CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Annual Report

2025-26

Stronger together. **Safer** together.

Contents

Executive Summary

Impact and Effectiveness

Working Together 2023 was the relevant statutory guidance applicable for the year, however for the purposes of testing the effectiveness of the safeguarding arrangements, the more robust requirements of Working Together 2026 (published March 2026) have been applied as the basis for this annual report.

During 2025–26, the Croydon Safeguarding Children Partnership (CSCP) operated in a context of sustained system pressure, national reform and increasing complexity of need. Across the borough, some of our most vulnerable families experienced overlapping pressures including housing instability, domestic abuse, mental ill-health, neglect, exploitation, online harm and contextual risk. These challenges were experienced alongside workforce shortages, financial constraint and structural change across key safeguarding agencies including Children's Social Care, Health, Police, CAMHS and Probation.

Against this backdrop, the CSCP moved decisively away from describing activity alone and towards demonstrating the difference safeguarding arrangements made for children and families. This Annual Report presents a fair, honest and evidence-based assessment of safeguarding effectiveness in Croydon.

Independent assurance was provided through the Independent Scrutineer, Young Scrutineer and Cabinet process, and through an Ofsted focused visit in February 2026. Inspectors confirmed that children coming to the attention of services generally received timely first responses, thresholds were applied consistently and multi-agency collaboration within the Multi-Agency Safeguarding Hub (MASH) was strong. This provides clear external validation that partnership working is making a tangible difference at the point where risk is highest.

There is also strong evidence of impact across key areas of practice:

- Improvements in Police referral quality and joint working reduced delay at the front door
- Children's Social Care strengthened oversight and reduced drift in long-term child protection planning
- Health partners ensured children presenting in clinical settings were recognised within their family context
- Youth Justice Service demonstrated measurable impact through reduced custody rates and strong prevention work
- Family Hubs provided early help that prevented escalation for families in crisis

At the same time, the CSCP is clear that effectiveness is not yet consistently experienced across all parts of the safeguarding system. Capacity pressures, variable partner engagement, inconsistent data quality and the continued impact of housing instability affect the resilience and sustainability of improvement.

These challenges are not minimised. They represent areas where progress remains fragile and where sustained partnership attention is required to ensure improvement is maintained. They have directly informed the Partnership's priorities for 2026–27.

Evidence sources for this report include quarterly reports, multi-agency audits, partner updates, safeguarding datasets, Quality Assurance Group outputs, learning from Local and National Reviews, and independent scrutiny including the February 2026 Ofsted focused visit.

Reflections from the Delegated Safeguarding Partners (DSPs)

Stuart Collins

Croydon's Corporate Director of Children, Young People and Education; and Delegated Safeguarding Partner (LA)

"2025–26 has been a year of safeguarding practice shaped by sustained pressure, rising demand and increasing complexity in the lives of children and families. Workforce challenges, placement sufficiency and the impact of housing instability have continued to place significant strain on Children's Social Care and the wider system. These demand pressures are overlaid by central government mandated reforms across social care, SEND and youth justice services.

A key point of assurance this year was the February 2026 Ofsted focused visit, which confirmed that children coming to the attention of services were receiving timely and appropriate responses at the front door. The findings reflected not only the work of Children's Social Care, but the strength of multi-agency collaboration within MASH and a shared commitment to consistent thresholds and effective information-sharing.

The partnership has also used audit, data and professional challenge more confidently to identify drift and delay, particularly within long-term child protection planning. Strengthened oversight and clearer expectations around progression and permanence have contributed to tangible improvement, including a reduction in the number of children remaining on child protection plans for extended periods.

At the same time, the partnership has been honest about the challenges that remain. Assessment timeliness, placement sufficiency and the safeguarding impact of housing instability cannot be addressed by the Local Authority alone. The collective recognition of these risks, and the shared accountability set out in Working Together 2026, has been a defining strength of the partnership this year.

Overall, this has been a year in which the partnership has shown increasing maturity in naming risk, responding to scrutiny and using evidence to drive improvement. Sustaining progress will depend on maintaining this shared responsibility and focus on what makes the greatest difference for children."

June Okochi

Director of Quality South West London ICB and Delegated Safeguarding Partner (Health)

"During 2025–26, the Partnership has operated within a period of significant system transformation, driven by ICB reform alongside sustained and complex safeguarding demand. Despite organisational change, partners have maintained a strong focus on safeguarding children, with continued emphasis on embedding a Think Family approach across health services.

Health agencies have strengthened the identification and response to children's safeguarding needs across key settings, including Emergency Departments, primary care, mental health and sexual health services. Learning arising from audits, reviews and case analysis has been systematically shared through professional forums, safeguarding networks and supervision structures, enhancing practitioner awareness of children as victims in their own right, particularly in relation to domestic abuse, child sexual abuse and parental vulnerability.

The Partnership has demonstrated a mature and transparent approach to risk management and challenge. Pressures affecting safeguarding capacity across health services, including CAMHS and MASH contributions, have been openly recognised and escalated through governance arrangements, reflecting a culture of shared accountability and collective responsibility for safeguarding outcomes.

Overall, the Partnership's key achievement has been its ability to sustain safeguarding focus and partnership effectiveness during a period of substantial structural change. Looking ahead, priorities include stabilising safeguarding capacity, ensuring learning is consistently translated into frontline practice, and strengthening evidence of the impact that improved health engagement has on outcomes for children and families."

Lewis Collins

Detective Superintendent Metropolitan Police and Delegated Safeguarding Partner (Police)

"From a police perspective, safeguarding children in Croydon during 2025–26 has taken place against rising demand and increasing complexity of harm, including online abuse, exploitation and serious youth violence. These challenges have required policing responses that are both operationally robust and firmly child-centred.

The work of the partnership this year aligns closely with the intentions of the Metropolitan Police Children's Strategy, particularly the emphasis on placing the child at the centre of decision-making, strengthening information-sharing and working collaboratively with partners. Improvements in safeguarding referral quality and joint working within MASH have reduced delay and strengthened front-door decision-making for children where risk is identified.

Police have also maintained a focus on reflective practice through mechanisms such as the 'Every Child Every Time' audit process, which places children's lived experiences at the centre of scrutiny. Alongside this, specialist responses to child-on-child sexual abuse, online harm and exploitation have continued to develop through enhanced capability and collaboration with specialist units.

Importantly, the partnership has engaged openly with challenge. Capacity pressures and necessary adjustments to how Police engage in some safeguarding forums have been discussed transparently rather than defensively, enabling adaptation while maintaining safeguarding responsibility.

From a policing perspective, the strength of the CSCP lies in its shared ownership of risk and commitment to the principles of the Children's Strategy. Sustaining progress will require continued investment in partnership working and effective information-sharing across agencies."

Keith Makin

CSCP Independent Scrutineer

"As the Independent Scrutineer, my role during 2025–26 has been to provide challenge and assurance regarding the effectiveness of safeguarding arrangements in Croydon. Evidence across the year demonstrates a partnership that is increasingly willing to test its own effectiveness, engage in respectful professional challenge and use learning to inform improvement.

Strengths include improved front-door working, more purposeful use of audit and data, and a clearer focus on impact rather than activity alone. The February 2026 Ofsted focused visit provides important independent validation that children are being appropriately identified and protected at the point of highest risk, while ongoing audit activity demonstrates growing confidence in self-scrutiny.

The partnership has also been appropriately honest about its limitations. Capacity pressures within MASH, Health and CAMHS services, variability in data quality and the systemic impact of housing instability remain significant risks. Importantly, these issues have not been minimised and have been consistently escalated through governance.

Engagement with children and young people, alongside strong voluntary and community sector involvement, provides further assurance that safeguarding is not viewed solely through statutory lenses. This was

particularly well evidenced at the CSCP Annual Conference, co-delivered with Reaching Higher. Feedback demonstrated the event's impact, with some attendees describing 'lightbulb' moments in their safeguarding awareness.

Overall, my judgement is that safeguarding arrangements in Croydon are effective and improving, though not yet consistent across all areas. The partnership's openness to challenge, commitment to learning and recognition of shared responsibility provide a strong foundation for continued improvement."

The CSCP Shared Values and Focus Areas

All CSCP members uphold and champion the following shared values, embedding them into their work. The CSCP actively seeks to evidence how these values are demonstrated and achieved across its safeguarding commitments.

The CSCP's key focus areas for 2025–27 align with the expectations set out in Working Together 2026 and are as follows:

Shared Values	Focus Areas
Outcomes-focused Working collaboratively with families, communities and professionals to create opportunities that empower children to reach their full potential. **Voice of the Child** We actively seek children's perspectives and champion their use in improving safeguarding practice. **Trauma-informed** Trauma-informed practice is the foundation of effective safeguarding. **Ownership and Commitment** We each value accountability and reliability and we each commit to delivering high-quality actions and tasks on time. **Equitable Practice** Culturally competent with a commitment to equity across all protected characteristics. **Holding to Account** Respectful challenge or enquiry of all agencies to ensure accountability and transparency.	**Focus 1** Evidence the impact of the work of safeguarding partners to improve outcomes for children. What are we doing and how do we know it is effective? **Focus 2** Evidence the impact of existing partnership priority areas. For the areas/cohorts we are already concerned about, how do we know agencies are making a difference? **Focus 3** Be assured that organisational standards are in place and are effective. Are Section 11 self-assessments, or other appropriate assurance processes, being completed to a good standard? **Focus 4** **Communication**: Strengthening communication processes to ensure learning from local and national reviews, including Rapid Reviews, is shared effectively, understood and embedded into practice. **Focus 5** Promote effective multi-agency working and constructive professional challenge to support accountability, transparency and better safeguarding outcomes.

