Southwark Safeguarding Children Board

Annual Report
March 2011

Contents

Southwark Safeguarding Children Board Annual Report 2010/11

Welcome by Chris Davies, independent chair, Southwark Safeguarding Children Board

I have now been the chair of the Southwark Safeguarding Children Board (SSCB) for just over a year. I have very much enjoyed getting to know the borough and its people, and I am grateful for the generous welcome I have received. As well as the formal meetings, I have visited the police station, a primary and secondary school, all three major hospital trusts serving the borough, Sunshine House, the children's' social care teams, and met with the PCT Executive among many others.

I have also met with the Speakerbox representatives of looked after children, the cabinet member with lead responsibility (before and after the election), case conference chairs, the designated nurse and doctor, the lead GP and voluntary sector representatives, as well as walking her ward with a borough councillor. I have met several times with the director of children's services and with the assistant director for social care. I recently met with the chair of Lambeth SCB, together with our board managers, to explore areas of possible collaboration.

I was asked to carry out a review of the effectiveness of the SSCB at the start of my tenure, in light of changing expectations, and building on earlier work and the PricewaterhouseCooper audit. I am grateful for the openness and willingness to consider change which colleagues displayed. In very brief summary, I found a board which had been very effective and won widespread respect for its work in advising, briefing and training the workforce, and in building inter-agency understanding and working together. I recommended ways in which we could do more to assure the quality of safeguarding work across all our services, and to build a "learning culture" around child protection. My report is available should you wish to read it. Action on the changes which I recommended is included in this report.

There is no doubt that expectations of us in child protection are rightly very high, and there is no room for complacency. So you will see that we have not simply described our work in this report. Rather, we have undertaken a self-evaluation, and identified improvement priorities. We welcome your feedback on whether we have got that right.

This report, then, looks forward as well as back, and in doing that, I want to highlight a few features that are particularly important to me. First, that we sustain an efficient engine-room to drive the board's agenda. That means our small and very able and effective executive team, and the new configuration of sub-groups which we have just agreed. The team must have the capacity to deliver the board's reasonable expectations and it is vital that those sub-groups now move forward urgently and purposefully with their key agendas. We know very well, across the UK, that local SCBs can only be effective where the responsibility and the workload is shared across all the agencies, and not left to a small core of people in children's social care.

Second, that we consolidate our new approach to assurance reporting. The executive of the board now meets three times a year to receive, consider and challenge reports from each of our partner agencies on how well they are fulfilling their child protection duties ("Section 11"). At the first of these meetings, our NHS colleagues set a very high bar in terms of the diligence which they showed in their management arrangements, and in reporting to us. Our aim is that that will be reflected across the services.

Third, that we position ourselves well to respond to the changes which are bound to follow the Munro Report. It seems that local SCBs will continue to have a leadership and assurance role, perhaps enhanced. There will be less emphasis on guidance, process and targets, and more on quality of professional practice in the frontline. I think Southwark is well-placed to adapt to this direction of change, and I hope we will embrace it with enthusiasm. I have been

very much struck by the commitment to high standards in our services, and to supporting excellence in practice through training and supervision. We will need to build on that strong base, and move up another gear. I hope that we will be able to construct opportunities for professionals to learn from reflecting together on their own practice, which is much more likely to transform quality than the top-down approaches which government has insisted on for too long.

Of course, not everything in the garden is rosy. All our constituent agencies face major budget challenges. In the climate we are in, no services can claim immunity from the need to make savings. I have made clear my expectation that all services will look very carefully at the implications for children's safety of any cuts they are making, and examine the broader implication with their partners. We must avoid unilateral cuts, and the serious danger that the cumulative effect of them across services is to amplify the risks. We are also expecting major organisational changes (as in almost any year!), especially in our local NHS. I have been impressed by the care which Guy's and St Thomas' Trust is devoting to assuming responsibility for community services. But we will lose the whole-system leadership which the PCT has brought, and we must protect the "designated" roles, which are vital to an effective local SCB, and build stronger relationships with GPs, who will become the shapers of local services through commissioning.

I can report that the accountabilities for leadership in safeguarding in Southwark are clear and effective. I account to the director of children's services and the council for the work of the board. But the safeguarding work of all agencies (including the council and its children's services) is scrutinised by the board. We make our report to Southwark's Children and Families' Trust, but the SSCB also scrutinises and challenges the trust and its Children and Young People's Plan, to ensure that it deals effectively with safeguarding issues. The trust and the board work together to ensure that we are always clear where leadership lies for particular workstreams. Learning from national evaluations of local SCB effectiveness, the SSCB takes the lead in the narrower areas of safeguarding, perhaps still better called child protection, whilst the trust leads on the broader safeguarding agenda, advised and challenged by us.

I must express my thanks to Southwark for extending to me the privilege of being involved in this way in safeguarding children in Southwark. My thanks also to all those colleagues who have been so willing to work with me, and especially to the director of children's services for her support. And to Elaine Allegretti and her team, especially for their work on the self-evaluation and this report. To all the board members for their commitment and hard work, which is so often on top of heavy workloads in their employing agencies. But most of all to Malcolm Ward, Tina Hawkins and Nina Scott in the board's executive team, who bring great experience, knowledge, skill and enthusiasm, without which my job would be very much more difficult.

Lastly, I intend to keep applying this key test: "So what difference does all this make to the lives of children and families in the borough of Southwark?" Measuring outcomes is much more easily talked about than done. But the discipline of the question is important in itself, and we must look for practical means of finding out what really does make it easier for people in the front-line to be most effective in keeping children safe.

Chris Davies,
Independent Chair, Southwark Safeguarding Children Board

1.0 Introduction

The outcome of Lord Laming's most recent review of safeguarding following the death of Baby P recommended that "Local Safeguarding Children Boards should report to the Children's Trust Board and publish an annual report on the effectiveness of safeguarding in the local area". The purpose of the Annual Safeguarding Board Report (ASBR) is to support improved practice and best use of local board arrangements in a local area. Guidance requires the report to be an honest assessment of the local safeguarding arrangements and identify clearly the challenges to be addressed within a local area to improve outcomes for children and young people.

Locally, we have used our local framework of self evaluation to undertake the report, which has been widely consulted upon and used a broad range of information provided by partners. The report covers the period April 2009 to March 2011, and is due for sign off by the Children's Trust Board in March 2011. It provides an outline work programme for the SSCB for the coming 12 months and will form the basis of future self evaluation of the SSCB's work. The ASBR self evaluates the following areas:

- Local priority areas for safeguarding
- Governance and accountability arrangements
- Assessment of safeguarding policies, procedures and training
- Monitoring and evaluation and quality assurance activity
- Serious case reviews
- Child death overview panel (awaiting section)

In reviewing each of these areas, the ASBR has identified a number of strengths, areas for development and recommendations by the independent chair to support system wide safeguarding improvements. However, priorities for particular local focus over the coming 12 months are set out in section 3 of the report, as well as independent chair recommendations made throughout, often pertaining to particularly partners or aspects of the board's work.

The role and priorities of the SSCB

The purpose of the SSCB is to develop, support, co-ordinate and assure the quality of activities in Southwark which protect children and young people from significant harm, and also to advise on the broader challenge of keeping all children and young people as safe as they can reasonably be.

The methods which we use to achieve that purpose are -to develop, agree and promote guidance and procedures which will support good practice in partner agencies -to commission, and sometimes deliver, training, to the same end -to conduct and ensure lessons are learned from Reviews in cases of serious injury or death of children which may have resulted from abuse or neglect -to capture and promote learning from reviewing the circumstances of all child deaths -to encourage inter-professional and inter-agency net-working -to assure the effectiveness of safeguarding activity in all Agencies in membership of the Board.

Based on the evaluation of our strengths and weaknesses which we have summarised in this Report, our priorities for the coming year will be

- to consolidate and embed our new approach to the assurance of safeguarding (with all Agencies reporting on their S.11
- responsibilities)
- to continue to address the priorities identified in the "staying safe" part of the C and Y P Plan
- to ensure that the revised sub-groups are working effectively to deliver the Board's agenda

- to adopt a commissioning role in training, based on sound needs analysis, and including quality assurance of delivery
- to use an effective methodology to review those "near miss" cases which do not quite reach the SCR threshold
- to lead consideration of what follows from the current Munro review of child protection in England, and the implementation of consequent changes
- in the light of any changes arising from the Munro review, to review the capacity of the Board to ensure that it is sufficient to fulfil its key responsibilities
- to build on the established network of designated safeguarding lead persons within Agencies, encouraging their effective use by practitioners, contributing to their professional development, and encouraging planning for their succession
- to work with partner Agencies to try to ensure that, where functions move as a result of re-organisation or commissioning decisions, S.11 responsibilities are clearly defined and assured
- to build effective relationships with the new leadership structures emerging from the NHS changes, especially with Community Health and the GPs
- to emphasise the need for a sharp focus on safeguarding through the potential disruptions of organisational changes and spending cut-backs
- to welcome and facilitate the distinctive contribution of our new Lay Members
- to find ways of listening better to the voices and views of children and young people about safeguarding in Southwark
- to facilitate and support cultural change in our partner organisations which will move us away from over-reliance on over-detailed procedures towards transformational learning and development for front-line professionals, and from over-use of referrals which shift responsibility, towards conversations which share it, and through which we agree how we can all work together to best help families and protect children.

