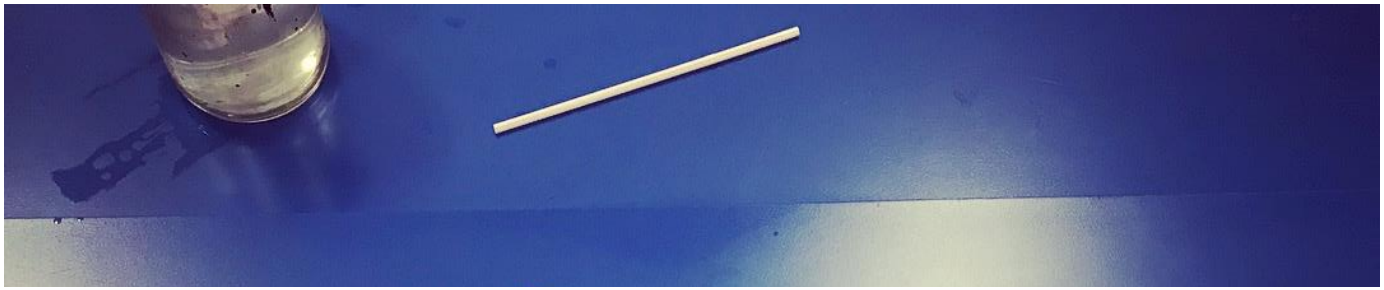

Annual Report 2025-26

Waltham Forest Safeguarding Children Partnership

Waltham Forest
Safeguarding
Children Board

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Delegated Safeguarding Partners' Opening Remarks

"2025-26 has been a year of change and progress for the Waltham Forest Safeguarding Children Partnership. We have responded to rising demand, system pressures and national reform, while continuing to strengthen how we work together to safeguard children.

This year, we implemented our refreshed three-year strategic plan, with a clearer focus on assurance, impact and continuous improvement. We have made good progress in key areas, including neglect, child sexual abuse and risks outside the home, alongside strengthening governance, scrutiny and our learning culture. We also welcomed our new Independent Scrutineer, whose support and challenge are helping to drive improvement.

We know there is more to do. In particular, we need to be more consistent in showing the difference our work is making for children and in responding to ongoing capacity pressures across the system.

We remain committed to working openly and collaboratively to address these challenges. Together, our focus is on delivering safer, more joined-up services so that all children and young people in Waltham Forest can thrive."

London Borough of Waltham Forest

Nicky Crouch, Strategic Director – Children's Services

Metropolitan Police Service (North East London BCU)

Rhona Hunt, Borough Commander, North East Basic Command Unit

NHS North East London Integrated Care Board

Korkor Ceasar, Deputy Director for Safeguarding and Rob Nicholls, Director of Nursing and Safeguarding

Purpose of this Report

This report explains how organisations worked together from April 2025 to March 2026 to keep children and young people in Waltham Forest safe and promote their wellbeing through the local safeguarding partnership.

It is a legal (statutory) report, produced in line with the Working Together to Safeguard Children (2026) guidance and the Children Act 2004 (as updated by the Children and Social Work Act 2017).

Partners

The statutory safeguarding partners in Waltham Forest are Metropolitan Police, NHS North East London (NHS NEL) Integrated Care Board (ICB) and local authority, London Borough of Waltham Forest.

Relevant agencies contributing to local safeguarding arrangements include Barts Health NHS Trust, North East London Foundation Trust, GP Care Group and His Majesty's Prison and Probation Service.

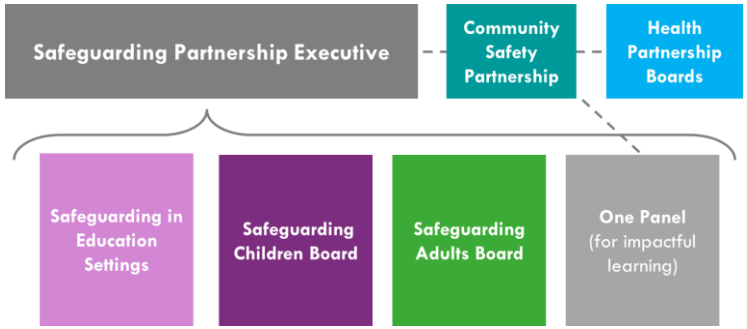
Education and early years providers are engaged and represented within our safeguarding governance and assurance processes through our Safeguarding in Education Settings subgroup.

Governance

During 2025–26, we introduced a new governance approach through our three-year strategic plan. This is designed to improve shared accountability and reduce duplication across the system.

Our work is guided by four key principles: assurance through scrutiny, equitable safeguarding, impactful learning and commitment to collaboration. These principles have shaped how we set our priorities and focus our work.