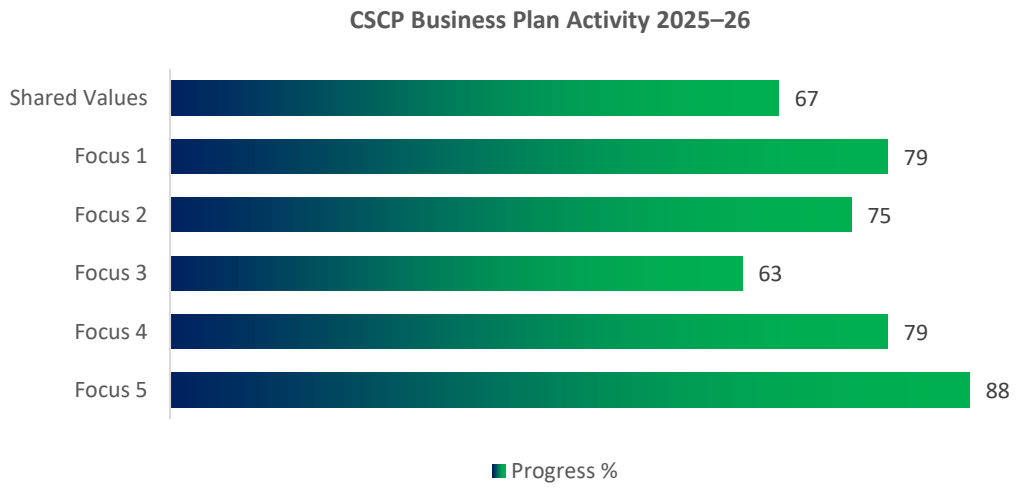
Partnership Activity

The CSCP Business Plan is aligned to the requirements of Working Together 2026, providing assurance that partner agencies are working effectively together to safeguard and promote the welfare of children. Progress across all five strategic aims demonstrates strong partnership engagement and increasing delivery against agreed priorities. It should be noted that we are halfway through a two-year business plan, so progress over 50% is positive.

Overall Progress

- Shared values have improved significantly from 50% in Q1 2025–26 to 92% in Q1 2026–27, indicating strong alignment across partner agencies.
- All five strategic aims show sustained progress, with several areas now exceeding 80% completion.
- Governance activity is well established, with most actions either completed or in final sign-off stages across partnership groups.

Progress Against Strategic Aims



The partnership continues to demonstrate strong progress against its statutory safeguarding responsibilities. Significant advances have been made in embedding shared values, strengthening communication, evidencing impact and improving multi-agency working. Governance arrangements are mature, with the majority of actions completed or finalised, providing assurance that the CSCP is effectively delivering its responsibilities under Working Together 2026.

Partnership Engagement and Meeting Attendance

Partner participation is a key measure of the effectiveness of local safeguarding arrangements. Consistent contributions from agencies provide the assurance, challenge and intelligence needed to identify emerging risks, monitor performance and drive improvement across the Partnership.

Effective partnership working depends not only on attendance at meetings, but also on how consistently agencies contribute to the wider work of the CSCP. During 2025–26, participation was therefore monitored across two distinct but complementary areas:

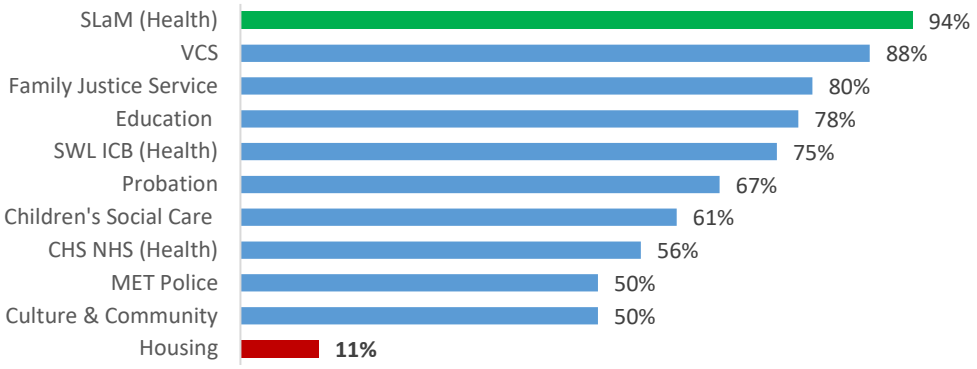
- **Partner engagement** reflects how consistently agencies responded to Partnership communications and requests for information, including data submissions, partner updates, audit activity and other assurance requests.
- **Meeting attendance** measures agency representation across the Partnership's governance structure, including attendance at the Executive and relevant sub-group meetings.

Considering these measures separately provides a clearer picture of participation. An agency may, for example, attend meetings regularly but be less consistent in responding to data or assurance requests, while another may contribute strongly to Partnership activity despite variable meeting attendance.

Guest attendance reflects the involvement of external organisations, practitioners and subject-matter experts who are invited to governance meetings to present reports, share learning, provide specialist advice or contribute to discussions on emerging safeguarding issues. Guests are not members of CSCP governance groups and are therefore not expected to attend routinely. Attendance figures are shown to demonstrate the Partnership's use of external expertise and its commitment to informed decision-making. Contributions during 2025–26 included presentations on national reviews, thematic safeguarding activity, inspection findings and emerging local risks.

Taken together, these measures provide a fuller picture of how actively agencies participate in and contribute to the local safeguarding arrangements. Engagement during 2025–26 varied across the Partnership. While some agencies consistently provided information, attended meetings and contributed to partnership activity, others participated less frequently, creating gaps in the assurance available to the Executive Group. The findings below highlight the strengths of multi-agency collaboration and the areas requiring further improvement to support effective safeguarding governance.

Partner Engagement



Meeting Attendance

Partner Agency	Executive Group	Review Group	Quality Assurance Group	Editorial Group	Dataset Group
Chair (Named Person)	100%	100%	100%	100%	100%
Colleges / Schools	-	-	50%	-	-
Commissioning	-	-	33%	-	-
CYPE: Family Hubs	-	-	67%	-	-
CYPE: Corporate Director	83%	-	-	-	-
CYPE: CSC	83%	75%	83%	40%	100%
CYPE: Data Team	-	-	-	-	100%
CYPE: Education	50%	100%	33%	80%	100%
CYPE: Quality Assurance	-	75%	100%	80%	100%
CYPE: Youth Justice Service	-	50%	50%	-	100%
Family Justice Service	-	-	-	-	67%
Guest	50%	50%	83%	100%	-
Health: CHS NHS	100%	100%	100%	100%	100%
Health: SLAM / CAMHS	67%	100%	83%	80%	100%
Health: SWL ICB	67%	100%	100%	100%	100%
Housing	83%	50%	50%	-	33%
Independent Scrutineer	83%	75%	100%	-	-
MET Police	100%	75%	100%	80%	67%
Probation	-	-	50%	-	-
Public Health	-	50%	-	-	-
Culture & Community	-	-	33%	-	-
VCS	-	-	50%	100%	100%
VCS: CGL	-	-	-	-	0%
Young Scrutineer	67%	-	-	-	-

KEY

	Consistently strong attendance
	Generally good attendance with occasional gaps
	Attendance needs strengthening
-	Not part of this group's membership
	Guests are not mandatory members of this group.

** Attendance percentage for each partner agency across CSCP governance groups is based on scheduled meetings for 2025–26.*

Croydon's Safeguarding Context

Croydon is one of London's most diverse boroughs, with children growing up in communities that experience both opportunity and significant disadvantage. During 2025–26, partnership data, audit findings and review activity consistently highlighted that children and young people experiencing harm are affected by multiple and overlapping harms, rather than single issues in isolation.

Croydon has a large and relatively young population, with approximately one in four residents aged under 18, highlighting the continued importance of strong, responsive services for children and young people across the borough.

Key Performance Metrics Summary

This section provides a strategic evaluation of key performance indicators within Children's Services, comparing outcomes and activity levels between the 2024–25 and 2025–26 reporting periods.

The overall trajectory of the service is highly encouraging, with positive progress observed in eight of the thirteen primary performance measures. Four measures have remained stable within normal operational tolerances, whilst only one metric (Early Help re-referrals) has registered a slight increase in pressure.

Indicator / Performance Area	2024–25	2025–26	Variance	Strategic Status
Early Help Referrals (Avg. Monthly)	205	206	+1	Stable
Early Help Re-referrals	15%	17%	+2%	Of Interest
Contacts to MASH (Avg. Monthly)	2,126	2,099	-27	Stable
Referrals (Avg. Monthly)	663	644	-19	Slight Improvement
Referral Re-referrals	27%	21%	-6%	Improved
Child Protection Plans (Total Cohort)	599	554	-45	Improved
CPPs Lasting 2+ Years (Duration Rate)	50 (8.3%)	24 (4.3%)	-26	Significant Improvement
Repeat Child Protection Plans	24%	19%	-5%	Improved
Missing Children (Avg. Monthly)	86	70	-16	Improved
Children Looked After (Total Placements)	551	555	+4	Stable
UASC Population	101	98	-3	Stable
Children in Custody	7	4	-3	Improved
First-time Entrants to Youth Justice	272	231	-41	Improved

Comparison with 2024–25 demonstrates a mixed but largely positive picture of safeguarding effectiveness. The partnership has achieved significant improvements in several outcome-focused indicators, including reductions in repeat referrals, long-term Child Protection Plans, missing children episodes, youth custody and

first-time entrants to the youth justice system. These improvements suggest that children are receiving more effective interventions and that safeguarding responses are becoming increasingly targeted and preventative.

However, these gains have been achieved against a backdrop of increasing workforce pressure. Caseloads have risen across several service areas; the timeliness of assessments has declined and performance against some statutory Children Looked After measures has worsened. This indicates that, while outcomes for many children are improving, the sustainability of these improvements cannot be assumed. Workforce resilience, assessment capacity and the quality-of-care planning remain significant priorities for 2026–27.

Safeguarding at a glance

This snapshot provides an overview of key indicators from 2025–26, highlighting the areas where partners have focused their collective efforts to prevent harm, respond to risk, and improve outcomes. Together, these measures provide important context for the work described throughout this report.

Domestic abuse remained a pervasive feature of safeguarding activity and frequently intersected with neglect, parental mental ill-health and housing instability. Audit and review learning repeatedly reinforced that children affected by domestic abuse are victims in their own right, a principle that aligns directly with the strengthened expectations set out in Working Together to Safeguard Children 2026.