Our focus will increasingly be on facilitating the behaviours and relationships which will safeguard children, and less on procedures and structures. It is adults acting appropriately which keeps children safe.

2.0 Southwark's Safeguarding Context

The profile of safeguarding in Southwark shows very high levels of need, coupled with a range of complexities arising from the local environment such as cultural safeguarding practices, child trafficking and families with no recourse to public funds.

Nationally, there are approximately 382,000 children in need (CIN), of which 3737 reside in Southwark, representing a 20% increase against figures for 2009. This is the fifth highest figure in London with Haringey, Lambeth, Newham and Croydon only slightly higher. Our overall CIN population shows 'family in acute distress' as the most common category, although for those that come into public care, abuse and neglect remains the most prevalent category, with family dysfunction and family in acute stress also featuring quite significantly.

Southwark continues to have high rates of referrals to its chid protection service with some 4900 referrals made a year to its referral and assessment service. Of these Southwark undertakes around 3000 initial assessments of children thought to be at risk of harm a year. There continues to be an increase in the number of children subject to child protection plans, and in March 2010, at any given time there is around 330 children subject to plan, and on average around 400-450 children subject to plans throughout a year. Some of these had a plan previously (58 children in 2010) and two thirds have plan for three months or more. As a borough, we commence care proceedings for around 80 children a year, where it is assessed that children need to enter the care system as they are not safe enough at home or within the community. Often a reflecting a younger cohort, these children generally live with parents with acute or chronic difficulties including substance misuse, domestic violence, learning difficulties and/or disabilities and mental health problems.

Southwark numbers of children in care is generally above that of statistical neighbours. The trend for the past few years has been of decline, but figures are once again on the rise and currently standing at around 540. Analysis of trends of those entering care shows that of our current children in care population some 235 children entered into care at aged five or under (41.7%), of these some 89 of were under one (15.8%) and 145 (25.7%) were aged 13 or above at time of entry. Nearly one fifth of children are on interim care orders (102), with 65% of these under one, and many young people entering into care under voluntary Section 20 orders.

High risk families, where children are taken into care or subject to child protection plan often have multiple problems. Families often have repeated involvement with children's social care regarding safeguarding or caring concerns, local police and housing officers due to nuisance or criminal behaviour or domestic violence. In addition to local health and vulnerable adult services, due to learning disability, mental health and substance misuse. In most cases, family members will be unemployed and have little experience of life outside the benefits system. The prevalence of domestic violence locally is very high, and a risk factor in more than half of all cases. Another local dimension to safeguarding are those arising from the local environment. Cultural safeguarding practices, including chastisement, private fostering and families where there is no recourse to public funds is very prevalent within our local system.

Story A
"M is 12 years old and from West Africa. She lived with her mother, brothers and sisters in a small village, but they were very happy. M would walk miles to go to school, but she loved to learn and did very well. She hoped that one day she could train to be a nurse.

"One day a lady came to the village to talk to M's mother. She said "M is a very bright little girl, and she should be given a chance to have a good education. If you pay me, I will find M a good home in the UK where she will be well looked after and get the best education." M's mother wanted the best for her, so paid the lady everything she had.

"M learned to cook and clean. She wasn't allowed to play, or watch TV. She didn't go to school. She was a slave. But there was no way to tell her mother who only found out about her progress through the lady. One day, when M was 17, she escaped the house and went to the authorities. The social worker had to undertake an age assessment, but she didn't understand why.

3.0 Local Priority Areas for Safeguarding

Southwark demonstrates many examples of good practice in regard to safeguarding which have been validated by external evaluations including our joint area review (JAR), unannounced inspection of contact, referral and assessment, and independent health led safeguarding children improvement visit (SCIV). Overall, there is evidence of good engagement by partners and the community in addressing local safeguarding issues as well as delivering core requirements as set out by statutory guidance. In ensuring a culture of continuous improvement, self evaluation and performance management support identification and strategic leadership of cross-cutting areas for partnership improvement. These include how we address high prevalence of domestic abuse, strengthening relationships with key partners and tackling high numbers of poor quality and/or inappropriate referrals. This also provides strong foundations for how the SSCB going forward will take a leadership role in ensuring safeguarding remains paramount in a climate of large-scale budget cuts and fast-moving changes to the governance and policy landscape, such as changes to key partner infrastructures and the Munro Review.

Strengths

- Commitment and engagement by partners and the community around safeguarding issues, including building capacity in voluntary, community and faith groups to help keep children safe
- Review of effectiveness of Board arrangements by independent chair, complemented by a self-evaluative approach to support strategic leadership of safeguarding arrangements

Areas for development

- Fewer children and families experiencing domestic abuse through less repeat victimisation and improvement in the safety and life chances for those children and families affected
- Partnership improvements in the quality of referrals and understanding of thresholds
- Reviewing and improving relationships and safeguarding practices of key partners within a changing governance landscape such as with GPs and schools
- To provide leadership on safeguarding practice and arrangements in a climate of significant change in policy, governance and resources

There is good engagement by partners and the community around safeguarding issues. The board is well attended by most partners who participate in a wide range of service development and delivery activities, both within and across organisations. The strong culture of partnership working and shared responsibility around safeguarding have been key to

supporting children at risk of harm, as recognised by our good JAR outcomes, no priority actions in our recent unannounced inspection, and most recently a favourable SCIV outcome which concluded an impressive approach to safeguarding in a context of a high volume of high-risk cases and some very challenging communities. There are well-developed links with the voluntary and community sector including a comprehensive free safeguarding training programme for the voluntary sector, relationship building with faith groups, and good progress on the appointment of lay members to the board. A key success of community work has been the strong local approach we now have to private fostering provision, where as a result of joint work and awareness raising, we have one of the highest notification rates in London. As the policy and governance landscape changes, the SSCB over the coming year will need to ensure it continually reviews arrangements for safeguarding compliance. For example, the strong links with the primary care trust (PCT) will change as it moves into a regional delivery arrangement and local GPs subsume the local health commissioning role. At present, links and governance between GPs and SSCB could benefit from further strengthening, and will need to be reviewed in light of forthcoming changes. Similarly, with schools, although there are very good links at present, as the implications of the education white paper take hold, the local authority will move to a strategic commissioner function and there will be a range of providers entering the education market through the inclusion of headteachers, private sector academies and free schools. The recent system-wide review of local governance arrangements by the SSCB's independent chair provide a sound basis for responding to these changes (for further details see section on Governance and Accountability Arrangements).

Story B - Survivor
"Taken into care 6 years ago with 3 siblings. Mum had drug and alcohol issues. Pregnant – abusive relationships, partner got arrested, served a sentence, removed child from at risk register. When partner released went through domestic violence – placed in refuge. Close to mother, trying to get love from mother, build a relationship but failed. Moved to another refuge in a different part of country. Worries child may have Asperger's or autism. Brought back to Southwark to a different area. Settled. A consultant has agreed to assess son. Support network for her in place. Support network for child."

Ensuring "fewer children and families experience domestic abuse" is key priority of the Children and Young People's Plan (CYPP), which through widespread consultation with stakeholders and robust needs assessment identified this as a significant contributory factor of safeguarding needs in the borough. Domestic abuse also features as a recommendation with actions in Southwark's last serious case review (SCR). In response to commitments in the CYPP and SCR, a joint review of the local approach to domestic abuse has been undertaken by the children's trust and the Safer Southwark Partnership (SSP), our local crime reduction partnership. Through dialogue with a range of senior stakeholders, the review took a whole-system view of current commissioning and delivery arrangements including considerations of thresholds, pathways and risk management. A proposed, single, partnership-wide model that will underpin the recommissioning of provision is currently being considered by the children's trust and the SSP for implementation from April 2011. This will provide a more targeted use of domestic abuse resources and specialisms to better support areas such as assessment of risk and support as part of agreed multi-agency plans, such as for those on a child protection plan. MAPPA will also be reconfigured with a stronger emphasis on perpetrators and enforcement, and a refocusing on the highest-risk cases.

Story C
"Initial engagement 'A' taken to hospital suffering multiple injuries, said dad has caused them. Two other children in family. Police called. Children were taken into police protection. Father arrested. Social services involvement which assisted with wider family assistance. It became apparent dad's partner/mother of children had suffered server domestic violence. As father would beat her up but then turn on children. He only hit them after he had finished hitting her… so she thought.

"All children initially pleased with extended family, who were not event aware of reason's mum left. All children received medical attention, A having more injuries but other too, it transpired also needed medical attention for minor injuries. Father arrested and went to court and eventually went to prison. Children met family members they were not aware of as father had beaten them for years.