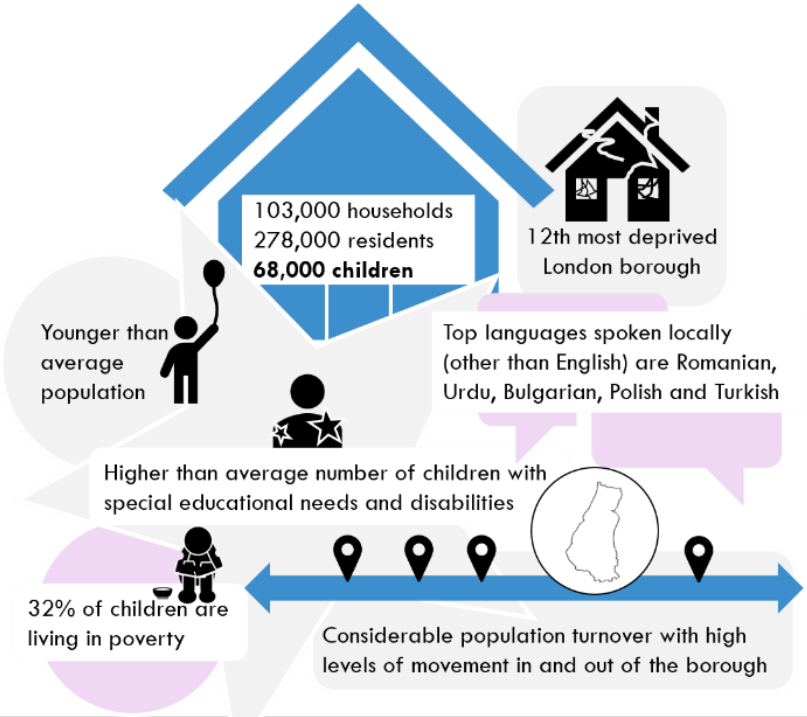
With a simpler meeting structure, the Safeguarding Children Board (SCB) plays a central role in coordinating multi-agency safeguarding, led by the Safeguarding Partnership Executive. Our governance is closely aligned with other partnerships, including the Safeguarding Adults Board (SAB), Community Safety Partnership and Health and Wellbeing Board, supporting a joined-up, whole-system approach.



Our SCB provides strategic leadership, oversight and challenge, helping to drive progress against our priorities. In 2025-26, the Board met four times, with a stronger focus on reviewing progress and improving safeguarding practice.

About Waltham Forest

Waltham Forest is a diverse outer London borough with a growing and mobile population. The borough has strong communities but also significant inequalities. There are differences between neighbourhoods in health, housing, education and access to services. These differences affect how children and young people experience safeguarding and where risks may arise. There is a relatively young population, with many children and young people from global majority backgrounds, and higher than average numbers with special educational needs and disabilities. Many families are affected by poverty, housing instability, the cost of living and mental health challenges, which can increase safeguarding concerns, especially when needs are complex or support is not well joined up.



Sources: https://www.walthamforest.gov.uk/council-and-elections/about-us/statistics-about-borough + https://trustforlondon.org.uk/news/new-interactive-map-what-poverty-looks-like-in-your-borough/

Summary of Safeguarding Children in Waltham Forest

4,370 requests for support or protection from Police *(4,142 in 24-25)*	3,345 requests for support or protection from Health *(3,532in 24-25)*
3179 referrals to children's social care during the year *(3616 for 24-25 at a rate of 595 per 10,000 vs 564 per 10,000 rates for similar areas)*	
203 children that were subject to a child protection plan (CP plan) at the end of the year *(**244** for 24-25 at a rate of 39 per 10,000 vs 38 per 10000 rates for similar areas)*	**90.1%** of children and family assessments completed within 45 days out of all children and family assessments for the year *(95.6% for 24-25)*
337 average no. of days a child had a CP plan during the fiscal year *(314 in 24-25)*	
13.3 % of re-referrals to Children's Social Care *(**16.5%** in 24-25)*	**18.5%** of children becoming subject to a second or subsequent CP Plan during the year *(**24.3**% in 24-25)*
157 children missing from home during the year *(**158** in 24-25)*	**70** children missing from care during the year *(**87** in 23-24)*
	157 children missing from home during the year *(**158** in 24-25)*
30% of children ceased to be 'looked after' (i.e., leaving care) due to returning to live with parents/ relatives with parental responsibility during the year *(**29**% in 24-25)*	**58%** of previously looked after children aged 17-18 and 42% aged 19-21 who are now in employment, education or training out of total number of looked after children during the year *(in 24-25 this was **56.5**% for 17-18yrs / **56.6**% for 19-21yrs)*

Snapshot of Child Protection Conferencing in Waltham Forest

204	children subject to a CP plan *(244 in 24-25)*	**470**	CP conferences *(440 in 24-25)*

6-10 year olds make up the largest number of children on CP plans with numbers steadily decreasing as children get older

(11-15 year-olds in 2024-25)

15-20	Child Protection (CP) conferences per week *(same in 24-25)*
70%	of children presented to conference were from a global majority background *(68% in 24-25 and previous two years)*

Children on a CP plan

51%	under **neglect**	**34%**	under **emotional harm**.