Child sexual abuse, including intrafamilial abuse and child-on-child sexual abuse, emerged repeatedly as a form of harm that is hidden, cumulative and difficult to identify. Learning from national and local reviews highlighted the importance of professional curiosity, clear articulation of risk and robust multi-agency responses where indicators may be subtle or fragmented.

Adolescents in Croydon were increasingly affected by contextual and extra-familial harm, including exploitation, serious youth violence and online risk. Dataset discussions during the year also identified emerging patterns, including:

- increasing mental health presentations among children under 11
- greater visibility of girls affected by contextual harm and exploitation
- concerns about disproportionality affecting Black children within safeguarding and youth justice systems

The CSCP's understanding of this context matured significantly over the year. In Q1, attendance at dataset meetings and data quality were inconsistent, limiting the depth of analysis. By Q2 and Q3, improved partner engagement and richer data submissions enabled more meaningful reflection on trends, risk and emerging need. Although data quality remains uneven in some areas, the partnership now has a stronger mechanism for identifying where children may be less visible to safeguarding systems and for challenging gaps in partner intelligence.

Review activity throughout the year repeatedly highlighted hidden harm, where children appeared to be coping but were living in unsafe or unsupported circumstances. This reinforced the importance of coordinated, whole-family and child-centred responses, underpinned by early information sharing and professional curiosity.

Data for the following indicators will be collected from Q1 2026–27, in line with the strengthened data and assurance requirements set out in Working Together to Safeguard Children 2026. As this is a new dataset, full-year comparative figures are not yet available.

- **Domestic abuse incidents involving children**
- **Children in temporary accommodation**
- **Homeless families with children**
- **Child sexual abuse incidents**
- **Exploitation referrals**
- **Online harm referrals**
- **Voice of the child participation**

Governance, Leadership and Professional Challenge

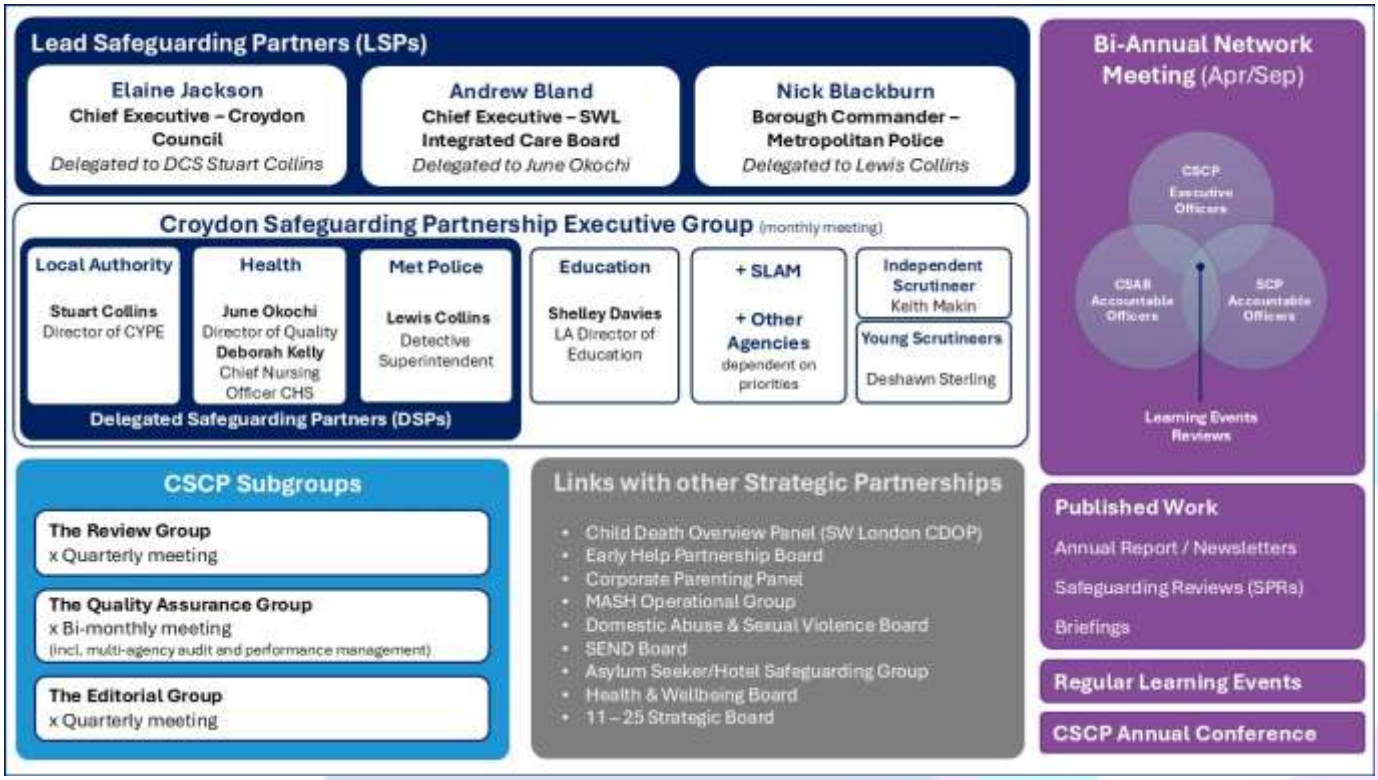
The CSCP operates in line with the statutory requirements of *Working Together to Safeguard Children 2026* and is led by the three Lead Safeguarding Partners:

These partners hold joint accountability for safeguarding arrangements and are supported by Delegated Safeguarding Partners who provide operational leadership.

Strategic oversight is provided by the CSCP Executive Group, supported by a set of integrated sub-groups:

- **Quality Assurance Group** – audit, data and performance oversight
- **Review Group** – rapid reviews, practice reviews and learning from harm
- **Editorial Group** – translating learning into training, guidance and communication

Independent scrutiny is provided through an Independent Scrutineer and strengthened by the inclusion of a Young Scrutineer, ensuring both professional challenge and the voice of children are embedded in governance.



Income and Expenditure

The income and expenditure for the year are set out below:

Income	£	%	Expenditure	£	%
London Borough of Croydon	345,319	77.69%	**Staff and related costs**	392,872	88.4%
Croydon Integrated Care Board	39,010	8.78%	**Independent Scrutineer costs**	25,925	5.8%
Croydon Health Services NHS Trust	33,850	7.62%	**CSCP training provided**	15,700	3.5%
South London and Maudsley NHS Trust	12,186	2.74%	**CSCP Conference (2025–26)** *Partly offset by a £2,500 contribution from Reaching Higher*	6,033	1.4%
Metropolitan Police (MOPAC)	5,000	1.13%	**Other IT costs** *(domain, website hosting and PHEW user licences)*	2,983	0.7%
National Probation Service	3,741	0.85%	**TASP membership**	750	0.2%
Reaching Higher (contribution to conference costs)	2,500	0.56%	**Mailroom, stationery, supplies, CSCP branding, bank charges**	241	0.1%
Income from LMS platform	1,498	0.33%			
Youth Arts *(funding unspent 2024–25)*	1,000	0.22%			
London Councils *(workshop facilitation, VCSE)*	400	0.09%			
TOTAL INCOME	**£444,504**		**TOTAL EXPENDITURE**	**£444,504**	

The resources are sufficient to provide the framework for delivering high-quality safeguarding assurance for Croydon. However, the contributions are not proportional, with the Local Authority bearing over 77% of the cost.

This is partly because staff costs also support non-CSCP business. The Child Death Overview Panel Coordinator role is a 0.5 FTE post, fully funded by the CSCP, while the Business Manager co-chairs the MASH Operational Group and supports a number of local authority workstreams.

The Metropolitan Police Service is increasing its contribution, in line with arrangements across London, to £25,000 for 2026–27. This is welcome and will reduce the overall percentage contributed by the local authority to CSCP funding.

The income generated by the CSCP is notable, as most local safeguarding children partnerships do not generate their own revenue. It reflects previous investment in systems that support the development of chargeable, high-quality resources, together with the subject-matter expertise of the CSCP Business Team. This income-generating activity is expected to continue in 2026–27.

Leadership during the year was characterised by a shared understanding of risk and responsibility. Safeguarding standards were not lowered in response to pressure. Where risks emerged – including inconsistent data submission, poor training attendance, concerns about MASH capacity, reduced CAMHS safeguarding capacity and gaps in partner engagement – these were openly discussed, escalated and revisited through governance arrangements.

Examples of this include:

- Escalation of CAMHS safeguarding capacity concerns to Executive level when the safeguarding lead role reduced to part-time.
- Sustained Executive scrutiny of MASH capacity, particularly in relation to Health input.
- Challenge to inconsistent attendance and engagement from some partners, including Housing, resulting in improved participation in governance activity later in the year.

By Q4, Executive discussions had matured to include not only whether arrangements were in place, but whether they were sufficient, sustainable and delivering impact in line with the enhanced expectations of Working Together 2026. The full Multi-Agency Safeguarding Arrangements (MASA) are available on the CSCP website.

The CSCP also presented the previous CSCP Annual Report at Cabinet alongside the Croydon Adult Safeguarding Board (CSAB), demonstrating its commitment to working together to tackle cross-cutting themes such as domestic abuse, suicide prevention and the development of an all-age exploitation strategy.

Safeguarding Partnerships

Multi-Agency Safeguarding Hub (MASH) Effectiveness

The effectiveness of the front door to children's services was one of the most significant areas of focus during 2025–26. The Multi-Agency Safeguarding Hub (MASH) is where safeguarding arrangements are most immediately tested, requiring timely information-sharing, shared thresholds and confident decision-making across agencies. Throughout the year, daily multi-agency working within MASH brought together Children's Social Care, Metropolitan Police, Health, Education and other partners to consider safeguarding concerns and determine the most appropriate response. These included decisions relating to statutory intervention, early help, or No Further Action (NFA) where risk was not substantiated.