"As started father went to prison, children received proper medical attention, A was attending school regularly, other two children attending pre school and nursery. Due to social service involvement, and liaising with extended family children's mother (who had left a few years ago) was traced and mother and children reunited. They were re housed away from area.

Improving the quality of referrals, including reducing the number of inappropriate referrals remains a key priority for the SSCB. The last unannounced inspection found that high numbers of inappropriate referrals are made by agencies to the referral and assessment service that result in no further action and lead to a deterioration in the timeliness of initial assessments. Southwark has one of the higher rates of contact in London although it remains in line with statistical neighbours such as Hackney and Tower Hamlets. Analysis of contact and referral conversion rates against last year shows that contacts are decreasing. Improvements in particular agencies are attributed to the range of joint working arrangements put in place which have in all cases included an increased focus on improving the quality and appropriateness of referral. For example, a relatively large proportion of referrals stem from hospitals, which provide the highest number of referrals for children under five, and are important partners in our pre-birth work. As Southwark has no general hospital provision within the borough, work has been undertaken to establish close liaison with Guy's and St Thomas' and Kings' hospitals, particularly around pre-birth assessments. Work with colleagues in hospitals has started to improve the understanding of the referral process by ensuring that the designated nurses take a central role in mediating inter-agency referral forms. Moreover, threshold management and quality of referrals around pre-birth cases has seen marked improvement as a result of the pre-birth team and joint working arrangements.

In order to respond to improvements in partners' understanding of thresholds to access safeguarding services, thresholds have been revised and simplified. This is accompanied by work to change the local referral process in line with the preliminary *Munro Review of Child Protection*[1] to overcome a strong local culture of referral, to one of facilitating more dialogue between professionals prior to referral. Analysis by contact, referral and assessment shows a heavy reliance on the use of written referrals (well over 50%), too often with poor-quality information, which after further investigations leads to no further action. In response, transition to a new approach will commence in January 2011 which will better secure a professional dialogue prior to referral. Furthermore, in line with SCR findings, developmental work with designated leads is taking place to help them champion in their own agencies thresholds and quality of referral issues. Under development are a range of measures to support performance management of this change, including data to support agencies to help address where designated lead professionals need to be better utilised as part of a referral and threshold management process.

[1] http://www.education.gov.uk/munroreview/downloads/TheMunroReviewofChildProtection-Part%20one.pdf

Story D
"A came to my attention when she was 12 and in year 8. Many of her teachers said her behaviour was dreadful and sometimes strange. She was often dirty and smelly and the other girl in her class teased her. She started seeing the learning mentor, and one day told her that her mother had severely beaten her after a phone call home from school about her behaviour. A referral was made to social services, mum was interviewed and asked to sign a contract agreeing not to beat A when on her own with her mentor, or in a small group. A was delightful and her behaviour appropriate. She showed empathy with others and kindness.

"Problems in class continued; observation showed that A was still being persistently bullied by classmates, and continued to behave poorly. A was put on a pastoral support plan and withdrawn from same classes to the behaviour support classroom, while there she said, in front of pupils and staff, that when in Nigeria and in UK, she had been sexually abused. Another referral was made to social services, who found that A was sharing a room with her mother and little sister in a house with a transient population. Mum said that A was lying and shouldn't be believed. Eventually mum gave up her job involving shift work and was around more; social services closed case. No evidence of sexual abuse has been found.

"A works with a governor of the school who comes in once a week and does art projects with her; she is a talented artist and a bright girl. She is still bullied in class and despite being made aware of observations, including a new one by the Educational Psychologist, doesn't seem to see her as a victim. I (and others) am still very worried about A- she is smelly again, she doesn't have lunch money (£5) a week; she is unhappy. Other students report that she is having a hard time. We invite mum in to see us about our concerns; she doesn't respond. The head of house has received a request for information from another school: mum wants to move her school. We plan to have a CAF meeting: we have been monitoring A every 6 weeks at multi agency meetings.

A key priority for the SSCB this year will be how it supports and challenges agencies' safeguarding practice in times of significant change and budget reductions. Both the local authority and its partners will experience cuts of well over 20% to their budgets, not including a wide range of grants that are coming to an end. Locally, these have provided a resource to improve safeguarding capacity at specialist, early intervention and universal levels. Large-scale changes in the governance of organisations will also accompany budget cuts such as changes to the statutory nature of the children's trust and the development of new strategic commissioning partnerships such as the GPs, schools and health and wellbeing boards. In regard to the future direction of safeguarding policy and practice, Professor Eileen Munro is currently reviewing the child protection system on behalf of the coalition government, with findings due in April 2011. Interim findings by Munro state that current processes and procedures have become barriers to social workers being able to spend time undertaking direct work with vulnerable children and families and hindering their ability to make informed judgements around risk. Recommendations arising from Munro are likely to centre around a number of areas including current procedures including targets and timescales, reducing emphasis on identifying families at risk at the expense of supporting families at risk, serious case reviews and professional and organisational development. The SSCB will need to ensure that work of the board is reviewed and reflects the requirements of the outcomes of Munro in its role in system leadership of safeguarding practice and training.

4.0 Governance and accountability arrangements

The SSCB is a well-established and ambitious partnership, which has provided visible community and professional leadership to safeguard and promote the wellbeing of Southwark's children and young people. The SSCB promotes regular dialogue between partners underpinned by a shared vision and priorities, and its work has led to system-wide improvements in community and professional safeguarding practices. The strengths and maturity of the partnership support a culture of external challenge and continuous improvement in both the board's own development and the work of partners. Further work, however, is needed to ensure regular and systematic involvement of service users in the board's work. In order to secure better outcomes from the local partnership, the board commissioned a review of its governance by internal external auditors PricewaterhouseCooper (PwC) and the board's new independent chair. As a result, the board has introduced improved, smarter ways of working, and strengthened its ability to challenge and hold partners to account in regard to local safeguarding practice, section 11 compliance and overall improvements in safeguarding outcomes for children and young people. A reconfiguration of the board, including the successful introduction of the new model in autumn 2010, provides a strong foundation for the board to meet both current and future challenges including assuring compliance with safeguarding requirements by partners, delivery of local priorities such as those within the CYPP or falling from inspection, outcomes of the Munroe review and the transformation of safeguarding provision needed in order to safely deliver system-wide efficiency targets.

Strengths

- The SSCB provides ambitious and visible community and professional leadership to safeguard and promote the wellbeing of children, underpinned by a shared and clear vision and priorities for improvement. There is regular dialogue between the SSCB and wider partners to deliver system-wide improvements
- There is well-established partnership working and communication across key partners, including voluntary and community sector, which are leading to practice improvements and increased community capacity to keep children safe.
- There is effective involvement of key partners such as health, where as a result there is good assurance measures in place to ensure children and young people are safeguarded adequately
- The recent review of governance and changes it has introduced provide a solid foundation to further strengthen challenge and accountability in regard to partners' safeguarding practice and achieve the step change need to meet the requirements of Working Together guidance

Priorities for improvements

- Further improve robustness of challenge and accountability of partners through the systematic review of section 11 compliance, and to drive improvement in frontline practice around local priorities for improvement
- Building on good work so far, to ensure regular and systematic involvement of service users in the strategic review of services, policies and procedures to help build capacity in the community to keep children safe

The SSCB continues to provide ambitious, visible leadership to safeguard and promote the wellbeing of children locally. It provided good leadership in determining borough-wide priorities for safeguarding within the new CYPP, working jointly with a wide range of stakeholders. This shared vision for safeguarding services includes reshaping how we work with families in most need, building capacity in the local safeguarding system to meet community safeguarding needs, and work with partners to reconfigure services and improve outcomes for children and young people at risk of harm due to domestic abuse.

In its local leadership role for safeguarding children, the board is represented on the children's trust, and safeguarding issues raised by the board is a standing item of children's

trust business. This regular dialogue enables the SSCB to exercise its scrutiny role and hold the children's trust to account, while also ensuring partners are aware and address new and continuing pressures on safeguarding services. The SSCB works closely with key partnerships, including the local strategic partnership, Southwark Safeguarding Adults Partnership, the Safer Southwark Partnership and other partnerships groups, to ensure that safeguarding children is integral to their work. In addition, joint work with the Lambeth Safeguarding Children Board has supported cross-borough working including sharing the child death review panel and coordinating work on areas of shared interest, such as safeguarding arrangements in agencies which serve both local authority areas, for example health trusts. Examples of joint work include a joint section 11 audit for agencies serving both boroughs to support shared assurance of compliance with the requirements of section 11 of the Children Act 2004.

An example of effective leadership by the SSCB and children's services was the approach taken to address significant deficits in the referral and assessment team in 2009, where there were significant vacancies and capacity risks for the local system in meeting safeguarding demands. Partners took decisive action through a refreshed approach to workforce development that led to a successful overseas campaign, the appointment of key staff to all 19 vacancies and improved frontline capacity. An authority-wide organisational and development offer also supported staff in their transition into UK life and social work practice, including support with housing and a tailored training and development programme.

