31 January 2023

Pinaki Ghoshal, Executive Director for Children and Young People, Lewisham Council
Ceri Jacobs, Place Executive lead, South East London Integrated Care Board
Sir Mark Rowley, Commissioner of the Metropolitan Police Service
Sophie Linden, Deputy Mayor for Policing and Crime
David Goosey, Independent Scrutineer, Lewisham Safeguarding Children Partnership

Dear Lewisham Local Safeguarding Partnership

Joint targeted area inspection of London Borough of Lewisham

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency identification and response to initial need and risk in the London Borough of Lewisham.

This inspection took place from 21 to 25 November 2022. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

Headline findings

Lewisham's Safeguarding Children Partnership (LSCP) arrangements are well established and are becoming increasingly effective. Stability of leadership since 2019 and a shared ambition and determination to drive forward continuous improvement are key factors positively influencing the partnership's progress in strengthening their 'front door' services.

The partners know their services well and have an accurate understanding of the collective local and national challenges they face. Shared priorities that are informed by the experiences of local children and their families are communicated across the partnership and inform renewed strategic and operational plans. Committed staff, managers and multi-agency teams are working proactively in a complex multi-faceted and demanding environment. A resolute focus on protecting children living with neglect and parental domestic abuse and children who are criminally and sexually exploited or missing from home is beginning to ameliorate children's circumstances before risk of harm escalates.

Leaders are fully aware that they have more to do together to ensure that children receive consistently effective help and protection. In particular, further work is needed to resolve a significant shortfall in capacity out of hours, to develop child safeguarding practice and multi-agency engagement with adult mental health services, and to address barriers to effective communication systems across teams and within agencies.

What needs to improve?

- The length of time children spend in police stations out of hours.
- Staffing capacity in the emergency duty team, the police missing persons unit and the referral and assessment teams.
- The inclusion of all relevant professionals in meetings and their access to pertinent information about children and their families.
- Internal and external information-sharing systems in all agencies, so that appropriate individuals and organisations receive the correct reports and decisions following the outcome of referrals, strategy meetings, child protection investigations and assessments.
- Systems to track the invitations, attendance and contributions of all partners at strategy meetings.
- Timeliness of completion and sharing of multi-agency hospital discharge and protection plans prior to the birth of vulnerable babies.
- Adult mental health services' child safeguarding and risk-assessment practice.
- The LSCP's understanding about the impact of multi-agency training.

Strengths

- Despite increased demand pressures, leaders' continuous and strenuous efforts to collectively drive forward improvement are making a positive difference to the quality of front door practice with their most vulnerable children and residents. Leaders know their services well. They are unwavering in their efforts to drive improvement but acknowledge that practice is not consistently strong enough.
- Good engagement by partners in LSCP multi-agency sub-groups ensures that their work is aligned to shared partnership priorities and strategies. Together, the partners are focusing on improving how they analyse, evaluate and report on their impact on children's experiences. Joint working is augmented by the objective challenge provided by the independent scrutineer.
- Targeted support in the newly reconfigured multi-agency early help 'Family Thrive' service means that multidisciplinary early help is starting to be prioritised for the most vulnerable families. Action by local authority leaders to reintegrate early help into children's services is helping to accelerate the requisite multi-agency improvements.
- Partnership leaders provide effective guidance and training to help practitioners identify children in need of help and protection. Consequently, professionals understand thresholds for statutory interventions and how to refer concerns about children.

- The voice of children and their families is captured and analysed effectively in hospital emergency departments, in police and school referrals and in subsequent safeguarding meetings and assessments.
- Children who are at immediate risk of significant harm receive a prompt, proportionate and, in most cases, effective response across the partnership through the multi-agency safeguarding hub (MASH).
- Multi-agency partners are sensitive to pressures on parents who are living with poverty, food and fuel debt, and homelessness, but this does not detract from them being curious about the impact on children's well-being or from making child-centred decisions based on their assessment of needs, risk and harm.
- Most strategy meetings are timely and include relevant agencies, although multi-agency attendance is not consistent enough.
- The incidence of knife crime and serious youth violence is high and supporting children at risk of extra-familial harm is a key priority for the LSCP. Black Caribbean and African boys and young men are disproportionately represented as victims and perpetrators of serious youth violence in the borough. Professionals across agencies work conscientiously to understand children's cultural heritage and diverse needs and to challenge discrimination.
- Practitioners from across all agencies increasingly benefit from effective safeguarding supervision, case direction and support.

Main findings

Thresholds of risk and harm are understood well by professionals in Lewisham. Most children who need a statutory service are referred promptly to the MASH. A revised early help pathway through the MASH supports a team around the family multi-agency approach to early intervention to address families' needs.