The February 2026 Ofsted focused visit provided important independent assurance regarding the effectiveness of these arrangements. Inspectors found that children and families generally received timely first responses, that thresholds were applied consistently by experienced practitioners, and that multi-agency collaboration within MASH was strong. Information-sharing was effective, and management oversight supported sound decision-making. This external validation was a significant marker of system effectiveness. However, the positive position identified by Ofsted was not accidental. Earlier in the year, partner intelligence and quality-assurance activity highlighted a number of challenges that required focused attention. Metropolitan Police safeguarding activity, particularly within CAIT, identified substantial referral backlogs, at one point exceeding 120 cases per day. Inconsistent referral quality and incomplete information delayed decision-making and increased pressure on MASH practitioners.

In response, Police implemented targeted quality-assurance activity focused on improving referral accuracy, completeness and timeliness. This work was supported by closer operational dialogue with Children's Social Care and clearer expectations regarding safeguarding submissions. By mid-year, daily safeguarding backlogs had reduced to fewer than 20 cases, significantly improving the timeliness of decisions for children and reducing the risk of drift at the point of entry into the system.

Alongside this, the MASH Operational Group began a programme of audits examining referrals that resulted in No Further Action. These audits were deliberately framed not as a compliance or blame exercise, but as an opportunity to understand whether opportunities for early help or protection were being missed. Learning from this work identified variability in how risk was articulated across agencies and highlighted the importance of clear, child-focused narratives within referrals. As a result, revised operating processes, clearer expectations of partner contributions and stronger escalation pathways were developed.

Despite these improvements, the partnership has been clear about ongoing risks to sustainability. Assessment delays, high caseloads within the Family Assessment Service and limited capacity from Health and CAMHS partners present continuing challenges. Working Together to Safeguard Children 2026 places explicit shared responsibility on safeguarding partners to ensure that front-door arrangements are sufficiently resourced. As a result, the CSCP Executive Group has maintained active scrutiny of MASH capacity and requested assurance from partners regarding mitigation and future planning.

WHAT DIFFERENCE DID WE MAKE?

Improved timeliness and quality of decision-making at the front door. Children were seen and protected more quickly, with Ofsted (February 2026) confirming effective multi-agency working. Risks to sustainability are better understood and actively escalated. Health partners agreed to start working in person within MASH.

Providing Help, Support and Protection – Working with the Whole Family

Beyond the front door, Croydon continued to strengthen a whole-family approach to safeguarding and support throughout 2025–26. This approach recognises that children's experiences of harm and risk cannot be understood in isolation from family circumstances, environmental stressors and wider structural factors.

Family Hubs played a central role in delivering early help across the borough. Acting as accessible points of contact, Family Hubs enabled earlier identification of need and provided coordinated, relational support to families experiencing domestic abuse, financial hardship, housing instability and parental mental health difficulties. Navigator-led support focused on understanding family context, reducing immediate stressors and maintaining engagement with services.

Partner updates provided clear examples of early help preventing escalation. In several cases, sustained navigator involvement ensured that children's immediate needs for safety, warmth and care were met during periods of crisis, including homelessness and domestic abuse. This support often acted as a stabilising factor while longer-term statutory processes were ongoing, reducing the likelihood of escalation into child protection.

Safeguarding assurance activity within Family Hubs demonstrated that staff understood safeguarding responsibilities and escalation pathways, and that concerns were appropriately shared with statutory partners when risk increased.

At the same time, the year highlighted ongoing structural challenges that limited the effectiveness of early help. Housing instability emerged as one of the most significant and persistent drivers of safeguarding risk across the system. Children's Social Care partner updates repeatedly described the extent to which housing issues directly impacted children's safety and wellbeing, often requiring intervention under Section 17 to mitigate risk after housing duties had been discharged.

This creates a structural pressure within the system, where statutory safeguarding services are required to respond to risks that originate from wider housing constraints rather than parental behaviour alone. Families experiencing homelessness or insecure housing are more likely to face additional risks, including overcrowding, disrupted education, increased stress and heightened vulnerability to exploitation and harm. They are also harder to track and more likely to disengage, increasing the risk that children become less visible to safeguarding systems.

The CSCP has been clear that, while early help and statutory intervention can mitigate immediate risk, housing instability is a wider system issue that cannot be resolved by safeguarding services alone. Addressing it will require stronger alignment between housing and safeguarding systems, clearer escalation routes and sustained strategic focus. The wider Partnership still needs to make fuller use of both Family Hubs and the support offered by the voluntary, community, social enterprise and faith sectors.

WHAT DIFFERENCE DID WE MAKE?

Children and families received earlier, more coordinated support, with Family Hubs helping to stabilise crises and reduce escalation. Multi-agency working improved how risks were identified and responded to, although housing instability continues to limit sustained impact.

Children Experiencing Multiple and Overlapping Harms

One of the clearest learning themes from 2025–26 was the extent to which some of the most vulnerable children in Croydon experience multiple, overlapping harms. Domestic abuse, neglect, child sexual abuse, mental health escalation, exploitation and online harm frequently coexist, requiring practitioners to maintain professional curiosity and avoid treating one presenting issue as the full picture.

Domestic abuse remained a consistent feature of safeguarding activity throughout the year. Audit and review learning demonstrated that children affected by domestic abuse are victims in their own right, often experiencing cumulative harm even where they are not the direct target of abuse. This learning informed revised guidance, training content and contributed to wider strategic work, including Public Health's Violence Against Women and Girls strategy.

Child sexual abuse (CSA) emerged repeatedly as a form of harm that is often hidden, intrafamilial and difficult to identify. Learning from national reviews informed local audit frameworks, which in turn shaped the development of the Strengthening CSA Practice programme. This programme aimed to improve practitioner confidence, professional curiosity and multi-agency responses to CSA, recognising that indicators may be subtle and risk may escalate over time rather than presenting as a single incident.

In response, the partnership developed a bespoke webinar training series focused specifically on child sexual abuse. This training was designed to strengthen understanding of CSA, improve recognition of subtle indicators and support more confident safeguarding decision-making. Legacy learning resources were also developed to ensure that key messages and tools remained accessible for ongoing workforce development.

Online harm and exploitation were increasingly visible during the year. Metropolitan Police updates described specialist work in response to online CSA, including the use of AI-enabled technology to scan and interrogate devices and collaboration with specialist units such as the Regional Organised Crime Unit. Education partners continued to signpost schools to online safety guidance and training, while health partners, including Croydon Health Services, incorporated online harm into safeguarding training and supervision.

Health partners made a significant contribution to the recognition of multiple harms. Children presenting through Emergency Departments, sexual health services and primary care were increasingly recognised as safeguarding cases rather than isolated clinical incidents. Learning from domestic abuse, mental capacity and suicide reviews was shared through GP forums and safeguarding networks, strengthening professional understanding and improving information sharing with Children's Social Care and MASH.

The CSCP is clear that, while awareness and practice have improved, measuring the population-level impact of this work remains challenging. There is good evidence that training, audits and resources have strengthened recognition and response, but less consistent evidence that this has reduced harm across the population. This remains a priority for 2026–27.

WHAT DIFFERENCE DID WE MAKE?

Recognition and response to multiple harms improved, with practitioners better identifying overlapping risks such as domestic abuse, CSA and exploitation. Targeted training, audits and strengthened multi-agency working have increased professional curiosity and earlier intervention, although consistent evidence of reduced harm at a population level is still developing.

Adolescents, Exploitation and Contextual Safeguarding

Safeguarding adolescents remained a critical focus for the Croydon Safeguarding Children Partnership throughout 2025–26. Partner updates consistently highlighted the complexity of adolescent risk, particularly where harm occurs outside the family home and is shaped by peer relationships, community environments, online spaces and wider structural pressures.

Contextual and extra-familial harm in Croydon includes serious youth violence, criminal and sexual exploitation, online harm and peer-on-peer violence. These risks are often dynamic and rapidly evolving, requiring coordinated responses across Police, Youth Justice, Education, Children's Social Care, Health and community partners.

The Youth Justice Service (YJS) provided some of the strongest evidence of sustained impact across the year. Despite operating with reduced management capacity, YJS consistently demonstrated effective safeguarding through prevention, participation and partnership working. Quarterly data showed historically low custody rates and reductions in serious youth violence, supported by strong court confidence in YJS assessments and plans.

Mock inspection activity and audits undertaken by YJS highlighted improvements in systemic practice, while also identifying areas requiring continued development, including consistency of parental inclusion and articulation of theory within assessments. Rather than minimising these findings, YJS used audit learning to inform in-house training and management oversight.

YJS placed the voice of the child at the centre of adolescent safeguarding. Children engaged directly with senior leaders and national figures, influencing discussions about education, custody and safety. Youth participation activity included structured engagement, creative methods and youth-led contributions to partnership events.

Following serious incidents in the borough, including stabbings, YJS worked jointly with Metropolitan Police to identify children at potential risk, review peer groups and support early safety planning with families. This coordinated response enabled some families to keep children safe at home during periods of heightened risk, reducing escalation and disruption.

Police contributions to adolescent safeguarding included specialist responses to exploitation, child-on-child sexual abuse and online harm. Partner updates described increased use of AI-enabled technology to scan and interrogate devices, collaboration with the Regional Organised Crime Unit and participation in strategic and operational MACE processes.

Education partners contributed to adolescent safeguarding by supporting schools to recognise early indicators of exploitation and online harm, strengthening referral quality and participating in multi-agency discussions. Health partners supported identification of exploitation and mental health escalation through Emergency Departments, sexual health services and CAMHS.

Despite these strengths, partners were clear that contextual safeguarding remains resource-intensive and challenging. Placement availability for children leaving custody, workforce capacity and the complexity of adolescent risk continue to place pressure on the system. Sustained partnership focus and investment will be required to maintain and build on progress.

In 2024–25, Ofsted inspected six areas under the Joint Targeted Area Inspection (JTAI) theme of serious youth violence (SYV). The CSCP Business Team created a benchmarking tool to assess the effectiveness of Croydon's multi-agency response to serious youth violence. It provided a structured approach to evaluating partnership arrangements, frontline interventions and strategic planning against national standards and best practice.