In developing its strategic priorities for the CYPP, the board supported an innovative 'storytelling' programme of consultation and engagement of key stakeholders. More than 1,000 children, young people, parents, carers, staff and practitioners responded – all providing stories which brought fresh insights into what we could do to improve services. These insights, coupled with a comprehensive needs assessment and dialogue with strategic leaders, led to the development of shared local safeguarding priorities, particularly those in regard to a more family based approach to safeguarding and reconfiguring provision to better support those at risk of harm from domestic abuse, which appears to prevalent locally.

In providing visible community and professional leadership in regard to safeguarding, the SCCB has worked steadily to raise the profile of safeguarding. This has included raising awareness of risks and signs of abuse, and when and how to share information, as well as promoting community awareness of safeguarding issues such as private fostering, child-on-child abuse and gang violence through training, information and guidance such as a parenting handbook and practice guidance. In 2009, the board commissioned from the authority's communications team a borough-wide publicity campaign to raise public awareness of child abuse and how to report it. This involved creating bespoke materials distributed across the borough including schools, libraries and GP surgeries, backed by articles in the authority's residents' magazine and local press. An evaluation of the campaign, through a community survey of 1,000 face-to-face interviews, found a significant increase in the percentage of respondents who would refer a child they thought at risk and a similar increase in the percentage who would contact the NSPCC, whose details featured in the publicity material.

Story E - My gang, my family

"Referral received via school that a number of boys were developing gangs within the school, intimidating peers and taking property. Our potential Gang Bangers were 8-9yrs old. The area they lived in was known for multiple gang activity so a lot of this behaviour was learned and offered immediate dividends. Our team (gangs-youth offending team) was called in to deliver a number of group presentations and individual 1:1 sessions. As part of the latter I met up with one boy's parents who were very disturbed to hear about their son's behaviour, especially as it went against their religious and social/cultural norms.

"We invited the parents to participate in a parenting group (voluntary) and despite initial reluctance they became active participants. The individual work with their son looked at issues such as: consequential thinking, who/why join gangs, legislation in terms of sentencing powers, letters from prisoners encouraging others not to join gangs, joint enterprise, criminal records and impact on future as well as the use of some shock imagery in terms of weapons (gun/knife) and the damage they can have on the body.

"Whilst my story does not have the fairy tale ending, I am aware that disruptive behaviour within the school has reduced (boys will be boys), he is conscious about his peers/friends but aware that his brother is part of a known gang. Maybe a seed has been planted for the future, seed for change."

The SSCB continues to provide strong leadership in the development of key partnership working arrangements and communication to enable improvements in frontline practice to address local safeguarding issues. The board's partnership approach to safeguarding ensures blanket, as well as targeted, support to individual organisations to help manage partnership-wide risks to safeguarding. For example, there is a wide range of joint working arrangement to address identified high risk areas, such as those arising from serious case review or audit.

The SSCB supported the introduction of substance misuse and mental health teams in specialist and generic maternity services, and a senior social work practitioner from referral and assessment based in the hospital to address issues arising around vulnerable parents. In addition, a senior manager from the London and Maudsley NHS Foundation Trust has been seconded to offer consultation sessions to children's social care staff to support risk management and decision-making. There are also arrangements to provide mentoring support to social workers in the Maudsley mother and baby unit to further support safeguarding practice. Children's social care and adult mental health, substance misuse, and physical and learning difficulty services now jointly assess and support families.

Story F - I'm really worried

"Y started school at 4. He would bite and kick. Mum dropped him and ran. He would not cooperate and would have tantrums. This continued as he moved up the school. We talked to mum many times. She and dad were separated and she wouldn't allow dad to see Y and his older brother. There were many different boyfriends. Mum is an ex user of heroin and she drinks. Both children seemed clean and looked after but Y was always defiant, combative and moody. His brother X was quiet and withdrawn. Mum then went back on to heroin.

"The school counselled mum who could not admit to herself that her chaotic home lifestyle was impacting on both boys. There was not always food in the house and both boys had to get themselves up and to school. The older brother was acting as carer and head of household (he was 10yrs old). The younger Y was afraid to come to school as he was so worried about what his mum might do. The school persuaded mum to ask for help in a residential detox unit then arranged for a placement (temporary) with a family friend in another school. We also paid for after school care for both boys while mum was away.

"After detox things were better for a while. Dad came back into the picture and both parents seemed to want to work together. However it soon broke down and arguments began again. Y was sent to live with dad. It didn't last. The school has supported both parents, arranging support and advice sessions in school help. We have arranged family counselling and CAMHS [child and adolescent mental health services] plus in-school behaviour support for Y.

"Mum is using again, the arguments continue. There is no more residential detox available. Both boys are looking pale and ill. The police were involved with an 'incident' with the family recently but can't tell us what it was. Y looks terrible, he is quiet and low and over compliant in school – most unlike him. I am really worried but have run out of ideas. The family have gone through many layers of social service help. I don't know what to do next. How do I protect this child when they've had all the services going, but the situation is worse than ever. I'm really worried."

Strong professional links between local acute hospital trusts and the PCT, including South London and Maudsley NHS Foundation Trust, have also been facilitated in response to practice improvements identified for this area. The designated nurse now attends the trust safeguarding children board meetings at the acute hospitals, and also meets bi-monthly with each of the named nurses from the provider trusts to review and implement changes to practice based on issues arsing from cases. The designated and named professionals for safeguarding children also now collaborate across Lambeth, Southwark and Lewisham and the wider London and surrounding areas.

The board's sub-groups, which carries out the detailed work of the board, have undertaken robust work in investigating and improving safeguarding practice across partner agencies. The child-on-child abuse sub-group, for example, oversaw the implementation of national guidance on safeguarding young people who are vulnerable to sexual exploitation. An inter-agency panel now meets regularly to review risk and agree service plans for this small, but high-risk group, of young people. The trafficking group, meanwhile, led a pilot project to improve the identification and subsequent service to children who may have been trafficked, backed by a suite of materials, training and a borough-wide awareness campaign. A member of the sub-group, employed in the council's housing service, is a member of a national steering committee and continues to input our local experience into the development of national materials. An audit, which identified that 13 children had been assessed in the eight months to April, found good evidence of inter-agency working and use of specialist consultants in children's services, and recommended further steps to ensure better use of the national referral system and toolkit.

The SSCB holds an annual stakeholders' conference to set inter-agency priorities for the year, promote the board's work and hear the views of stakeholders. The annual conference is also used to showcase a particular safeguarding theme. There is good evidence that children, young people and their families participate in decisions regarding their individual support. Safeguarding services routinely involve families in assessment, evidence shows that 75% of families subject to a child protection plan contribute to the decisions and plans regarding their support. All children and young people are seen on their own and where appropriate their views are taken into consideration when being assessed for services, and always sought in the course of section 47 investigations. Young people are also involved in the work of the board, for example the local children in care council (CiCC) plays a key role in the development and delivery of the annual stakeholders' conference and the review of the board. In supporting a culture of external challenge, there is also regular dialogue between the CiCC and the independent chair to help drive practice improvements. As one example, young people raised the issue of care leavers who are about to become parents being referred as a matter of course for a pre-birth assessment. The chair referred this to the Head of Social Work Improvement, whose review led to a change in practice, so that assessments are now carried out based on risk rather than the previous blanket approach.

Partners continue to look at family based approaches to managing children at risk and supporting families to find solutions. Over the past year, there were 107 family group conferences, and there have continued to be good rates of parents attending child protection conferences, with some 755 family members and 164 children attending. The quality assurance unit is leading on increasing the number of young people given the opportunity to present their views to conference, as well as supporting young people to attend case conferences where appropriate. Many who have child protection plans also have individual counsellors or mentors in school and this is another means by which young people are able to have their wishes and feelings heard. In its ongoing review of its governance, the SSCB is investigating how the voice of children, parents and community groups can be enhanced on the board. It will also be appointing a local parent to the board in line with recent guidance.

There is well established partnership working and communication across key partners, including the voluntary and community sector, which are leading to practice improvements and increased community capacity to keep children safe. Over the past year, the SSCB has continued to work across the borough's diverse communities, including promoting safeguarding training to faith communities and providing free training to the voluntary and community sector. Due to the high levels of black African children in our child protection system, it has continued to work with community organisation Afruca to support capacity in responding to local needs. Afruca has undertaken staff training and worked in the black African community to raise awareness of safeguarding issues, including facilitating relationship building between safeguarding services and community groups. It also began working more collaboratively with the voluntary sector to develop a network and information exchange for local community organisations, faith groups and communities to promote safeguarding awareness. In addition, the board worked with the authority's planning department to produce a handbook on places of worship, in response to concerns about some local churches using light industrial premises not intended as places of worship.

Story G - Clash of cultures
"I have found it difficult to marry my role as a faith group leader taking on board what is right in the eyes of my faith and what are the safeguarding rules in this country. Spare the rod spoil the child springs to mind.