The quality of police referrals is improving, with the voice of the child and their family's needs captured well. Safeguarding children and maternity safeguarding teams provide valuable support and consultation to all health staff employed by Lewisham and Greenwich NHS Trust, helping to ensure that children's and parents' vulnerabilities are identified earlier and referred appropriately. Schools are valued and respected partners and are an integral part of the decision-making process. Their involvement adds a richness to referrals and strengthens the focus on the voice and needs of the child.

Staff in the emergency duty team routinely share information with day services but, despite their endeavours, they do not have the capacity needed to respond effectively and consistently to increasing demand out of hours. A single social worker is responsible for covering referrals for children at risk, adults' social care and approved mental health assessments. Consequently, children who are subject to

police protection are too often left for long periods of time in the police station. This has a negative impact on the work of police officers, who are routinely diverted to support these children while they are waiting for suitable accommodation. The situation is exacerbated by insufficient placement availability.

Diligent and collaborative work undertaken by co-located MASH professionals is highly valued across the LSCP and leads to effective and timely information-sharing and child-centred decisions. Prompt and extensive checks and historical information inform analysis of harm and current risk to vulnerable children and their families. Consent to share information is routinely sought, or appropriately overridden when necessary to safeguard children.

MASH staff work together to understand the impact on children of domestic abuse, child exploitation, physical, sexual and emotional abuse, and poor mental health and neglect. Professional curiosity and respectful challenge when consulting parents help families to understand concerns for their children.

Management direction and analysis about next steps guide practice and are clearly recorded. Daily MASH information-sharing meetings are an effective multi-agency forum, helping professionals understand and share known risks for children or families. Professionals quickly prepare useful summaries of key risk and protective factors to inform the course of action to be taken. All partners contribute to a holistic picture of the child's lived experience, with school information in particular helping to articulate the voice of the child and the impact on the child of known concerns.

The process of accessing the MASH is swift, simple and easy for health, police and school leaders. Where they identify concerns, maternity services use a safeguarding notification MASH information request form when booking newly pregnant women. Women are informed about any referral, which is also shared with health visitors and GPs. Maternity services report that the police are responsive to escalating risk and they have a good working relationship with them. Leaders accept that hospital discharge plans following the birth of vulnerable babies are not being compiled and shared early enough.

Headteachers and designated safeguarding leads in schools are actively involved in LSCP sub-groups. They have effective systems to identify children in need of help or protection and they make timely referrals to early help or children's social care when appropriate. Children receive good support within schools and from external agencies. Operation Encompass is embedded within the MASH, ensuring that most police information about domestic abuse incidents is shared with schools. This helps to ensure that vulnerable children can be identified and supported within their education settings. School leaders highly value the role of school police officers, whose bespoke support across schools and direct support for pupils are preventing escalation of harm. Action by school leaders is reducing the disproportionately high

number of Black boys who are being excluded from school. Arrangements for children electively home educated and children missing education are managed well. Levels of risk are prioritised appropriately and the rationale for decisions is recorded clearly. Professionals respond quickly to children at immediate risk of harm. Police staff understand vulnerability and use risk-assessment tools that support their role in protecting children. Cumulative risk is identified, recorded and shared. Health practitioners within the MASH make good use of information about parents' mental health to inform decision-making for children. Particular consideration is given to the potential impact of deteriorating mental health and how this may influence parenting capacity and the child's lived experience.

Most strategy discussions take place promptly. Most include information from partners and result in appropriate multi-agency action. However, the referral and assessment teams are not consistently including some agencies in these discussions or giving them updates following meetings. This means that some services that are actively supporting a child may not be aware of the current safeguarding concerns, which limits their ability to keep them safe.

Child protection investigations are mainly thorough. Most children are seen alone and there is evidence of persistent child-centred social work to engage the child and parents across teams and services. Proportionate action is taken to safeguard and prevent harm escalating for most children. A diverse workforce that reflects the local community is a real strength, leading to better engagement by children and their parents. Consideration of family identity, diversity and inequality is integral to assessments.

Knowledgeable workers use a range of tools, including games, to understand and evaluate children's unique and diverse needs. Although the quality does vary, analysis using children's services social work motivational practice tool is assisting practitioners to identify harm and risk. The tool also helps parents understand what professionals are worried about, although the written records involved can be formulaic and repetitive. Gaps in training have limited the extent to which frontline practitioners and their managers across the wider partnership are able to use this tool in child protection conferences to measure risk and harm.