The overall score was 45 out of 50, placing Croydon in the upper threshold of 'Progressing Well' and demonstrating a solid and maturing approach, particularly in strategic coordination and outcome delivery. While the borough is close to entering the 'Highly Effective' tier, targeted improvements are needed to strengthen consistency, data use and family engagement.

The CSCP developed and launched a bespoke Contextual Safeguarding eLearning course to strengthen practitioner understanding of extra-familial harm, exploitation, online risk and adolescent safeguarding. The course was specifically designed around emerging themes identified through local audits, reviews, serious incidents and partnership datasets, ensuring the learning reflected the lived experiences of children and young people in Croydon rather than relying solely on generic national content.

WHAT DIFFERENCE DID WE MAKE?

Improved multi-agency coordination and strong Youth Justice practice contributed to reductions in custody and serious youth violence. Children at risk of exploitation were identified earlier and supported more effectively, although the complexity and resource demands of contextual safeguarding remain significant.

Voluntary, Community and Faith Sector Engagement

Engagement with the voluntary, community and faith sector was a significant strength of the partnership during 2025–26 and extended safeguarding reach beyond statutory services.

The CSCP Quality Assurance Officer led targeted engagement with a wide range of community organisations, including evangelical churches, mosques, youth organisations, holiday activity providers, libraries and voluntary sector networks. This work focused on strengthening safeguarding awareness, improving policies and procedures and supporting organisations to understand escalation pathways.

Examples of this work include:

- Presentations to over 60 participants from evangelical churches, resulting in multiple organisations requesting safeguarding support.
- Direct support to a small Pentecostal church with no previous safeguarding arrangements, leading to the development of basic safeguarding processes.
- Collaboration between London Road Mosque, Young Roots, Police and community organisations to support children and young people seeking asylum.
- Completion of the Section 11 tool on the PHEW platform by P4YE, strengthening safeguarding assurance.

This work was recognised beyond Croydon. The CSCP's approach to voluntary and faith sector engagement was presented at the London Safeguarding Children Partnership Summit and shared through a national webinar for LSCP business managers, positioning Croydon as an example of good practice.

WHAT DIFFERENCE DID WE MAKE?

Safeguarding reach was extended into communities that may not routinely engage with statutory services. Community confidence increased, safeguarding arrangements in smaller organisations were strengthened, and new pathways for early identification and support were created.

Education and Safeguarding in Schools

Throughout 2025–26, Education partners delivered robust early intervention, training, and targeted support across the borough.

For example, the Croydon Education Partnership Wellbeing Conference at Selhurst Park focused on training education professionals in child mental health, trauma-informed practice and emotionally based school avoidance (EBSA). More than 90 Croydon schools attended, with 80% enrolling in further training, forums and resources.

In addition, the Croydon Wellbeing Mark was established as a framework for best practice and awarded to more than 30 schools for outstanding mental health support for children and young people. This work responded to findings from the Croydon Children and Young People's Health and Wellbeing Survey commissioned by Public Health.

To embed stronger safeguarding cultures in schools, Education partners facilitated the Year 6–7 Transition Programme, a two-week summer-term initiative covering identity, online safety and risk awareness. It included a Safeguarding Day that brought primary and secondary designated safeguarding leads together to strengthen handovers for vulnerable children, alongside online safety workshops for parents and carers.

Partners delivered governor audits and training focused on safeguarding culture and practice, as well as joint safeguarding audits with governors to strengthen direct scrutiny and leadership accountability. They also integrated trauma-informed training into designated safeguarding lead check-ins and forums, attended by more than 50 Croydon schools, to address neglect and online harm.

Partners continued to facilitate multi-agency 'Missing Mondays', a weekly collaboration between local authority Attendance and Inclusion Officers, schools and families to identify children missing education quickly and provide early intervention.

Education repeatedly escalated formal concerns regarding Children's Social Care (CSC) communication, specifically unnotified case closures and missing strategy discussions, shaping Executive discussions on thresholds and information-sharing.

Education partners also strengthened quality assurance scrutiny. The CSCP welcomed three new school representatives to its Quality Assurance Group, improving representation from the independent sector, primary and secondary schools, and a pupil referral unit.

WHAT DIFFERENCE DID WE MAKE?

Earlier Identification: Missing Mondays and DSL handover days closed critical information gaps during transitions, securing swift support for high-risk pupils.

Stronger Governance: Joint audits shifted governor oversight from passive compliance to active, informed accountability.

Improved System Alignment: Sustained challenge improved multi-agency communication and threshold clarity with Children's Social Care.

Embedded Trauma-Informed Practice: Wide adoption of the Wellbeing Mark and trauma training equipped schools to proactively address emotionally based school avoidance, online risks, and student mental health

Equity, Disproportionality and Anti-Discriminatory Practice

Equity and anti-discriminatory practice were explicitly prioritised during 2025–26 and embedded within the CSCP Business Plan. Partner updates, audit activity and dataset discussions increasingly referenced trauma-informed practice, culturally sensitive approaches and the need to address disproportionality within safeguarding systems.

Data and review activity continued to highlight the over-representation of Black children within safeguarding and youth justice systems. At the same time, limitations in ethnicity and gender recording were identified as a significant barrier to understanding differential outcomes fully. These limitations were particularly evident in data submissions from some partners, including Police, Croydon Health Services and parts of the voluntary sector.

In response, the CSCP engaged directly with national learning on racism and safeguarding, including the *It's Silent* report. Reflective discussions within Children's Social Care generated specific pledges to strengthen culturally competent practice. Youth Justice refreshed its disproportionality action plan and launched an Anti-Racist Policy, while cultural competency training was developed and progressed through the Editorial Group.

Family Hubs and voluntary sector partners also demonstrated culturally sensitive practice, supporting families who may be less likely to engage with statutory services. This included work with asylum-seeking families, faith communities and newly arrived children and young people.

WHAT DIFFERENCE DID WE MAKE?

The CSCP moved equity from aspiration into more visible activity. Agencies developed training, policies and reflective practice aimed at improving culturally competent safeguarding. However, the CSCP is clear that it cannot yet evidence the full impact of this work because data quality remains inconsistent. Improving ethnicity recording and using data to understand disproportionality and outcomes must therefore remain a core priority for 2026–27. An audit specific to racism and anti-racist practice is planned for September 2026.

Impact of Current Partnership Priorities

Priorities During 2025–26

The table below outlines how the partnership has delivered against its 2024–25 priorities during 2025–26, including the difference this has made for children and families.

What we said	What we did	What difference did it make?
Embedding CSCP Shared Values	• Published new arrangements incorporating Working Together 2026 requirements. • Shared values examples captured at every CSCP meeting.	• Greater clarity of roles, responsibilities and accountability across partners. Improved line of sight between frontline practice, audit learning and strategic decision-making.
Embedding a Whole Family Approach		
More Croydon-specific Learning	• Created CSCP-specific learning resources. Delivered annual safeguarding conference with a strong focus on Voice of the Child, including direct participation from young people. • Introduced revised training model supported by a new Learning Management System, increased eLearning access, expanded Level 2–3 training and targeted inputs (CSA, DA, online harm, cultural competency).	• Legacy resources, tailored to Croydon. Increased visibility of children's voices within training and strategic planning, contributing to a more child-centred safeguarding culture. • Increased access to and participation in safeguarding training. However, attendance at face-to-face sessions remains inconsistent. Clear next step identified: evidencing impact on practice, not just completion.
Embedding Equitable Practice	• Used governance structures to highlight duplication across multi-agency forums, improve clarity of purpose, and strengthen alignment between safeguarding, community safety and health agendas.	• Increased ability to identify gaps and avoid duplication, though continued monitoring required as system reforms evolve
Brent LSCP – online harm	• The CSCP Independent Scrutineer also serves as Brent LSCP's Independent Scrutineer. Online harm is a priority for Brent, and the two partnerships are sharing information to avoid duplicating activity.	• Online resources and access to other training are now more visible.
Neglect	• Continued development of Family Hubs, including navigator-led support, improved safeguarding governance. • Launch of a multi-agency SWL Neglect Strategy • Launch of Croydon's Multi-Agency Pre-birth Guidance	• Earlier identification of need and prevention of escalation. • Children benefited from coordinated whole-family support, although impact remains constrained by wider system pressures such as housing instability. • New guidance provides clarity for multi-agency partners working at pace

What we said	What we did	What difference did it make?
	• Intention to refresh the Graded Care Profile 2 tool	to create a more aligned system to protect vulnerable babies.
Publication of Suicide/Self Harm Cluster Strategy	• Led by Public Health, with contributions from the CSCP and CSAB. • Thematic Review on Suicide	• Publication delayed until 2026–27, but work has led to a better understanding of how suicide impacts across all ages.
Refresh/relaunch multi-agency Pre-birth Guidance	• Pre-birth safeguarding practice strengthened through audit activity, learning dissemination and improved professional awareness, particularly within CSC, Health and partner agencies.	• Greater consistency in identifying and responding to risk pre-birth. Improved professional understanding of early risk factors, contributing to earlier intervention and planning.
Implement fee-based training model	• Introduced revised training model supported by a new Learning Management System, increased eLearning access, expanded Level 2–3 training and targeted inputs (CSA, DA, online harm, cultural competency).	• Increased access to and participation in safeguarding training. However, attendance at face-to-face sessions remains inconsistent. Clear next step identified: evidencing impact on practice, not just completion.
Network oversight to reduce the impact of exploitation	• Strengthened multi-agency oversight through MACE and related forums, improved Police and YJS joint working, and enhanced identification of exploitation and contextual harm across agencies. Contributed to the draft All-age Exploitation Strategy led by CSAB.	• Reduced serious youth violence and historically low custody rates (YJS). Improved identification and coordinated response to children at risk of exploitation, though work remains resource-intensive.
Engage with the LA System Review with external consultants	• Used governance structures to highlight duplication across multi-agency forums, improve clarity of purpose, and strengthen alignment between safeguarding, community safety and health agendas.	• Increased ability to identify gaps and avoid duplication, though continued monitoring required as system reforms evolve.
Tackling health inequalities (ICB Priority)	• Health partners aligned safeguarding activity with Health Equity Partnership Group priorities, including prevention, community empowerment and self-care. Promoted Think Family approaches across adult-facing services.	• Improved recognition of unmet need and wider determinants of risk for children. Strengthened multi-agency understanding of inequality, though data quality and disproportionality analysis remain areas for development.