"I was asked to write a safeguarding policy to ensure that the children who attend our church are safeguarded. When this was being constructed, it struck me that what was culturally and religiously acceptable was not OK based on safeguarding principles. I feel that Southwark should spend some more time with us to help us understand the issues.

"Working with families with different perspectives on discipline is challenging but we all know that there are other ways of rebuking our children without resorting to physical punishment. I have been commended on how I interact with the children and their families in the faith group setting."

The Annual Performance Assessment for 2007, recommended action to reduce the number of staying safe actions in childcare inspections, and was subsequently commended in the APA 2008. Overseen by the board, this was achieved through a coordinated programme of work with the sector including annual audits, a comprehensive training programme informed by these audits and individual work with settings where concerns had arisen. This action was linked with the commissioning process, with providers required to demonstrate they meet acceptable standards before they can receive grant aid or offer funded places.

In its work to support continuous improvement, the board actively reviewed and successfully implemented changes that strengthened its governance and enable enhanced challenge and support of safeguarding practices across the local area and of its partners. Key themes of the review were the need to streamline and strengthen senior governance arrangements, refocus subgroup arrangements and enhance the board's approach to measuring outcomes and its way of both monitoring and evaluating how effectively local organisations are meet their safeguarding obligations. Improvements include the appointment of an independent chair in October 2009, reconfiguring the executive to ensure presence of senior leaders from partner organisations, which now meets four times a year, and refocusing the board as a wider stakeholder forum to ensure representatives across a range of partners. The number of subgroups has been reduced to create a smaller number of standing groups with key tasks and responsibility for commissioning projects of local importance. The work of the subgroups will be coordinated and monitored by the wider SSCB. The remit of the executive has been refocused on overseeing the development and action of the annual report, ensuring regular dialogue and account to the children's trust in regard to local safeguarding issues, ensuring persistent and strategic safeguarding issues are addressed, such as those arising from serious case reviews (SCR) or inspections and taking action to resolve them, and ensuring compliance and improving outcomes in regard to borough and individual agency safeguarding practices.

In order to further increase democratic accountability, the board has appointed the lead cabinet member for children's services as a participant observer to the board and supports her to exercise accountability for safeguarding through chairing the children's trust, receiving monthly briefings in regard to outcomes and key issues facing local safeguarding services, and by chairing the corporate parenting panel, which holds council-wide responsibility for our most vulnerable children and young people. All elected members are also encouraged to attend SSCB safeguarding training and child protection update seminars. In line with new national requirements, the board is recruiting two lay members, with selection criteria agreed and circulated widely across the community and voluntary sector.

All partners are committed to continued investment in safeguarding services, with core member agencies contributing to a joint budget of £80,000, which funds board management and administration, and the inter-agency training programme. A separate contribution from

Southwark's children's services meets additional administration, officer and management support.

There is already good representation on the board from a wide range of partners such as schools and the voluntary and community sector. The board is working to strengthen accountability in some areas – for example, ensuring that there are clear governance arrangements and opportunity for regular feedback and dialogue between representatives and associated sector-based governance arrangements, such as those between headteacher SSCB representatives and the Headteachers' Executive, the local leadership forum for schools.

Locally, there are good examples of how this works, for example, some agencies, such as our health partners, proactively ensure that actions from the board are disseminated and implemented in their individual organisations. It is less clear, however, how SSCB actions are communicated in other agencies, such as probation and the police, which have centrally managed systems and have an impact on safeguarding outcomes. To address issues such as these, the chair recommended the strengthening of single-agency and inter-agency assurance processes. In response, the board introduced a systematic framework of review of partner's safeguarding practice underpinned by self evaluation and evidence. The executive now requires member agencies to present for its consideration an annual report of the effectiveness of their section 11 safeguarding function with a focus on frontline practice and quality assurance, which enables the SSCB to assure the effectiveness of safeguarding arrangements as well as contributing usefully to each individual agency's actions to improve outcomes for children and young people. This improved, smarter way of working significantly strengthens the board's approach to holding partners to account, building on an already strong culture of peer challenge and introducing a more evaluative, systematic and transparent approach. The board has laid out expectations in the introduction of this new way for working that there is a special focus on the experience and outcome for the child and family, and on staffing matters.

Story H - A safe return

"A boy, S, arrived at school in year 2. Exceptionally challenging behaviour – outbursts of anger, physical aggression, self-harm (banging head against doors, glass panels, one of which he actually broke). Queries immediately about who was caring for him, what his 'home' experience was. S lied about where he lived, disclosed he'd been paid to do this. Referral made to Social Services.

"Lots of digging resulted in background being shared with agencies – S had been 'snatched' from mother overseas by one of his father's 'friends' because the father had broken bail and come illegally to this country. He thought, wrongly, having a child here would enable him to stay. Child lived in a cupboard in girlfriend's house. Lots of violence and police involvement. Child trusted nobody, desperately wanted affection from dad.

"On Child Protection Register, S and father moved around from borough to borough, wherever the current girlfriend' had an address. Ended up sleeping on floor under bed in hostel. Thrown out when social worker bought S own bed for his birthday, cos they weren't supposed to be there. Eventually, after long meetings with dad, persuaded him to give S up into care.

"S began, slowly, to be teachable and trust. We gave 1:1 support for mornings in school. A strong bond formed between S and this young mentor. Through persistent efforts on the part of social worker, S's mum was found and there was not a dry eye on the day S flew, with the social worker, back home."

There is widespread evidence of good assurance measures to ensure children and young people are safeguarded adequately. For example, local health trusts – King's College Hospital, Guy's and St Thomas' (GSTT), and South London and Maudsley NHS Foundation Trusts – all take a proactive approach to ensuring strategic and senior management commitment and oversight of safeguarding and child protection issues. Each trust has its own safeguarding executive, which is chaired by a senior member of staff and where all actions from the SSCB, SCRs and other safeguarding issues are regularly reviewed. This model of accountability and communication provides an important mechanism to ensure safeguarding outcomes across the partnership, and the SSCB encourages other agencies to consider how senior accountability and communication can similarly be exercised in their agencies.

The PCT strengthened its processes around child protection activity, including the reconstruction of the Southwark PCT child protection executive group following a review of its leadership and governance arrangements relating to child protection activities last May. Chaired at director level, the executive group now ensures a direct link between the SSCB and the management of frontline health services, and includes the reviewing of performance monitoring and outcome measurements. GSTT also reviewed its governance arrangements last year to ensure that the framework in place would meet the requirements of national policy. The central safeguarding team responsible for child protection and vulnerable adults, established last year, is providing invaluable support, led by a deputy chief nurse. An additional safeguarding post for maternity services was appointed this year, in recognition of the high volumes of complex cases being referred. Complicated or difficult cases are reviewed at a weekly meeting attended by key stakeholders, with agreed actions and outcomes monitored.

A key objective of the SSCB's new way of working is to ensure that the practice is consistent across all agencies. The changes to governance arrangements provide good foundations for the board to meet current and future challenges. There is evidence that the new model will support greater impact on frontline practice, strengthen its oversight of effectiveness of partner agencies and improve its ability to call partner agencies to account. This will be central to enabling the board to meet new challenges such as the outcomes of the Munroe review and continuing to ensure safe services within a climate of significant budget reductions, rising demands for services and the necessary transformation of services in order to meet national and local efficiency targets.

5.0 Assessment of safeguarding policies, procedures and training

The SSCB ensures that local safeguarding practice is guided by a comprehensive set of regional and local policies and procedures. Through its role as lead commissioner of training for safeguarding, it drives a partnership-wide commitment to workforce development demonstrated by a wide-ranging training programme available to all partners, including the voluntary sector. The SSCB has taken the lead role in developing a range of approaches to support good information sharing to improve safeguarding practice and has facilitated a number of multi-agency arrangements to support good communication between key professionals. The introduction of strengthened governance arrangements for the board will support systematic and robust review of partner's compliance with national and local safeguarding procedures, as well as take up of training and other workforce development activities. There is evidence that further work could be done to ensure compliance of safeguarding guidelines in all local commissioning arrangements. In response to delivering the step change required to safeguarding practice, and in line with initial findings from the Munroe review, the board is leading the rebalancing of the focus on the bureaucracy and processes with outcomes, including the introduction of transformational learning to deepen staff skills and knowledge.