(50% in 24-25 under the category of neglect and 41% under emotional harm)

Impact and Effectiveness of Arrangements

Partnership Priorities

Over the past year, we have been clearer about our priorities and tried to turn them into real improvements within safeguarding. We have sought to make better use of learning, evidence and data to focus our work where it is most needed. Stronger governance and independent scrutiny have also helped to increase challenge and accountability. Together, this shows a more joined-up and effective partnership working in line with our safeguarding duties.

Priority One: NEGLECT

In our strategic plan, we committed to strengthening how we identify, respond to and prevent child neglect by improving multi-agency pathways and building practitioner confidence.

In February 2026, we launched our 'Quality of Care Toolkit' following a successful multi-agency pilot. Practitioners tested the toolkit in real cases and took part in reflective learning sessions, helping to refine the guidance before wider roll-out. The toolkit, alongside new Fabricated or Induced Illness (FII) guidance, provides clearer support for recognising concerns where children may not be receiving safe, consistent or good-quality care.

Early feedback suggests the toolkit is helping practitioners to have more constructive conversations with families, better understand thresholds, and use escalation routes more confidently. It is also supporting stronger

professional curiosity, proportionate challenge, and earlier multi-agency responses.

Looking ahead to 2026-27

Our focus is now on embedding this work into everyday practice. A multi-agency group is being established to maintain momentum, support consistent use of the guidance, and ensure it is making a difference in practice.

We will also strengthen how we use data to understand impact. This includes tracking outcomes for children and families and identifying any groups who may be over or under-represented in services. Alongside this, we will continue to share learning and key messages across the workforce to ensure improvements are sustained and consistently applied across the partnership. Our aim is to clearly demonstrate what is different for children as a result of this collective work.

Priority Two: RISKS OUTSIDE THE HOME

In our strategic plan, we have committed to ensuring that children are effectively safeguarded from risks outside the home, using trauma-informed and rights-based approaches.

Previous serious incidents showed that more children are experiencing harm beyond the family home, including sexual and criminal exploitation, violence and contact with the criminal justice system, such as stop and search. These experiences can be traumatic and are more likely to affect children from global majority backgrounds, particularly Black boys.

Drawing on learning within London, we are continuing to strengthen our Multi-Agency Child Exploitation (MACE) arrangements, particularly how we use data. This has been challenging, as partners have needed to agree what information each agency can share and how to do this consistently. The lack of a dedicated data analyst remains a barrier, although partners are working together to improve this. This work links closely with wider youth justice improvement activity following the 2024-25 inspection.

Our thematic review into violence affecting Black boys, published in October 2025, highlighted the impact of trauma, race, racism and system responses, as well as the disproportionate experiences of some children.

Learning from the Safeguarding Stop and Search Project has reinforced the need for trauma-informed, rights-based approaches when children come into contact with police and the criminal justice system.

A multi-agency audit of children who go missing found strong commitment and good relational practice across the partnership. However, it also identified areas for improvement, including better communication, more consistent practice, and a stronger focus on the child's voice.

Looking ahead to 2026-27

We will build on progress in MACE and align our work with London-wide guidance on extra-familial harm. Community Safety and Children's Services are now working more closely together, including sharing analytical capacity, which is helping us strengthen our response to exploitation and disrupt harmful individuals, exploitative networks and organised criminal groups.

Better alignment between safeguarding, youth justice and community safety is already supporting more joined-up prevention and intervention. We will build on this by reviewing our response to modern slavery and exploitation, including county lines, the use of the National Referral Mechanism (NRM), and how well partners understand thresholds, roles and data requirements.

We will also focus on fully implementing recommendations from our thematic review and missing children audit, to ensure a more coordinated, preventative and trauma-informed response that keeps children's experiences at the centre.

Finally, we will further strengthen local practice around stop and search making sure it reflects what children and young people have told us needs to change. We will also take learning from the findings from the evaluation of the London Safeguarding Stop and Search Project.

Priority Three: MISSING EDUCATION

In our strategic plan, we have committed to ensuring that children missing education, or experiencing disrupted schooling, are identified early and kept safe and included.

Children who are not in education, including those who are electively home educated, can be at greater risk of harm such as exploitation and isolation. National and local reviews, including the Children's Commissioner's report Children Missing Education: The Unrolled Story and our own local child safeguarding practice reviews (LCSPRs), highlight gaps in how well services identify and respond to these risks.