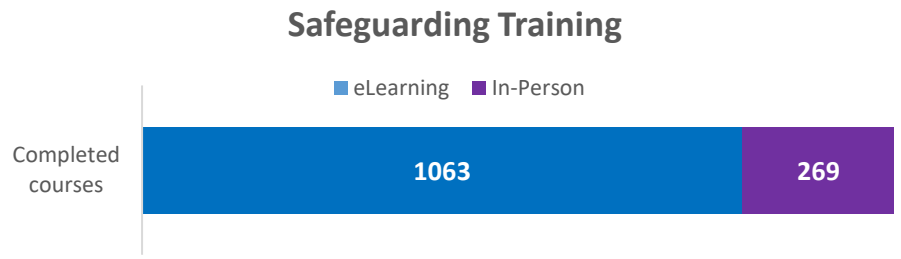
Learning, Quality Assurance and Continuous Improvement

The CSCP made significant progress in strengthening its learning and quality assurance framework in 2025–26. The CSCP moved increasingly towards a model where learning from audits, reviews and data was actively used to influence practice, rather than existing as standalone activity.

Workforce Development and Training

Workforce development remained a central priority for the CSCP during 2025–26, reflecting the need to strengthen practitioner confidence, improve consistency of safeguarding practice, and align learning with emerging local and national safeguarding risks.

Over the year, the CSCP significantly evolved its training offer through the introduction of a redesigned Learning Management System, which improved accessibility, reporting capability and scalability across the partnership. This enabled a substantial expansion in eLearning delivery, with over 1,000 eLearning courses completed during the reporting period, significantly increasing workforce reach and flexibility for practitioners. In-person learning continued to support reflective practice, multi-agency discussion and complex safeguarding themes, with 42 training sessions delivered across the year.

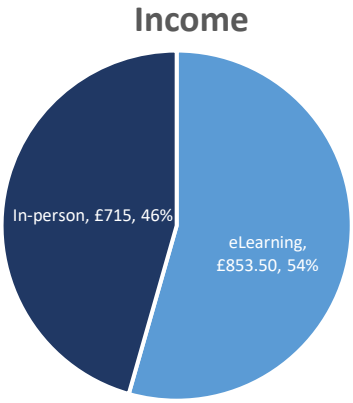


The strengthened digital infrastructure also provided improved oversight of workforce engagement and attendance patterns. Data identified areas where uptake from specific agencies remained inconsistent, alongside high levels of late cancellations and non-attendance within parts of the in-person programme.

During the year, 408 bookings were made for in-person sessions, with an attendance rate of 66% and a no-show rate of 34%. These findings highlighted both operational and financial pressures associated with unused training capacity and missed learning opportunities.

Multi-agency Engagement

As a result, the CSCP began implementing a revised charging and accountability model designed to improve attendance commitment, strengthen organisational oversight and support the long-term sustainability of safeguarding learning. This included enhanced reporting to service managers, improved monitoring of attendance trends and the development of more targeted approaches to workforce engagement.



Training content became increasingly responsive to learning from audits, reviews and national guidance. Targeted inputs were developed in areas including:

- Child Sexual Abuse
- Domestic Abuse
- Cultural Competency and Anti-Discriminatory Practice
- Online Harm and Exploitation
- Contextual Safeguarding

The annual safeguarding conference further reinforced this approach, with a strong focus on the Voice of the Child and direct contributions from young people. This ensured that practitioner learning was grounded in lived experience rather than abstract theory.

The conference served as a catalyst for systemic change, moving beyond theoretical discussion to practical, youth-led insights. An average recommendation score of 8.9 out of 10 demonstrated the strength of collective partnership engagement.

- **Youth-led design:** The collaboration with Reaching Higher ensured that the lived experiences of Croydon's young people were central to the learning. This has resulted in 75% of delegates reporting a change in how they record "the voice of the child" in their formal assessments.
- **Networking and integration:** The conference successfully broke down professional silos, with 94% of attendees establishing new multi-agency contacts. This has directly improved the speed of informal consultation across the partnership.
- **Knowledge dissemination:** Post-conference surveys indicate that 82% of attendees have shared key learning with their immediate teams, effectively amplifying the reach of the event to practitioners who were unable to attend in person.

Following the 2025 Voice of the Child Conference, young people from the Reaching Higher Youth Board presented directly to senior leaders, reinforcing the conference's impact on improving practitioner confidence in child-centred safeguarding and meaningful youth participation. The presentation prompted wider discussion about how children and young people can more consistently influence service design, safeguarding practice and strategic decision-making across the partnership.

Despite these developments, the CSCP was honest about limitations. Attendance at face-to-face training sessions remained a significant challenge throughout the year. High levels of non-attendance and late cancellations reduced efficiency and limited the reach of some learning activity. More importantly, there remains variability in how learning is applied in practice, particularly within larger organisations where workforce scale and turnover present additional challenges.

The CSCP recognises that measuring training through attendance and completion alone is insufficient. There is not yet a consistent method for evidencing how training translates into improved safeguarding decisions, stronger professional curiosity or better outcomes for children.

The next phase of development must move beyond measuring attendance and completion alone. The CSCP recognises that the true measure of effectiveness is whether learning leads to demonstrable improvements in professional decision-making, multi-agency practice and outcomes for children and young people.

WHAT DIFFERENCE DID WE MAKE?

The CSCP significantly strengthened the accessibility, relevance and strategic reach of safeguarding training during 2025–26, particularly through the expansion of its eLearning offer and the implementation of a redesigned Learning Management System. This enabled practitioners across the multi-agency workforce to access safeguarding learning more flexibly and consistently, increasing engagement with core and specialist safeguarding themes.

Quality Assurance

The Quality Assurance Group (QAG) increased the frequency and consistency of its meetings, reflecting the expanded audit programme and the enhanced expectations set out in *Working Together to Safeguard Children 2026*. The introduction and further embedding of the PHEW platform improved the structure, consistency and efficiency of audit activity, enabling clearer tracking of findings, actions and impact.

Audit activity during the year covered a wide range of safeguarding themes, including:

- Domestic Abuse
- Professional Attendance at Child Protection Conferences
- Complex Cases
- Contextual Safeguarding and Exploitation
- Stop and Search
- Youth Justice Inspection Preparation

Importantly, audits were increasingly designed to answer the 'so what?' question, testing not only whether processes were followed, but whether children were safer as a result.

Domestic abuse audit findings informed revised guidance and directly contributed to Public Health's Violence Against Women and Girls strategy. This ensured that learning from safeguarding activity influenced wider system priorities rather than remaining siloed within children's services. The CSCP also published a new website resource page bringing together the two domestic abuse audits, their key findings and practical guidance to help practitioners identify, support and safeguard children affected by domestic abuse.

Other audits led to specific actions. For example:

A CAMHS audit identified that safety plans were missing in approximately one third of cases reviewed, prompting actions to test and strengthen safety planning processes.

An audit on professional attendance at child protection conferences identified that a significant proportion of schools had not provided reports when requested, leading to direct engagement through DSL forums to clarify expectations and support improved participation.

Section 11 Assurance

The CSCP is clear that embedding learning consistently remains a challenge, particularly across large statutory organisations and in the context of workforce turnover and pressure. While there is strong evidence that learning is influencing training, guidance and leadership discussions, the next phase of development must focus more explicitly on testing whether learning reaches frontline practice and improves outcomes for children.

Learning from Reviews

The CSCP Review Group coordinates the review process. Further information about each type of review is available on the CSCP website. Activity during the year included:

One Rapid Review, which did not progress to a Local Child Safeguarding Practice Review because it did not identify significant new learning for the safeguarding Partnership.

Four escalations, in which the CSCP brokered conversations that enabled the relevant professionals to resolve matters.

Three Cases of Concern were published during the year:

Carlos: This case identified significant communication breakdowns and procedural gaps in safeguarding processes. He was discharged from hospital into police custody without his mother being informed and without adequate consideration of his post-surgery needs. Throughout agencies' responses, Carlos was viewed primarily as a perpetrator, with insufficient recognition of his vulnerability, victim status and the influence of adultification. This case highlights the importance of maintaining a child-centred approach, particularly where bias may affect professional judgement.

Camille: This case highlighted the complexity of safeguarding children with additional needs who require urgent placement. It demonstrated the need for professionals to adapt their practice when working with neurodivergent children or those with communication difficulties, ensuring their views are fully understood and actively inform decision-making. The child's voice should be central to care planning and review processes. Where their wishes cannot be realised, clear and transparent explanations are essential to maintain trust and engagement.

Christine: This case highlighted the risks associated with children living in unverified or unsupported arrangements. Following her parent's imprisonment, she lived largely independently from the age of 14. Learning from this case reinforced the need for robust verification of living arrangements, timely follow-up of early notifications and sustained professional curiosity. It emphasised the importance of recognising how low-level concerns, when considered cumulatively, can indicate significant risk.

Learning from all three cases was shared through seven-minute briefings, supervision, group discussions and training forums. Evidence of dissemination was provided through partner updates and follow-ups at Review Group meetings.

No Local Child Safeguarding Practice Reviews were initiated during the year.

National Reviews That Influenced Practice

CSCP Independent Scrutineer Keith Makin authored a national review of the Church of England's handling of allegations of abuse by John Smyth QC. This review ultimately led to the resignation of the Archbishop of Canterbury. The CSCP used the review as the basis for a briefing that raised awareness of the need for due diligence in relation to people in positions of trust.

