southwark you should notify us immediately on [MASH@southwark.gov.uk](mailto:MASH@southwark.gov.uk).
- If the child has been injured you should seek advice from their GP, or in an emergency call 999.
- If you believe a crime has been committed you should notify the police.

<b>Meeting Name:</b>	Education and Local Economy Scrutiny Commission
<b>Date:</b>	3 December 2025
<b>Report title:</b>	Connect to Work
<b>Lead Member:</b>	Councillor John Batteson
<b>Ward(s) or groups affected:</b>	All
<b>Classification:</b>	Open
<b>Reason for lateness (if applicable):</b>	N/A

## BACKGROUND INFORMATION

1. The Education and Local Economy Scrutiny Commission has requested information on how the council is implementing the Connect to Work programme locally, in support of the council's commitment to create a strong and fair economy.
2. On 8 April 2025, the commission received an outline of the proposed Connect to Work programme in relation to its role supporting improved employment outcomes for young people. It was noted that, while not exclusively targeted at young people, Connect to Work employment specialists would add greater capacity to existing Southwark Works provision for young people facing some of the most significant barriers to securing meaningful long-term employment, including:
  - Young people with long term physical or mental health conditions and disabilities.
  - Care leavers
  - Young people with SEND
  - Young people involved or at risk of being involved in serious violence
3. This report and the appended presentation provide a more comprehensive overview of the Connect to Work programme. It sets out the emerging policy context and how the council's approach to local implementation aims to ensure that additional support is fully integrated with existing health, social care and employment provision in Southwark to provide more effective support for residents.

## KEY ISSUES FOR CONSIDERATION

1. Connect to Work is a Department for Work and Pensions (DWP) funded programme of supported employment to be delivered over five years from April 2025 to March 2030. Its primary objective is to support people with health and disability related barriers into good quality, sustainable employment using tested models of support known as Individual Placement and Support (IPS) and the Supported Employment Quality Framework (SEQF).
2. Connect to Work is among the first initiatives linked to the Get Britain Working white paper, published by the DWP in November 2024. Planning for roll-out of the programme across England and Wales began in early 2024. It is designed as a devolved programme that encourages local approaches to its design and delivery and responds to the needs of local populations and labour markets, making use of the knowledge and partnership networks that local authorities hold within their areas. In London, Connect to Work has been devolved by DWP to sub-regional partnerships which will act as the accountable bodies for funding and delivery in their member boroughs. For Southwark, the accountable body for Connect to Work will be Central London Forward (CLF).
3. From 2026-27, funding for the programme is anticipated to be included in London's Integrated Settlement and control of programme budgets will pass to the Greater London Authority.
4. According to DWP modelling, Southwark is anticipated to have the highest number of Connect to Work participants of all central London boroughs, with up to 700 starts per year when the programme is at full capacity. Over the five-year delivery period, over 2,000 people are expected to benefit from support. The total funding available for delivery in Southwark is £8.3 million.
5. Each borough within the CLF sub-region was able to select its preferred delivery model. In January 2025, the Cabinet Member for Climate Emergency, Jobs and Business agreed that Southwark would adopt a mixed approach to the delivery of Connect to Work in Southwark. The selected approach included a commissioned service working alongside a new in-house delivery team. This approach was selected as offering the highest level of local influence over programme design and delivery, enabling flexibility and responsiveness in the model and driving integration with health, care and wellbeing services delivered by the council and its partners. This approach was also selected so that the council could ensure the programme was delivered under the established Southwark Works brand and inform future decisions on strategy for the Southwark Works service. The decision report, which includes the options appraisal that informed this approach, is referenced in the background papers to this report.
6. The council's in-house team was recruited over the summer of 2025 and began supporting residents on the programme in October. The council

conducted a procurement exercise for the contracted elements of the service over the same period, awarding contracts in October. The contracted delivery partner will begin taking referrals in January 2026.

7. Detail of the service offered to residents, the programme structure and targets and activities delivered to date are set out in the slides appended to this report which will be presented to the commission.

## APPENDICES

No.	Title
1	Presentation - Connect to Work

## BACKGROUND DOCUMENTS

Background Documents	Held At	Contact
<a href="#">Connect to Work IDM</a>	Local Economy Team	Nick Wolff
<a href="#">Connect to Work Grant Guidance - England</a>	Local Economy Team	Nick Wolff

## AUDIT TRAIL

<b>Lead Officer</b>	Danny Edwards, Assistant Director of Economy		
<b>Report Author</b>	Nick Wolff, Employment and Skills Manager		
<b>Version</b>	Final		
<b>Dated</b>	28 November 2025		
<b>Key Decision?</b>	No		
<b>CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</b>			
<b>Officer Title</b>		<b>Comments Sought</b>	<b>Comments Included</b>
Director of Law and Governance		No	No
Strategic Director of Finance and Governance		No	No
Cabinet Member		Yes	Yes
<b>Date final report sent to Constitutional Team / Scrutiny Team</b>			28 November 2025