Learning from LCSPR Children M (published October 2025) showed that children who are not regularly seen by services are particularly vulnerable. It highlighted the need for clearer escalation, stronger multi-agency accountability, and earlier challenge, especially for children with special educational needs and disabilities (SEND) needs.

In response, partners strengthened their approach during the year. This included clearer roles and guidance across agencies, better oversight of elective home education, stronger safeguards for children with education health care plans (EHCPs), and closer links between education decisions and safeguarding risk. There has also been a greater focus on engaging families early where home education is being considered, to reduce the risk of children becoming hidden from services.

Looking ahead to 2026-27

We will continue to embed learning from LCSPR Children M and other area or national reviews (for example Sara Sharif). We will strengthen how we use data and insights, including from the Children's Commissioner, to better understand risks and outcomes, particularly for children with additional needs, care-experienced children, and those in the youth justice system.

Our focus will be on ensuring that we can clearly demonstrate the difference this work is making to children's safety, wellbeing and inclusion.

Priority Four: MENTAL HEALTH

In our strategic plan, we committed to ensuring that children with mental health needs are protected and supported through joined-up, multi-agency working. In 2024-25, our previous focus on emotional wellbeing was too broad, which limited progress. Partners agreed to retain this as a key priority for 2025-28, with a clearer and more targeted approach.

We know that mental health needs can increase vulnerability and affect safeguarding outcomes. National and local learning highlights the close link between mental health, safeguarding risk and inequality, particularly for younger children, and for those whose needs overlap with issues such as exploitation, violence and family adversity.

During the year, we strengthened our understanding of local needs by drawing on learning from reviews, including our thematic review on violence affecting Black boys, national safeguarding reports, and wider evidence on health inequalities. This has helped us better identify where risks are highest and where the system needs to improve.

We are now working more closely with health and community safety partners to strengthen how services respond to children's mental health needs within a safeguarding context. This includes a specific focus on the mental wellbeing of Black boys and young men, recognising the links between mental health, inequality and lived experience. Work is underway with young people and the voluntary sector to design more targeted and preventative support.

Local analysis has also identified children spending extended periods in A&E due to mental health crises, sometimes alongside substance misuse. This highlights the need for earlier help and more coordinated responses.

Looking ahead to 2026-27

We will build on this stronger evidence base to focus on impact. This will include using national learning to review and challenge our local approach, and carrying out multi-agency case file reviews to better understand children's pathways into crisis and where earlier intervention could have made a difference.

We will strengthen the role of schools within this priority and improve alignment with the 'i-THRIVE' model to support a clearer and more consistent approach across services. We will also focus on making support and advice more accessible for children, parents and carers. Alongside this, we will continue to strengthen how safeguarding and mental health services work together, share learning across the workforce, and gather evidence of what is improving outcomes for children, particularly those most at risk.

Priority Five: CHILD SEXUAL ABUSE

Child sexual abuse has a lasting and serious impact on children. National reviews, including "I wanted them all to notice", show that services do not always recognise or respond to abuse within the home as well as they should. Locally, this remains an area requiring strong and consistent practice.

During 2025-26, we focused on strengthening professional curiosity, relational safeguarding and trauma-informed practice. This reflects the shared responsibility across all services to notice concerns, listen to children and take action.

Working with Newham Safeguarding Children Partnership, we have co-produced a joint Child Sexual Abuse Strategy (2026-2029). This makes best use of shared resources and learning across boroughs. The strategy is informed by data, national research, and lived experience, and is supported by learning from the Centre of Expertise on Child Sexual Abuse.

The strategy sets out a stronger approach to prevention, early identification, joint working and recovery for survivors, with a clear focus on equity and workforce confidence. It supports practitioners to recognise signs of abuse without relying on children to disclose. Joint working across boroughs is also helping to improve consistency in how risks are understood and responded to.

There has also been improved use of specialist services, including increased referrals to the 'Sunrise Clinic', supported by stronger links with frontline teams, including within the Multi-Agency Safeguarding Hub (MASH).

We recognise there is more to do to strengthen our understanding of child sexual abuse locally. This includes improving both quantitative and qualitative data, particularly capturing the voices and experiences of children and young people, and ensuring we remain aligned with national developments.

Looking ahead to 2026-27

Our Child Sexual Abuse Strategy will be published by August 2026. Over the coming year, we will focus on building workforce confidence, improving survivor support pathways, and ensuring a consistent response across agencies.

We will strengthen how we use data and insight, including children's lived experience, to better understand need and measure impact. We will also continue to promote awareness of national developments, including emerging requirements and guidance. This work provides a strong foundation for a more consistent, trauma-informed and equitable approach to protecting children and supporting survivors.