There were two reviews published by the Child Safeguarding Practice Review Panel:

- **I Wanted Them All to Notice** which focused on intrafamilial sexual abuse and led to the CSCP creating its own series of webinars with practical advice for professionals such as how to recognise abuse and support the non-abusive parent, particularly when the abuse is unsubstantiated and how to support victims whilst awaiting court proceedings.
- **'It's Silent': Race, Racism and Safeguarding Children** reviewed 53 Rapid Reviews and Local Child Safeguarding Practice Reviews from across England and concluded that race and racism are largely ignored when reviews are conducted. This reflects wider concerns about racism and bias in how professionals view and respond to children.

Impact of Audit Activity

Audit activity increased significantly during 2025–26, reflecting the Partnership's strengthened approach to quality assurance and continuous improvement. The programme focused on areas of strategic priority, emerging safeguarding risks and national learning, providing greater assurance about the quality and effectiveness of multi-agency safeguarding practice.

During the year, the CSCP completed the following multi-agency audits:

- **Stop and Search** – London-wide audit led by Hackney Safeguarding Children Partnership (final report awaited).
- **Domestic Abuse** – Joint Targeted Area Inspection (JTAI) theme examining the response to children under seven affected by domestic abuse.
- **Domestic Abuse** – Audit of the quality of interventions for children experiencing domestic abuse.
- **Youth Justice Service** – Audit undertaken to support inspection preparedness.
- **Child Sexual Abuse** – Audit informed by the I Wanted Them to Notice report.
- **Racism and Bias** – Audit informed by the 'It's Silent' report.

Importantly, learning from audits was translated into practical improvements rather than remaining within reports. Findings from the 'It's Silent' review informed multi-agency discussions to raise awareness of racism and bias, strengthen anti-racist practice, and challenge assumptions within safeguarding. The learning is also being used to inform the development of the Local Authority's new anti-racist policy, helping to embed anti-racist principles across both safeguarding practice and wider organisational culture.

To further strengthen the dissemination of learning, the CSCP developed a dedicated Learning from Audits section on its website. This resource converts audit findings into accessible practice guidance, learning summaries and supporting resources for practitioners.

The first to be published were the Domestic Abuse learning resources, with Child Sexual Abuse resources scheduled to follow. This approach supports the Partnership's commitment to ensuring that audit findings lead to measurable improvements in frontline practice and outcomes for children.

Partner Agency Impact Summaries

This section draws directly from partner update returns across all four quarters of 2025–26. It provides a balanced narrative of activity and impact alongside explicit consideration of limitations and ongoing risks.

Metropolitan Police Service

Across 2025–26, the Metropolitan Police in Croydon strengthened both the quality and timeliness of safeguarding decision-making, particularly at the front door and in complex exploitation cases. Early partner updates highlighted significant pressures, including safeguarding referral backlogs, inconsistent data quality and challenges around attendance at child protection conferences due to rising demand.

Rather than allowing these pressures to erode safeguarding standards, Police implemented targeted improvements. Quality assurance activity within CAIT focused on improving referral accuracy and completeness, reducing backlogs that had previously delayed MASH decision-making. By mid-year, daily safeguarding backlogs had reduced substantially, enabling more timely multi-agency responses.

Police also demonstrated child-centred practice through the "**Every Child Every Time"** audit meetings, which examined police activity from the child's perspective. Learning from these audits informed refreshed expectations around joint visits, strategy discussions and early information sharing. Alongside this, Police strengthened responses to child-on-child sexual abuse and online harm, including the use of AI-enabled technology and collaboration with specialist units.

Despite ongoing volume pressures and necessary adjustments to meeting attendance, evidence across the year shows that children benefited from clearer risk information, faster decisions and more coordinated safeguarding responses.

Limitations and ongoing risks: Sustained volume pressures and workforce realignment affect consistency of engagement. Child-level outcome evidence remains limited in some areas, and sustainability of improvements remains dependent on capacity.

Children's Social Care

Children's Social Care faced sustained demand and workforce pressure throughout 2025–26. Early audits and data identified drift in long-term child protection planning, particularly in neglect cases, with some children remaining on plans for extended periods.

In response, CSC strengthened oversight of long-running cases, reviewed thresholds for progression and invested in practice improvement activity. This included bi-monthly audits, targeted training focused on "what good looks like" in core group work, and rollout of the Graded Care Profile 2 in a culturally sensitive way.

By the second half of the year, CSC reported a reduction in long-term child protection plans, indicating improved progression and focus on permanence. This improvement was reinforced by the February 2026 Ofsted focused visit, which found a largely positive picture at the front door.

Limitations and ongoing risks: Placement sufficiency pressures, workforce sickness and rising demand remain significant risks, and effectiveness is not yet consistent across all teams.

Health: Integrated Care Board and Croydon Health Services

Health partners made a sustained contribution to safeguarding throughout the year, particularly in relation to domestic abuse, neglect, mental capacity and exploitation. Across all four quarters, health updates consistently evidenced a 'Think Family' approach, ensuring children's needs were considered within adult-facing services such as Emergency Departments, sexual health services and primary care.

A key area of impact was the dissemination and use of learning. Health partners shared Domestic Abuse audit findings and resource packs through GP forums and safeguarding networks, directly influencing professional understanding of children as victims in their own right. Health also contributed to CSA and contextual safeguarding audits.

Health audits highlighted cross-cutting risks, including homelessness, suicide and extra-familial harm, informing wider CSCP discussions. Although capacity pressures within safeguarding teams remained on Trust risk registers, these risks were escalated transparently to Executive level.

Limitations and ongoing risks: Evidence of direct frontline impact for children is variable, and capacity pressures within safeguarding teams remain a risk to sustainability.

South London and Maudsley NHS Foundation Trust (CAMHS)

CAMHS partner updates demonstrated effective professional challenge and advocacy for children. Practitioners consistently worked with Children's Social Care to ensure that emotional harm and contextual factors were fully recognised in assessments and conferences.

In several cases, CAMHS staff successfully challenged child protection categorisation where harm was being under-acknowledged, leading to revised plans that better reflected children's lived experiences. Learning from serious incidents, including suicide, informed clearer risk assessment language.

CAMHS also engaged in audit activity and delivered training, including safeguarding in private law proceedings.

Limitations and ongoing risks: The reduction of the safeguarding lead role to part-time presents a risk to consistency and requires continued Executive oversight.

Youth Justice Service

The Youth Justice Service provided strong evidence of impact across prevention, participation and partnership working. Despite reduced management capacity, YJS achieved historically low custody rates and reductions in serious youth violence.

YJS promoted restorative and Child First approaches, engaged children directly through participation activity and responded swiftly to serious incidents alongside Police and Children's Social Care.

Limitations and ongoing risks: Placement availability for children leaving custody and the resource-intensive nature of contextual safeguarding remain challenges.

Education (Local Authority)

Education partners supported schools through safeguarding training, DSL engagement and guidance on neglect, online harm and referral quality. Education also provided sustained constructive challenge regarding communication with Children's Social Care, including feedback on case closures and involvement in strategy meetings.

Limitations and ongoing risks: Despite repeated escalation, evidence of resulting system-wide change remains limited, with similar concerns recurring across quarters.

Family Hubs

Family Hubs provided clear examples of early help preventing immediate harm. Navigators worked intensively with families experiencing housing instability, domestic abuse and financial hardship, often acting as a stabilising presence during periods of crisis.

Limitations and ongoing risks: Impact is constrained by wider system factors, particularly housing availability.

Probation

Probation updates demonstrated a growing focus on whole-family safeguarding. Practitioners routinely explored family dynamics and safeguarding risks within offender management, supported by training and improved use of the MASH portal.

Limitations and ongoing risks: Impact evidence remains largely developmental, and national reform presents ongoing stability risks.

Housing

The local authority Housing department was largely absent from CSCP and MASH Operational Group meetings, and its engagement is being challenged by the Director of Children's Services. However, Housing representatives attended a Review Group meeting and provided evidence of work to safeguard children, including the installation of several hundred window restrictors across local authority properties to reduce the risk of falls from height. A joint working protocol to improve coordination between Housing and Children's Social Care is in development.

Limitations and ongoing risks: Impact evidence is limited because infrequent attendance restricts opportunities to provide assurance about safeguarding activity.

Voice of the Child: From Listening to Influence

The voice of children and young people was increasingly visible across CSCP activity during 2025–26. Across agencies, there was growing evidence that children's views were being captured in assessments, supervision and decision-making.

Children's Social Care reported increased involvement of children in meetings relating to them. CAMHS provided case examples where children's views influenced acknowledgement of harm and resolution for families. Youth Justice Service demonstrated strong youth participation, including creative engagement and direct dialogue with senior leaders. Family Hubs used navigator-led approaches to capture children's experiences within family work.

Metropolitan Police embedded the child's perspective within the "**Every Child Every Time"** audit process, using the voice of the child as a specific theme for reflection on practice.

At a strategic level, the Young Scrutineer role was a notable strength. Young people influenced:

- Conference content
- Commissioning activity, including funding decisions
- Training design
- Executive-level discussions

Q4 partner updates described young people presenting reflections and aspirations directly to senior leaders, including commitments that children and young people would help shape the Families First Partnership framework locally.

WHAT DIFFERENCE DID WE MAKE?

Children and young people influenced both individual safeguarding decisions and wider system activity. Their voices shaped training, commissioning, conference content and strategic commitments. The next challenge is to close the learning loop more consistently by evidencing what children told the partnership, what changed as a result, and how those changes improved children's experience of safeguarding.

Independent Scrutiny and System Challenge

Independent scrutiny provided challenge and assurance throughout 2025–26. The Independent Scrutineer recognised significant strengths, including:

- one of the most developed safeguarding datasets in London
- strong engagement with voluntary, community and faith sectors
- effective youth participation

At the same time, scrutiny identified areas requiring continued attention, including:

- inconsistent audit participation by some partners
- variable use of data to drive action
- pressure on front-door capacity
- sustainability risks linked to workforce and resourcing

This challenge directly influenced Executive priorities, quality assurance arrangements and resourcing discussions. The CSCP's willingness to respond to scrutiny demonstrates a mature safeguarding culture, where challenge is used as a tool for improvement rather than defensiveness.