Strengths

- The SSCB has ensured national and regional policy and procedural frameworks, and local guidance are disseminated to all partner agencies to support local practice issues, such as those arising from SCRs and information sharing needs
- The board is strongly committed to workforce development and has commissioned a comprehensive programme of training which is highly valued by partners and staff

Priorities for improvement

- Improve compliance and challenge arrangements of partners in regard to national, regional and local policy, procedures and practice including training and development and borough-wide commissioning activities

Recommendations from independent chair

- In order to support staff to consistently recognise and act in a timely and appropriate fashion in regard to potential signs of abuse and neglect, the SSCB should simplify the range of procedures, guidance and policy going forward. It is recommended that in the main the basis of agencies' procedures should be national and regional guidance rather than local guidance, unless there is evidence that it will add value to improving local safeguarding outcomes
- Commission future training programmes using the principles of transformational and active learning approaches, such as audit based learning, to deepen staff's skills and knowledge with a view to improving frontline practice that helps keep children safe

The basis of Southwark's safeguarding practice guidance is Working Together and the Pan London Child Protection Procedures. In previous years, the SSCB, in being responsive to local need, also led the development and implementation of local joint protocols of particularly prevalent local safeguarding issues in regard to mental health, alcohol and substance misuse, domestic abuse, and parents with learning difficulties and/or disabilities (LDD). With time, however, the London procedures now reflect these issues and the future of these local procedures is now under review as the board seeks to simplify local guidance and protocols. For example, in response to recommendations in a recent SCR, the board suspended the use of a joint protocol on domestic abuse in favour of the London Child Protection Procedures, which are more detailed in this area. Inspection such as the JAR and the unannounced inspection of contact, referral and assessment have recognised that the well-established and clear strategies, policies, and procedures as contributing to ensuring a robust system for interagency working and support statutory requirements to safeguard children and young people are met. Generally, evidence of frontline practice across all agencies demonstrates that workers have a good working knowledge of national and local guidance. This includes the voluntary sector, which can overall demonstrate robust safeguarding practice, although both the SSCB and the local third sector umbrella organisation Community Action Southwark (CAS) recognise further work is needed to gain a full picture of standards across the whole sector. In response, CAS has set up a safeguarding committee for the third sector which is currently undertaking a survey of members' arrangements.

The SSCB takes a visible leadership role in ensuring partner agencies and its workforce are kept informed of the latest guidance and procedures. There is a regular programme of inter-agency update seminars and events available to all staff across the partnership. Good use is made of existing forums, for example a central theme of this year's annual safeguarding conference was promoting the revisions to Working Together guidance, while the designated safeguarding workers' networks managed the dissemination and practical implementation of new guidance for this key staff group. There is wide-ranging evidence that partners regularly review and update local practice in line with changes to relevant guidance. For example, all the borough's health providers revised their child protection policies to incorporate a new supervision policy to ensure that best practice and lessons learnt from SCRs were reflected. Another example of procedures responding to local need is GSTT and King's recent implementation of systems which more quickly identify those children subject to a child

protection plan in either Southwark or Lambeth – this constitutes an IT flagging system in GSTT, and a risk assessment and alert procedure within King's.

This SSCB has led on the development of practice and policy for sharing information across partners. Inspection has commended partners' effective information sharing at the early signs of abuse and neglect, as well as partners' contribution to the referral and assessment process. This includes well-established joint working arrangement for key child protection activity such as conferences and strategy meetings. Local joint working arrangements support greater information sharing and understanding between professionals, facilitated through the partnership working of the SSCB, including a range of collocation and specialist worker arrangements. For example, there is close working between health specialists and the pre-birth team with acute and community providers to support risk assessment and the delivery of child protection services for vulnerable parents. The SSCB has taken a lead role, for example providing training, on key developmental pieces of work such as developing information sharing protocols with the children's trust, disseminating guidance and training, and work on escalation procedures. The board has also led targeted work with partners, for example, following a SCR, working with mental health workers on how and when to share information in regard to parental safeguarding concerns.

Story I - Just want someone to love me
"I am a care leaver. I am 20 and was born in Southwark. I came in to care with my 2 brothers. My mother left us when we were very young. Father raped me when I was six and we suffered terrible neglect. At first I did not tell anyone about the abuse but after I was in a foster placement I told people. I was placed in a long-term foster placement outside of London but was isolated and perhaps a little over protected from life's realities.

"I was happy having a mum and a dad. When I was due to leave care I was placed in a hostel. But there were lots of young mums with babies and I found it hard to settle. I have lots of relationships with men who are much older than me. I am trying to have a baby because it is what I want most, my own family. Although I have only been with my boyfriend for one month, I may be pregnant.

"I have already had a termination which I felt railroaded into because social services understand that I have a functioning age of 14, and advised me to wait. I will and am determined to have a baby. Social services are supporting me and advise me not to take drugs, drink and to wait to see if my relationship lasts but I am determined and will run away if I have to. Social services know this and will support me through the pregnancy but it is likely that they will apply for a care order as I cannot really look after myself or keep myself safe. They are worried for my unborn/potential child. I know I will need 24 hour support to look after my baby. My adviser understands my need for a family but cannot force me to have an abortion. If they do I will run away. So they have to work with me. I do not know if they will take my baby away which will be more devastating than an abortion. But I am determined. Social services have serious concerns for my own safety as I take risks, and cannot really look after myself. All I want is the family that I never really had."

The strong leadership role of the SSCB in policy and practice development can be demonstrated by its work on safe recruitment. It has led efforts to ensure the safe recruitment of frontline staff in agencies, continues to widely promote guidance on safe recruitment and safe disciplinary measures across agencies, and provides advice, training and safe recruitment materials across the partnership. It has worked with partners in the authority to produce guidance for schools and similar settings, resulting in almost all educational settings now having appropriate training in safe recruitment. In addition, the board has introduced compulsory training for school governors and advises appropriate action to ensure safe

appointment where a negative Criminal Records Bureau check has been issued. It also plans to undertake an audit of safe recruitment through the introduction of its assurance framework.

These measures have contributed to high safeguarding standards across the borough's schools – of the 17 schools inspected by Ofsted since September 2009, when the criteria were amended, all but one has scored good or better for pupils feeling safe and all but two have scored good or better for the effectiveness of safeguarding procedures. Notifications of allegations against those in a position of trust in 2009/10 rose to 79, up from 59 the previous year, and are now more in line with other London boroughs and largely due to more notifications from schools.

Inter-agency audit against compliance with policy and procedures is central to the work of the SSCB. The outcome of this work shows that while the core elements of the London Child Protection Procedures are used, practice can be inconsistent. In order to address this issue, a key part of the revised governance and compliance arrangements, as set out in section two, includes the systematic auditing of performance across all partner agencies to support ongoing review and improvements of frontline practice to protect children from harm. A particular area this seeks to address is to seek greater assurance of adherence to local requirements of those partners covered by more regional management structures, such as the police and probation. There is also evidence from audit, however, that even where protocols and guidance underpin practice, it is difficult to show that compliance consistently results in improved safeguarding outcomes. This has been a key driver for the independent chair's recommendation for the introduction of transformational and audit based learning to deepen staff skills. As a result, the board is now rolling out a programme of inter-agency peer audits to support reflective practice and continuous improvement.

The leadership of the SSCB maintains a partnership-wide commitment to workforce development in regard to safeguarding practice ranging from core child protection to specialist training in regard to particular areas of need. The board commissions a comprehensive programme of training with participant feedback confirming that this is highly valued. Most training is inter-agency and some 800 staff training sessions are offered including conferences and action learning sets. In order to address core child protection training needs, all new local authority staff undertakes an e-learning programme on safeguarding vulnerable adults and children, and evidence shows a 98% compliance rate. Training programmes are designed around local needs such as themes arising from audit and SCRs. For example, last year saw the introduction of master classes on working with uncooperative families and work with social care practitioners on domestic abuse in case management. Local training programmes also seek to address local safeguarding needs, and the SSCB has led on developing a range of awareness-raising sessions with faith communities, particularly the African community, including the commissioning of locally based Afruca which runs sessions on safeguarding children with faith group leaders.

Partners are equally able to demonstrate a commitment to safeguarding training within their own organisations, for example GSTT has surpassed the 80% NHS London target for child protection levels 1, 2 and 3 training, with 97% of staff eligible for level 1 now trained and 86% for level 2. In recognising some deficits in its training uptake, King's has introduced new training requirements for staff at levels 1 and 2, such as all midwives now having annual mandatory training, based around learning from SCRs and addressing alcohol and substance misuse. The PCT recently introduced mandatory level 3 training for supervisors following an audit of existing supervision practice which identified this as a development need. The voluntary sector has good take-up rates for safeguarding training, with a recently commissioned Ofsted survey of third sector providers showing that 76% of local organisations reported that training on children's safeguarding was available from the SSCB, compared to a 49% rate nationally.

The SSCB recognises the importance of workforce development in regard to improving frontline practice and outcomes for families. In responding to the early findings of the Munroe review, the board is now embarking a programme of transformational and active learning approaches to deepen staff skills and knowledge. For example, recent study days and conferences have presented 'the story' of an abused child in a concrete interactive session, with the aim of prompting transformational learning. In addition the board manager runs an annual action learning set for frontline practice managers. This is supported by a move to tailor the training programme to the individual training needs of frontline workers, a model recognised as national best practice, and the use of IT to better gauge workers' training needs and to adapt local training practices accordingly.

6.0 Monitoring and evaluation and quality assurance activity

The SSCB has established a performance management and evaluation culture across the partnership to support sustained improvements in safeguarding outcomes. Management information, audit and quality assurance are used both at board and individual agency level to support improvements in frontline practice and outcomes. Overall, partners can demonstrate a robust approach to performance management and quality assurance, including review and changes in delivery in light of outcomes from SCRs. Going forward, however, the SSCB recognises the challenge is how it can further bring together outcomes from this work into a performance management framework which drives strategic areas for development and service improvement, such as future audit programme and the work of the SCR panel.