Priority Six: APPROPRIATE USE OF RESTRICTIVE PRACTICES

In our strategic plan, we said we want to be assured that restrictive practices are only used, when necessary, in a safe way, and with the least possible impact on children's dignity and rights.

This priority is linked to the LCSPR into the use of restrictive practices in special education settings. The review was commissioned following historic incidents of mistreatment between 2014 and 2017 at a local special school.

The review has taken longer than originally planned due to its complexity, and publication has been delayed. However, learning has continued throughout this period. Partners have strengthened oversight and assurance arrangements, with a clearer focus on recognising the use of restrictive practices as a safeguarding issue and responding to concerns appropriately.

Looking ahead to 2026-27

The LCSPR is due to be published in July 2026. We are clear that publication is not the end of the process, but the start of the next phase.

Our focus will be on learning from the review, implementing its recommendations, and making sustained improvements in practice. This will help ensure that children in special education settings are treated safely, respectfully and with dignity.

Strengthening Our Ways of Working

Our ability to safeguard children depends on how well we work together. Every partner plays an important role in improving practice. We share responsibility for delivering the strategic plan, with each agency accountable for its part. How we work together is key to achieving our priorities and strengthening partnership governance and practice.

DATA-INFORMED SAFEGUARDING

Our Safeguarding Children Partnership performance dashboard has given us a stronger starting point for using data to guide our work.

During 2025-26, we started to make more purposeful use of data to support our priorities and decision-making. This reflects our commitment to evidence-based practice. We are also using multi-agency operational forums more effectively to bring data into discussions and learn from different perspectives. Improvements to the dashboard are helping us better understand safeguarding trends, inequalities and progress against our priorities. This is strengthening shared accountability and helping partners focus on what makes a difference for children and families.

However, partners recognise that data-informed safeguarding is not yet fully embedded. While there are some areas of progress, overall approaches remain inconsistent and not fully joined up. There is still significant work needed to develop a fully integrated, multi-agency approach, including improving data sharing, analysis and confidence in how data is used.

Looking ahead to 2026-27

We will continue to strengthen how we use data across the partnership. This includes improving the quality and consistency of analysis, supporting earlier identification of risk, and ensuring data is routinely used to inform decisions and practice.

Our focus will be on creating a more joined-up approach, so that data is shared, understood and used effectively across agencies. This will help us provide clearer evidence of impact and better understand the difference we are making for children and families.

EMBEDDING VOICES OF CHILDREN

The experiences of children, young people and their families are central to how we approach safeguarding. Understanding how services are experienced helps us know whether they are making a real difference.

During this year, we continued to strengthen how children and families' voices shape our priorities, learning and service development. Our thematic review into violence affecting Black boys is a clear example of this, drawing on feedback from over 200 children through existing outreach work.

One of the key findings was the need to rebuild trust between young people and the police. In response, an inclusive mentoring pilot was co-designed with young people and delivered between October 2025 and March 2026. The pilot is now being evaluated with young people, and we are working with the police to reflect on the learning and how it can be applied more widely. The local authority is also exploring how this learning can be built into existing programmes, such as Stop, Listen and Engage, which supports police understanding of how to work more effectively with young people. This work is supported by three-year funding from the London Violence Reduction Unit, creating a strong opportunity for lasting impact.

Children and families' experiences have also informed our safeguarding reviews (LCSPRs), alongside data and practitioner insight. This is helping to shape both our priorities and how we check the quality of practice. Increasingly, partnership updates are expected to include a clear reflection of children's views and lived experience.

As a partnership we recognise that while there is a solid base of activity, this work is not yet fully consistent across the partnership. Embedding children's voices is developing well in some areas, but more needs to be done to ensure it has a strong and meaningful influence at a strategic level.

Looking ahead to 2026-27

We will strengthen expectations that children and families' experiences are routinely considered across all multi-agency forums, alongside data and professional judgement. We will also improve how we gather direct feedback from children and families, to ensure their voices shape decision-making, learning and service design.

Our focus will be on making sure this engagement is consistent, meaningful and clearly influences strategic priorities and practice, so that safeguarding approaches remain inclusive, accessible and responsive to local need.

A STRONG LEARNING CULTURE

In April 2025, we reflected on how well learning from reviews is making a difference and used this to shape our new strategic plan. This highlighted the need for a more joined-up approach and led to changes to how we work within our cross-partnership 'One Panel' (a forum responsible for oversight of SARs, Local Child Safeguarding Practice Reviews and Domestic Abuse Related Death Reviews), so learning leads to real improvement.

From July 2025, we introduced a new way of working, with meetings alternating between identifying learning and putting that learning into practice. This has strengthened accountability for review action plans and helped us find common themes across cases.