More work is required by partners to strengthen communication internally within their agencies to ensure that the right people receive the right information. For example, the outcomes of strategy discussions are not consistently being recorded on police systems; therefore, officers attending future crime incidents may not know about the family history when assessing current risk or harm. School record-keeping is not always ensuring that key information is immediately put on children's files; therefore, school professionals may not have access to up-to-date safeguarding information.

Adult mental health services' oversight of safeguarding children practice is underdeveloped. This is compounded by an electronic patient records system that does not assist in capturing children's details. Leaders were able to speak about safeguarding conversations that had been held with practitioners. However, no evidence was seen of adult mental health practitioners identifying a safeguarding concern for a child and making a referral to the MASH. There are currently limited processes in place in adult mental health teams to proactively monitor child safeguarding practice. Leaders are aware that this requires improvement.

The LSCP has identified supporting children at risk of extra-familial harm and missing from home and care as key priorities, due to high rates of knife crime and incidents of serious youth violence in the local area. Black Caribbean and African boys and young men are disproportionately represented as victims and perpetrators of serious youth violence in the borough. The partnership revised and strengthened multi-agency child exploitation (MACE) arrangements in early 2022, having identified that previous arrangements were ineffective. More work is needed by strategic leaders to embed and evaluate these changes across teams and services.

The partnership supports vulnerable adolescents well, providing a variety of specialist services that meet their needs. Tenacious child-centred practice with children and young people by skilled practitioners in the child exploitation safe space teams is making a real difference to reducing risks and protecting them from further harm. Decision-making when children are at risk is positive and timely. Prioritising the immediate deployment of officers to arrest perpetrators and make appropriate use of police protection powers prevents children's needs and risk from escalating.

Effective engagement with children and their families in the hospital emergency department helps to identify children who are exploited and those with emotional and mental health difficulties. Staff in the hospital have good access to commissioned services that provide swift help to young people, helping to disrupt the cycle of violence. Young people who have experienced trauma benefit from co-located child and adolescent community mental health and youth offending services, enabling opportunities to work with vulnerable young people to reduce violence and aggression. Weekly multi-agency joint meetings enhance case discussion and ensure that concerns are escalated promptly.

Children's social care responds effectively to risks to children who go missing from home and care. Two dedicated missing persons coordinators complete return home interviews to assess risk. Strategy meetings are convened when a child has been missing for over 48 hours or earlier if the risks are assessed to be high. Police notifications and a missing persons list are shared through the MASH, but these are sometimes delayed. The police response when children go missing regularly is adversely affected by high volumes of work. Staffing capacity within the police

missing persons unit limits the impact police officers can have on preventing future episodes of children going missing.

Performance information and quality assurance processes are improving, and they are increasingly informing LSCP priorities. A shared multi-agency database is in development to improve the analysis reported to the LSCP executive. Muti-agency and single-agency audits accurately identify strengths and areas for improvement. However, auditors are not consistently detailing how improvements can be achieved, and actions are not always tracked and the impact evaluated to inform future priorities.

A wide spectrum of training is available across the LSCP partnership, but uptake of training is not consistent. Leaders have responded to this issue, moving towards a more focused approach to make training more relevant to local needs. Through the LSCP learning sub-group, the partners have created training packs to make analysis and themes from learning reviews more accessible. Leaders recognise that there is more to do to evidence the impact of training on practice.

Skilled and committed frontline early help, social care and health practitioners, police officers and school staff work extremely hard to provide effective support to vulnerable children and their families and to prevent risk and harm escalating. Staff morale is good, despite high demands and complexity in the work, and capacity issues. There are staff shortages out of hours, in the referral and assessment teams and across some health services. Nevertheless, staff report that they feel well supported in their work and professional development by leaders who listen to them and work to ensure that their personal well-being is prioritised, for example if they are subjected to racism and discrimination. Regular safeguarding supervision is available across teams and services, and it is mostly effective.

Working relationships across the partnership at all levels are very positive and productive. A tangible culture of professional accountability and respectful challenge and collaboration between services in Lewisham is impressive. LSCP leaders know their services well. They have the components in place to drive the improvements needed to ensure that children consistently receive the right level of help and protection.

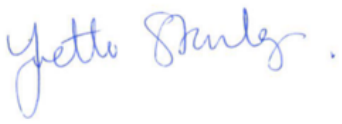
Next steps

We have determined that the London Borough of Lewisham is the principal authority and should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the individuals and agencies that this report is addressed to. The response should set out the actions for the partnership and, when appropriate, individual agencies. The local

safeguarding partners should oversee implementation of the action plan through their local multi-agency safeguarding arrangements.

Lewisham should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 11 May 2023. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely



Yvette Stanley
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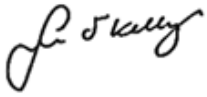

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