Strengths

- There is evidence of regular auditing and performance management by all agencies leading to changes in frontline practice and outcomes
- Equality and diversity issues are considered in the work with families which impacts on the delivery of provision and ensures it responds to individual and local community needs

Priorities for improvement

- Enable greater shared understanding and learning across the partnership from the work of individual partners' auditing and quality assurance processes to inform changes to partnership-wide frontline practice.

Recommendations of the independent chair

- Revise current performance management frameworks to enable greater monitoring of effectiveness, sustained improvements in safeguarding outcomes and support strategic areas for development and service improvement.

There is evidence that the majority of partners have in place a range of robust systems that assure service provision and quality, and lead to changes in service delivery and frontline practice. For example, the audit programme at King's has resulted in revisions to training to better address risk factors of domestic abuse and a new timeframe for medical staff to provide reports to police and social care for suspected child protection cases. At GSTT, a specialist youth worker has been employed to follow up cases of young people presenting with non-accidental injuries following an audit of cases of children presenting at casualty where prevalence in this area was high. The PCT's audit programme, meanwhile, last year highlighted some key areas for improvement around supervision. As a result the trust has introduced mandatory training, improvements in supervision for named nurses and three-monthly reviews of all vulnerable families. These measures will be subject to another audit next year to evaluate whether they have made a difference to practice and outcomes. All schools, including supplementary and independent sector provision, undertake guided safeguarding audits every 18 months. There is evidence that this has supported 16 out of 17 schools inspected by Ofsted since September 2009 scoring good or better for pupils feeling

safe, and 15 out of 17 scoring good or better for effectiveness of safeguarding practice. Going forward, however, the SSCB recognises it could promote better the sharing of outcomes from individual audits and changes in practice and, where appropriate, what these mean for strategic development of partnership-wide safeguarding practice and provision.

In children's services, quality audits by the youth offending service has driven improvements in safeguarding practice, with a regular liaison meeting between the contact, referral and assessment service and the youth offending service, which has improved the quality and appropriateness of referrals and support better risk assessment. The unannounced inspection of the contact, referral and assessment service also highlighted the good audits commissioned by senior managers, noting they have been appropriately used to focus service development and take action to address identified development issues. For example, audit and quality assurance in the service supported early and effective action to address unsatisfactory casework practice and managerial oversight in one of four teams following a period of instability in the management group. Remedial action was taken, including providing additional support from an experienced quality assurance manager, which is beginning to show improvement in the quality and management oversight of the team and evidence that these improvements have been embedded. Reflective of responsive and good-quality case work is the range of evidence that supports equality and diversity issues, which are well addressed in local safeguarding practice. The recent inspection of referral and assessment highlighted this as an area of strength and the service has developed a number of specialism in response to local needs analysis and audit findings. A key strand of development work for the local children's services and the SSCB has been raising awareness and knowledge around safeguarding issues in the black African community. Needs analysis has shown that there is over-representation of black African children in section 47 work and this has led to the commissioning of community organisation Afruca to enhance cultural understanding and how this should inform practice. There has been successful work with the community on raising awareness around private fostering and, as a result, Southwark has the most successful notification rates in London. The local authority has now appointed a head of social work improvement and quality assurance to oversee improvements in multi-agency practice around child protection, children in care and quality assurance of partnership areas for improvement as highlighted through national and local practice.

Story J
"Family A arrived at our primary school 2 years ago. Mrs A enrolled her daughter, aged 7, and twin daughter and son, aged 8, midway through a term. She was very late for the admission meeting and gave the excuse as the traffic. Her reasons for moving her children midterm seemed plausible – she was tired of travelling the distance to their current school, due to her disability – "her legs" she explained.

"All three children started at our school and on their first day – they were late. Very late. Half an hour late. Not the best start to their new school. A phone call to Mum to enquire why the children were late – "they wouldn't get dressed in time" she explained. Over the past 2 years – the children have continued to be late arriving to school – that's if they turn up at all. When they are in school, one, two or all three complain to staff they are hungry, they often don't have their glasses so they can't see the board, sometimes one of them may fall asleep. They are delightful children and love to learn, however a combination of tiredness, hunger and absence is preventing them from achieving their full potential. They are referred to the Education Welfare Services.

"More phone calls to Mum requested she comes in to discuss our concerns. "What have they been saying?" she asks, "whatever it is they're lying". I say a referral is being made to social services due to ongoing concerns about the children. She disagrees and says she cares for her children. The referral is completed and sent. Then, 13 days later, a response: No further action to be taken.

The next day, one of the twins arrives late, complains he's not eaten any breakfast... the other twin falls asleep in lessons. Is anybody listening?

There is evidence that the SSCB has supported learning and audit findings from partnership-wide areas of concern, and these have also led to improvements. For example, the SSCB standards sub-group carries out a range of inter-agency audits, choosing cases at random based on themes referred to them or following a SCR. During 2009/10, it audited cases that had been subject of a child protection plan for over two years and made a number of recommendations about chairing of child protection case conferences and risk assessments which have been fed back to the respective services.

Another recent example is the establishment of a dedicated pre-birth team in the contact, referral and assessment services in response to recommendations raised in an audit of pre-birth assessment, which was in response to a SCR. The audit identified the need for better long-term planning where pre-birth cases are likely to meet the threshold for a legal planning meeting and/or a child protection plan. The team, staffed by social workers and a health specialist, now provides specialist skills, works to build closer working relationships with key agencies and offers timely action to protect children at birth. A further audit is planned jointly between children's services and the PCT to assess the impact of vulnerable pre-birth casework and outcomes. Early indication suggest that less children are becoming subject to care orders as a result of the earlier sharing of information and the development of better risk management processes.

Another key partnership-wide theme arising from audit has been the better support of infants whose parents have mental health and/or substance misuse concerns. As result, the SSCB has led the considerable work to raise awareness of safeguarding issues in the adult workforce and promote better understanding of mental health and substance dependency issues in adult social work teams. This has included the publication of a number of dedicated local protocols and the creation of a specialist post working between adult and children's services. King's established a multi-agency working group to review pathways of care for pregnant women with mental health problems and which links into the work of the pre-birth team. The strengthened peri-natal and midwifery pathways came into effect in May and the

new system is supported by a weekly, multi-agency safeguarding meeting attended by representatives from both Southwark and Lambeth children and young people's services, mental health services and primary care.

Story K - Safe at last
"I was born in Central Africa. My mother died in childbirth when I was 7. My father died in prison after being arrested for political activity. I was arrested, tortured, raped, escaped, worked as a prostitute, made my way to the UK, helped by a client. My asylum was refused but I did find
my sister. I attempted to hang myself in the removal centre. I was allowed to leave and given temporary leave to stay.

"I have a new supportive mental health worker. They see me often and supervise my medication. They liaise with a housing provider. I am pregnant. A specialist midwife is overseeing my case. They will arrange for a mental health worker to see me after I have my baby to make sure I am well. The mental health team has referred to social services. This social worker was worried I couldn't look after my baby. They called a case conference. They did not make a child protection plan."

It is recommended that the future performance management framework of the work of the board is reviewed to reflect the introduction of recent developments in its way of working, as well as to ensure that the outcomes of audit and quality assurance practices both in individual agencies and across the partnership support the strategic areas for service development and improvement in outcomes. For example, the board plans to strengthen its oversight of day-to-day frontline operations through a larger programme of audits involving frontline workers and their managers so that learning is embedded and a culture of review and continuous improvement fostered. The standards sub-group has been charged with responsibility for designing and recommending to the SSCB a rolling programme of case audits, ensuring that the process should be one of 'reviewing with', in order to generate real learning, and less one of top-down 'auditing. The outcomes of this work need to be considered alongside the type of management information the board monitors, how this can link to service improvements identified through SCRs and add value to partners' own audits. This could include how this type of audit can be used in a targeted way to support where other audits have identified areas for improvement. One of the first areas that this new system will be applied to is improving the support to infants where parents have mental health and/or substance misuse problems, an area of particular local concern and which was highlighted in an overview of recent SCRs.

Story L - Never say never: sometimes the extended family helps
"T is aged 18 and presents with concerns around substance misuse. She has a psychotic diagnosis, lives alone and has just realised that she is five months pregnant!! Her mental health worker makes a referral to social services and mental health psychiatric consultant predicts an over 75% chance of a psychotic relapse. Suggestions are for the baby to be removed.

"As an allocated social worker to the case I start by exploring T's childhood and it emerges that she didn't have a good experience. At one point she was sexually abused at the age of 7, didn't finish her education and recently experienced a date rape from ex-boyfriend who is father of the unborn. I turn to T's wider family and their response was fantastic.

"They all pledged to support T, even though they had cut ties with her. Although T's baby was made subject to a child protection plan, he remained in the care of T with wide family support. It's four years now and T is in nursery. Current records indicate that he is thriving well, with his aunties and maternal grandmother still around for him."