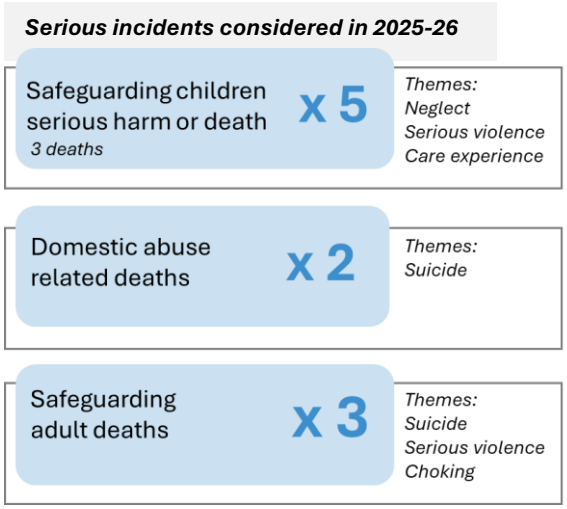
At the start of the year, eight statutory reviews (including four LCSPRs) were in progress. Three were completed during 2025-26, with five (including one LCSPRs) continuing into 2026-27. Learning from these reviews, along with wider incidents and partner feedback, has directly shaped our priorities. Key themes we agreed to particularly focus on were escalation and the quality of referrals.

Statutory review carried over from 2025/26	*Status of review*
Local Child Safeguarding Practice Review into Restrictive Practices	Active – remains in progress
Thematic Review into Violence Affecting Black Boys	Published in October 2025
Local Child Safeguarding Practice Review for Children L	Published in April 2025
Local Child Safeguarding Practice Review for Children M	Published in October 2025
Safeguarding Adults Review for Katie	Active – remains in progress
Safeguarding Adults Review for Lloyd	Active – remains in progress
Domestic Homicide Review for B	Active – remains in progress
Domestic Abuse Related Death Review for A	Active – remains in progress

Learning from serious incidents

Between April 2025 and March 2026, 16 One Panel meetings were held. Five focused on putting learning into practice, five were for children's rapid reviews, and the remaining meetings looked mainly at incidents involving adults.

During the year, 10 serious incidents were reviewed. Most reflected themes we are already addressing through our strategic priorities or existing learning, so they did not lead to further statutory reviews. One domestic abuse related death met the criteria for review and is ongoing.



The regional Child Death Review Hub is well connected to One Panel, which means that two parallel statutory processes are cohesive and complement each other. (See appendix 1 for an overview of the Child Death Review activity during 2025-26).

In November 2025, strengthened challenge between partners led to more consistent decision-making about which incidents meet the threshold for review, supported by a revised process.

In December 2025, we revisited the feedback from the National Panel on our rapid reviews for children, which back in 2023 had been particularly critical regarding quality and our ability to extract and act on meaningful learning. More recent feedback, however, has acknowledged and supported our decision-making, with comments becoming increasingly positive as the year progressed.

Regarding statutory timescales, serious incident notifications (SINs) and rapid review submissions to the National Panel frequently exceeded their

respective deadlines. Delays for SINs ranged from 4 to 94 working days beyond the required five-day submission period, while rapid reviews were submitted between 7 and 69 days after the 15-day deadline.

We have also made better use of national learning. This includes reflecting on reports such as "It's Silent": Race, racism and safeguarding children and the review into Sara Sharif. While these are from a children's perspective, we have applied the learning across both adult and children's safeguarding and shared key insights with frontline practitioners.

We made sure that all our children's rapid reviews, where relevant, drew upon national learning. This approach supported decisions not to proceed with a LCSPR in instances where the main themes were already well established. Instead, our focus has been able to be placed on reinforcing and implementing improvements, rather than repeating similar review processes.

Partnership Training

Multi-agency training is shaped by the partnership's priorities and learning from reviews and audits. However, financial pressures have limited what we can offer, meaning we rely heavily on staff from partner organisations to deliver training. Capacity has also reduced, following the loss of one coordinator in the team.

Between April 2025 and March 2026, partners worked together to deliver training across both adults' and children's safeguarding. While this shows strong collaboration, organising sessions remains resource-intensive and largely manual.

Although some data has been collected, it is difficult to fully measure the impact of training. In children's training, only 13% of attendees completed evaluation forms making it harder to understand outcomes and improve future sessions. Strengthening how we capture and use feedback is a key priority.

Overall attendance was relatively positive at 68% however reinforces the need to consider other ways of sharing learning in future. Engagement was strongest from local authority, particularly Education and Children's Social Care, with good all-round participation from health partners and the voluntary sector.