Conclusion

Throughout 2025–26, the Croydon Safeguarding Children Partnership demonstrated increasing maturity, transparency and effectiveness in how safeguarding arrangements are understood, challenged and improved.

Operating within a context of rising demand, workforce pressures, organisational reform and increasing complexity of need, partners remained focused on what matters most: whether children are safer and receiving the right help at the right time.

Evidence presented throughout this report demonstrates tangible improvement in several key areas. Front-door safeguarding arrangements were strengthened, supported by improved multi-agency working within MASH and independently validated through the February 2026 Ofsted focused visit. Children's Social Care reduced drift in long-term child protection planning, Youth Justice Service achieved positive outcomes through prevention and participation, Health partners strengthened their Think Family approach, and Family Hubs helped provide earlier support to families experiencing crisis and adversity.

Across the partnership there is growing evidence that learning, audit activity, professional challenge and performance information are increasingly being used to influence practice and drive improvement.

The Partnership has also strengthened its approach to quality assurance, independent scrutiny, community engagement and workforce development. Learning from reviews and audits has been translated into training, guidance and practical resources, while the voices of children and young people have become more visible within both frontline practice and strategic decision-making.

The contribution of voluntary, community and faith organisations has further strengthened safeguarding reach and improved connections with communities that may otherwise be less visible to statutory services.

The CSCP has been equally clear about the challenges that remain. Effectiveness is not yet consistent across all parts of the safeguarding system. Housing instability continues to create significant safeguarding pressures for children and families and remains one of the most significant barriers to achieving sustainable improvements in children's outcomes.

Capacity pressures within Health services, CAMHS and elements of front-door safeguarding arrangements continue to present risks to resilience. Partner engagement is variable, data quality remains inconsistent across some agencies, and the Partnership is not yet able to consistently evidence the impact that training, learning and improvement activity has on frontline practice or outcomes for children. While these issues do not undermine the overall effectiveness of safeguarding arrangements, they do affect the consistency and sustainability of improvement and therefore require continued strategic attention.

The overall judgement of the Partnership is that safeguarding arrangements in Croydon are effective and improving, although effectiveness is not yet consistently experienced by all children and families across the system. This judgement is supported by independent scrutiny, inspection findings, audit activity, performance information and partner evidence. Importantly, it is a judgement based not on the absence of challenge, but on the Partnership's willingness to identify risk, respond to scrutiny, learn from experience and hold itself to account.

Croydon enters the next year with a clearer understanding of both its strengths and its vulnerabilities, supported by partners who share responsibility, embrace challenge and remain committed to helping, supporting and protecting children and young people.

Priorities for 2026–27

Learning from 2025–26 demonstrates that the Partnership's next phase of development must focus on evidencing impact, strengthening system resilience and reducing variation in safeguarding practice. During 2026–27, the CSCP will prioritise:

1. **Strengthening MASH resilience and front-door effectiveness**, ensuring children consistently receive timely, high-quality multi-agency responses through improved Health and CAMHS capacity, enhanced decision-making and continued scrutiny of *No Further Action* outcomes.
2. **Using data and intelligence to reduce inequality**, improving data quality, strengthening disproportionality analysis and using performance information to better understand and address differential outcomes for children.
3. **Embedding learning and evidencing impact**, ensuring that learning from audits, reviews, inspections and national reports results in measurable improvements in frontline practice and outcomes for children.
4. **Developing a resilient and capable safeguarding workforce**, aligning workforce development with *Working Together 2026* and the Families First Partnership Framework, while evidencing improvements in professional confidence, decision-making and practice.
5. **Strengthening whole-system responses to children experiencing cumulative harm**, particularly where safeguarding concerns are compounded by housing instability, domestic abuse, mental ill-health and contextual risk.
6. **Ensuring children, young people and families influence system improvement,** strengthening co-production and evidencing how lived experience shapes strategic decisions, service design and safeguarding practice.

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

CSCP ANNUAL SUMMARY

2025/26 HIGHLIGHTS & 2026/27 PRIORITIES

Effective and improving, while operating under sustained system pressure.

Applicable guidance: Working Together 2023

Report assessed against: Working Together 2026

1 CROYDON'S CHILDREN & CONTEXT

AROUND 1 IN 4
residents are aged 18 and under.

OUR MOST VULNERABLE ARE IMPACTED BY:

- Multiple and overlapping harms
- Housing instability and domestic abuse
- Mental ill-health, exploitation and online risk

2 CHILDREN'S INFLUENCE
VOICE OF THE CHILD CONFERENCE

- **75%** changed how they record the voice of the child
- **94%** made new multi-agency connections
- **82%** shared learning with their teams
- Young Scrutineer influenced governance and commissioning

3 MEASURABLE OUTCOMES

8 OF 13 performance measures improved

- Long-term Child Protection Plans: 50 to 24
- Average monthly missing children: 86 to 70
- Children in custody: 7 to 4
- First-time youth justice entrants: 272 to 231

4 SYSTEM PRESSURES & RISK

- MASH, Health and CAMHS capacity
- Housing instability and homelessness
- Uneven data quality and disproportionality analysis
- Assessment timeliness and rising caseloads
- Placement sufficiency and workforce pressures

5 PARTNERSHIP IMPACT & LEARNING

- Ofsted validated timely responses and strong MASH collaboration
- Family Hubs helped prevent escalation for families in crisis
- Health embedded a Think Family approach across services
- Youth Justice strengthened prevention and Child First practice
- Community and faith engagement extended safeguarding reach
- Audits and reviews shaped domestic abuse, CSA and anti-racist practice

6 2026/27 PRIORITIES

- Strengthen MASH resilience
- Use data to reduce inequality
- Evidence learning in frontline practice
- Build a resilient safeguarding workforce
- Respond to cumulative harm
- Show how lived experience changes decisions

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Stronger together. Safer together.

Glossary

Term	Meaning
AI	Artificial Intelligence. Used within policing and safeguarding to support the identification and analysis of digital evidence.
CAMHS	Child and Adolescent Mental Health Services. NHS specialist mental health services for children and young people.
CAIT	Child Abuse Investigation Team. Metropolitan Police specialist teams responsible for investigating offences involving children.
Child Protection Conference (CPC)	A multi-agency meeting held when a child is considered to be at continuing risk of significant harm to decide whether a Child Protection Plan is required.
Contextual Safeguarding	An approach to safeguarding that recognises risks to children may occur outside the family home, including within peer groups, schools, neighbourhoods and online.
CSAB	Croydon Safeguarding Adults Board. The statutory partnership responsible for safeguarding adults at risk.
CSCP	Croydon Safeguarding Children Partnership. The statutory multi-agency partnership responsible for coordinating safeguarding arrangements for children in Croydon.
CSA	Child Sexual Abuse. Sexual abuse of a child, including both intrafamilial and extra-familial abuse.
CSC	Children's Social Care. Local Authority services responsible for safeguarding, supporting and protecting children.
Delegated Safeguarding Partner (DSP)	Senior leaders appointed by the Lead Safeguarding Partners to oversee the delivery of safeguarding arrangements on their behalf.
DSL	Designated Safeguarding Lead. The person responsible for leading safeguarding within a school or education setting.
Early Help	Support provided to children and families as soon as concerns emerge to prevent problems escalating and reduce the need for statutory intervention.
Family Hubs	Local centres providing integrated support to children, young people and families through a whole-family approach.

Term	Meaning
Families First Partnership Framework	National programme that strengthens multi-agency early help, family support and child protection arrangements through integrated partnership working.
ICB	Integrated Care Board. The NHS organisation responsible for planning and commissioning local health services.
JTAI	Joint Targeted Area Inspection. A joint inspection undertaken by Ofsted, CQC, HMICFRS and HMI Probation examining multi-agency safeguarding arrangements around a specific safeguarding theme.
Lead Safeguarding Partners (LSPs)	The three statutory safeguarding partners: the Local Authority, Integrated Care Board and Police, jointly accountable for safeguarding arrangements under *Working Together*.
Local Child Safeguarding Practice Review (LCSPR)	A review commissioned by the safeguarding partnership following serious child safeguarding incidents to identify learning and improve practice.
MACE	Multi-Agency Child Exploitation Meeting. A multi-agency forum that coordinates responses to children at risk of exploitation.
MASH	Multi-Agency Safeguarding Hub. The Partnership 'front door' where agencies share information, assess safeguarding concerns and make decisions about the most appropriate response for children.
No Further Action (NFA)	A decision that a referral does not require statutory intervention following multi-agency assessment, although other support may still be appropriate.
Ofsted	Office for Standards in Education, Children's Services and Skills. The inspectorate responsible for inspecting children's services and education providers.
PHEW	The CSCP's digital quality assurance and learning management platform used to manage audits, learning, training and safeguarding resources.
Quality Assurance Group (QAG)	The CSCP subgroup responsible for oversight of audits, safeguarding data, performance and quality assurance activity.
Rapid Review	A statutory multi-agency review undertaken following a serious child safeguarding incident to determine immediate learning and whether a Local Child Safeguarding Practice Review is required.
Section 11 Audit	A statutory self-assessment undertaken by partner agencies to demonstrate compliance with their duties under Section 11 of the Children Act 2004 to safeguard and promote the welfare of children.
SLaM	South London and Maudsley NHS Foundation Trust. Provider of specialist mental health services, including CAMHS.

Term	Meaning
SWL	South West London. Used to describe partnership arrangements or services operating across South West London boroughs.
VCSE	Voluntary, Community and Social Enterprise sector. Organisations that provide community-based support and safeguarding services outside statutory agencies.
Voice of the Child	A safeguarding principle that places children's wishes, feelings, lived experiences and views at the centre of assessment, planning and decision-making.
Working Together 2023 / Working Together 2026	Statutory guidance issued by the Department for Education setting out how organisations and agencies must work together to safeguard and promote the welfare of children.
YJS	Youth Justice Service. Multi-agency service responsible for preventing offending and supporting children involved in the youth justice system.