7.0 Serious case reviews

Southwark has completed three SCRs since March 2009. Practice in regard to this shows a good level of inter-agency cooperation and partnership working in the process of conducting the review and addressing the issues identified. A review of strategic themes arising from SCRs, as set out this report, highlights the reoccurring themes. The SSCB and the SCR panel should consider going forward how to ensure that actions and learning from SCRs are reviewed and embedded across individual agencies and the partnership as a whole. Common themes and learning from SCRs indicate that local improvement is needed in how different services working with vulnerable parents at pre-birth and in infancy, need to consider the risk of parenting capacity in regard to basic care and safety of the child; inconsistency in the compliance of protocols and procedures of staff acting in a timely way to signs of abuse and neglect; and where there are safeguarding concerns, more effective utilisation is needed of key infrastructures in place to support risk management, such as better use of the designated lead professional.

Strengths
- SCRs demonstrate a good level of inter-agency cooperation and partnership working to respond to indentified risks within individual agencies and across the partnership
- There are some examples of thorough and considered individual management reviews (IMRs) and overview reports that help support local learning and improvements in practice

Priorities for improvements
- Improvements in the local process for SCRs should include improving the quality and timeliness of key documentation, and ensuring analysis and learning are strategic and provide a sound basis for continuous practice improvement

Recommendations of independent chair
- An SCR panel be established to take overall leadership for previous and future SCRs. This should include ensuring that actions and learning from SCRs are reviewed and embedded across individual agencies and the partnership as a whole
- Further consideration should be given to how the section 11 process could further capture and support improvements in practice by individual agencies in line with their individual issues and actions arising through SCRs

Southwark has completed three SCRs since March 2009 of child G, F and I. Analysis shows there are a number of similarities in the three cases, with all three of the children being

infants in their first six months of life and all suffering physical trauma. There are number of reoccurring key themes, which are addressed in more detail below. As set out in earlier chapters, overall the SCR process illustrates good levels of cooperation and partnership working between agencies both in terms of completing IMRs, introducing changes to practice and monitoring improvements through audit and review. The board has been prompt in responding to changes in guidance on SCRs, with the last two reports written by an independent author, and the last SCR chaired independently.

Evaluation of local SCRs by Ofsted has found them adequate, with all evaluations suggesting further improvement is needed in the conduct of the local SCR process. Subject to future guidance, the past three SCRs highlight improvements are still needed in the overall quality and consistency of agency IMRs. Although, there are some very good examples of high-quality IMRs and work by agencies, overall the SCR process could be strengthened further. Key areas for improvement include the standardisation of key documentation to better support analysis, consideration of how clearer terms of reference could assist in specifying particular issues for agencies to address, and better quality assurance and challenge throughout the process of agencies and documentation provided. Although thorough, a reoccurring theme of local SCRs is that they could improve through providing more succinct and strategic recommendations and would benefit from fewer actions to provide a sound basis for strategic improvements in local safeguarding practice. In order to address this, the independent chair has established a standing SCR committee which will meet four times a year to oversee recommendations for new SCRs, review progress against SCR action plans and lead on the identification and delivery of strategic and systematic improvements to the inter-agency system in accordance with learning from the SCRs. The board will be responsible for putting in place arrangements to tighten the SCR process in accordance with revised chapter 8 requirements, including improved management of the reporting process, use of standardised documentation and the identification of key lessons to be disseminated to the wider system.

As the number of cases subject to SCR in Southwark is small, it is useful to put these cases in the context of national and pan-London SCRs. A confidential overview of London SCRs carried out 2004-06 noted some significant differences between children subject to SCRs in London and the national picture. Children in London were more likely to be young children and infants, and more likely to be the only child in the family household. Fewer deaths and serious injuries were related to the risks associated with parental drug or alcohol use but a higher number involved parents with mental ill health, although it is recognised that the national figures may be affected by under-reporting. The cases in Southwark would seem to reflect this picture. A recent report by the Government Office for London, on the period April 2006 to September 2009, does not find all these variations still present but does note the vulnerability of infants and the high number of families (60%) where childcare was affected by a parent’s mental health issues.

Story M - 'The cycle'
"19 year old pregnant young woman informs her personal advisor in the adolescent and after care service she is pregnant. As this young woman was in care since the age of 10yrs, and still open to our service, a referral was made to children's services for a pre-birth assessment.

"It transpired that in conjunction to her very sad and troubled childhood, she has been a regular abuser of alcohol. This has resulted in high levels of anti-social and criminal activities. She now has a tag. Her boyfriend likewise has been known to children's social services since he was born and struggles with substance misuse and criminal activities. They are however determined to give their baby a different life and are desperate to prove to professionals they can be good parents.

"Because of the very concerning risk factors the case did go to court. However, due to the hard work of all involved (including mum and dad) and social worker, the parents will have the opportunity to prove their commitment and determination in a residential parenting unit. Will this be different for this baby? Will the cycle stop? At what cost?"

The two most recent SCRs shared a number of common factors. They were both the first children of parents who had been known to services prior to the pregnancy and where there was a combination of risk factors including a history of some misuse of controlled substances, difficulties in the parents' relationship, including a level of domestic abuse, and a history of psychiatric and psychological problems. In these cases, there have been issues with communication between agencies working with the vulnerable parent, particularly in regard to agencies such as adult mental health and those working within peri-natal services such as health visiting and midwifery. This included poor recording of key information, inadequate sharing of information between key professional and insufficient risk assessment and consideration of history of the parent, to help form decisions regarding parental capacity to provide basic care, safety and protection. In both cases, the pre-birth work could have been improved.

As highlighted throughout this report, there has been much progress locally to address the key learning and issues arising from SCRs. With a focus and marked improvement on the work of key partners, such as acute trusts, and the development of provision such as the pre-birth team in the contact, referral and assessment service to better respond to this local area of need. Other local developments to address this include greater coordination of work with parents-to-be who have mental ill health, and formalisation of inter-agency risk assessment and planning through revised peri-natal liaison meetings, which now include increased management capacity following appointment by the PCT of a specialist safeguarding nurse. Further consideration, however, should be given by the board as to how the section 11 process could further capture and support more systematically and robustly the improvements in practice by individual agencies in line with their bespoke areas for development arising from SCRs; and would further inform the work of the newly established SCR committee.

Story N - I thought you were different
"T, 19, had been referred to the family nurse partnership programme at 17 weeks pregnant. She had had a difficult childhood and had a fractured relationship with her family and few friends. She had suffered physical and verbal abuse from her family. Her only support was her boyfriend and father of her child. Her pregnancy was unplanned and was initially difficult for T to come to terms with. She met her nurse frequently throughout her pregnancy and worked well with her named nurse. She had a healthy baby boy and was discharged to her temporary accommodation with the baby.

"T was very tired and low in mood in the initial few weeks. Her boyfriend was around but offered limited support. She disclosed to her nurse that she was frightened of her boyfriend, that he was physically and verbally abusive to her. The nurse explored this with T and explained she would need to refer to social services for support. T was in agreement, but said she was frightened of what might happen. The nurse referred to social services but was unable to get any further with T other than abusive texts, including 'I thought you were different'.

"The nurse was really upset, but never managed to re-engage T again. T arrived at a baby clinic in Southwark and the health visitor called the FNP to ask us if T was known to us. I said she was, but we had lost contact with her, but really needed to know if she still wanted a family nurse. Despite a 3 month gap she still requested to be part of the programme and worked with a newly allocated nurse with support from multiple agencies. She was allocated a safe place, but eventually made contact with the father of the child and domestic violence recommenced (at times severe). The domestic violence only ended when the father went to prison."

As with most SCRs, a key reoccurring theme was the inconsistency in compliance of protocols and procedures of staff acting in a timely way to signs of abuse and neglect. The past two SCRs highlight the timeliness of referrals to social care and raise questions as to whether the quality of referrals sufficiently addressed the history of parent. Whether London Child Protection Procedures or local procedures were appropriately followed remains an issue for both cases, with non-compliance with both local protocols on domestic abuse and mental health.

In addition, common to both local cases was the inappropriate use of workers, particularly in adult and universal services of the named and designated professional for safeguarding. In both SCRs, information was not shared with designated leads, nor were they appropriately consulted. As a result, work is underway by agencies to increase the use by frontline staff of safeguarding advisors, including the improvement of escalation processes. Other work includes a review of thresholds and clarity around the role and expectations of the designated lead professional in the identification, referral and assessment of safeguarding cases.

8.0 Child death overview panel-narrative

Strengths

- There is partnership commitment and strong leadership regarding the child death review process
- Cases are reviewed thoroughly and partners have committed resources to support this statutory requirement

Areas for improvement

- Due to the nature of the deaths, the learning arising from child death review is often clinical and does not necessarily further enhance learning for the system

Recommendation of independent chair

- Consideration as to how the child death review process continues to meet statutory requirements while supporting improved learning relative to resources committed