2024-25 Training - *Children*	**Measures**	**2025-26 Training**		
		Totals	*Children*	*Across*
8	**Total learning sessions delivered**	**14**	10	4
270	**Professionals attended**	**457**	286	171
419	**Professionals registered**	**677**	408	269+
64%	**Rate of attendance** (attending / registered)	**68%**	70%	64%
54	**Evaluation forms completed**	**95**	95	N/A
94%	**Participants reporting improved knowledge / understanding**	**84%**	84%	N/A

Multi-agency audits

Multi-agency audits continued to present a challenge for the Partnership during 2025-26. While this was an agreed area of focus, competing service pressures meant that planned audits were not delivered as intended.

Notwithstanding this, we finalised the multi-agency audit into children missing, which culminated in a learning event in February 2026. The

findings and recommendations from this audit will inform improvement activity within the risks outside the home priority and strengthen practice going forward.

Looking ahead to 2026-27

Changes to the One Panel have improved how we learn as a partnership. We now take a more structured approach, with clearer themes emerging over time, and growing confidence in decision-making. We are also making better use of national learning, although this needs to be strengthened further in adult safeguarding.

However, feedback shows that learning is not yet consistently shared or embedded into practice. While there are good examples, learning does not always reach all partners or lead to lasting change. There is also a need to make learning a shared responsibility across the whole system.

We recognise that wider partners need more support to engage with and apply learning, and that opportunities should be more accessible beyond statutory services. In response, our focus for 2026–27 will be to:

- improve how learning is shared so it is accessible, relevant and reaches all partners
- draw on high-quality, nationally aligned resources, utilising the National Panel's Learning Hub
- link learning more clearly to training, audit and quality assurance
- develop better ways to measure the impact of learning on practice and outcomes
- strengthen how learning is reported to and overseen by the partnership
- support partners and providers to apply learning in practice
- make better use of data to identify themes and track improvement

We will also continue to strengthen our audit and assurance work, so we can clearly show whether learning is leading to real and lasting improvements.

PROFESSIONAL CHALLENGE AND ESCALATION

During 2025-26, we strengthened our approach to professional challenge and escalation, recognising its importance in preventing delay and ensuring risks are addressed quickly.

The introduction of our Multi-Agency Escalation and Professional Challenge Guidance has helped clarify how concerns should be raised and resolved. This is supporting greater confidence among practitioners, clearer expectations, and more timely escalation when needed. Learning from reviews has also reinforced that challenge should be respectful, solution-focused and part of everyday safeguarding practice, not just a last resort.

However, feedback from partners shows that practice is still inconsistent. While professional challenge works well in some areas, it is not applied as consistently across the partnership as it should be. There are also questions about how well guidance is being used in practice, and whether information sharing is always leading to effective challenge or better outcomes.

We recognise the need to strengthen a culture of constructive challenge at all levels, including at a strategic level, where discussions can at times feel too comfortable. Overall, this is an area where there is some strong

practice, but more needs to be done to embed consistency and confidence across the system.

Looking ahead to 2026/2027

In the coming year, we will:

- strengthen a culture of constructive challenge across all partners, including at Board level
- improve consistency in how escalation and challenge processes are applied in practice
- use training and audit activity to test how well guidance is being followed and where improvement is needed
- ensure that information sharing leads to effective challenge and better outcomes
- improve partners' understanding of each other's roles, services and responsibilities, including developing a clear overview of what each organisation can offer. This will help partners make better use of each other's expertise and strengthen confidence in raising and resolving professional challenge

This will help ensure that concerns are raised, challenged and resolved promptly, reducing risk and improving safeguarding outcomes.

EFFECTIVE ALIGNMENT WITH REFORMS

During 2025-26, we continued to operate within a period of significant national reform. While our strategic plan anticipated changes in children's social care, the year also brought unexpected reform within the health system.

Health Reform

In March 2025, Integrated Care Boards (ICBs) were asked to reduce running costs by 50% and align to the Model ICB Blueprint and the NHS 10-Year Health Plan. A formal consultation ran from 1 December to 21 January, with changes continuing into 2026-27. The ICB remains responsible for safeguarding while these changes are taking place.

Throughout this period, partners worked hard to maintain effective safeguarding oversight and ensure that system pressures did not affect the safety and wellbeing of children and young people.

The NHS 10-Year Health Plan highlights ongoing pressures on child health and mental health services. Locally, this has helped the partnership to strengthen oversight of risk, build a more realistic understanding of system capacity, and maintain a focus on safe and resilient services.

Children's Social Care Reforms

This year marked a move from planning into early implementation of reforms. These aim to strengthen early help, improve multi-agency child protection, and support more children to remain safely within their families.

Children's Services led early work to align early help, child in need and child protection within a new 'Family Help' model. This is designed to provide clearer pathways, earlier identification of risk, and more consistent relationships for families. A partnership event in August 2025 and further engagement with schools in September helped to begin wider collaboration.

Engagement with partners has continued across the programme. While Children's Services have led much of the design, there has been strong

involvement in key areas such as Family Group Decision Making (FGDM). Workshops have supported a shared understanding of how to embed family-led approaches across services. Schools have been engaged through Designated Safeguarding Lead (DSL) forums and local cluster meetings, helping to raise awareness of Family Help and position it as part of a joined-up system of support.

In January 2026, Ofsted carried out a focused visit on our Multi-Agency Safeguarding Hub (MASH) arrangements. The visit highlighted a number of strengths, including strong multi-agency working and a clear focus on safeguarding risk. It also identified areas for improvement, particularly around consistency and timeliness. In response, a MASH development programme is now in place to strengthen practice, improve joint decision-making, and ensure children receive the right help at the right time.

Implementing Working Together

In preparation for the updated Working Together to Safeguard Children 2026, we reviewed our local arrangements against emerging expectations. This included a focus on inclusive and anti-discriminatory practice, better use of data to understand inequalities, and clearer evidence of impact for children and families.

We have strengthened the role of education within safeguarding arrangements. The Safeguarding in Education Settings Subgroup includes representation from all types of education providers, with members also sitting on the Safeguarding Partnership Executive. This ensures a strong education voice at a strategic level.

We recognise the pressures schools face in attending meetings, so we use a range of ways to stay connected, including 'The Hub', DSL forums, Headteacher networks and the Strategic Education Board.

Findings from the March 2026 Schools' Section 11 audits show strong engagement, with all 84 education settings taking part. Feedback highlights positive safeguarding practice, with children showing good awareness of how to stay safe and where to go for help. This reflects a strong safeguarding culture across schools. The audits also identified areas for improvement, including:

- ensuring appropriate spaces and support for DSLs
- making safeguarding information more accessible and child-friendly
- strengthening links with Family Help
- improving curriculum coverage of key risks
- ensuring consistent safer recruitment checks
- strengthening oversight of low-level concerns
- developing the role of safeguarding and SEND governors

The Local Authority Designated Officer (LADO) continues to receive most referrals from education settings. Oversight through the subgroup has supported clearer roles, appropriate escalation and increased confidence in reporting concerns. (An overview of the management of allegations against professionals by the LADO service is found in Appendix 2)

Looking ahead to 2026-27

As reforms continue, we will strengthen multi-agency child protection practice, with a clearer focus on shared responsibility. This includes reviewing the quality of strategy discussions, information sharing and joint decision-making, particularly in cases involving infants, neglect, domestic abuse and child sexual abuse. We will continue to expand family-led

approaches, including greater use of family networks in safeguarding decisions. Partner workshops and further engagement activity will support shared understanding and learning. We will also continue to work closely with schools, using findings from the Section 11 audits to drive improvement in safeguarding practice.

Throughout 2026-27, we will align our work with Working Together to Safeguard Children 2026, using it to guide assurance, delivery and continuous improvement across the partnership.

Conclusion

This annual report has given us the opportunity to reflect on progress made over the past year. The Strategic Plan has been instrumental in refining our focus on those areas requiring the greatest attention, and this period of reflection has enabled us to take stock, learn from experience and update our priorities accordingly.

As we move into 2026-27, we will build on the progress achieved to further strengthen the effectiveness, consistency and impact of our local safeguarding arrangements. Particular emphasis will remain on improving how we use data and ensuring that learning from reviews, audits and practice is translated into measurable and sustained improvement for children and families.

Key areas of focus for the year ahead are set out throughout this report, and we remain committed to delivering against them. We are confident that our local governance and statutory frameworks, supported by robust independent scrutiny, provide a strong basis for mutual accountability and continued improvement across the safeguarding system.

Independent Scrutineer Reflections

"The role of the "Independent Scrutineer" was introduced through Working Together 2023 (WT23) to provide support and challenge on the effectiveness of the Multi-Agency Safeguarding Arrangements.

I joined the Safeguarding Partnership in January of 2026, and since then I have been immersed within its operations. With these six months' experience of practice, I can offer my reflections on the strategic workings of the partnership as a whole.

Through my attendance at meetings, as well as having oversight and involvement within LCSPRs, I can unequivocally state that the partnership and services which serve it, are compliant within the parameters of WT23 and the updated policy of 2026.

Being compliant with national policy, however, is insufficient in itself. The measure of effective safeguarding practice and the protection of children, requires a culture and a commitment within which effective practice can flourish.

Whilst these qualities may be difficult to quantify, they are tangible and evident when present. They can be evidenced, within the way, individuals, groups and services operate. When they cannot be witnessed or expressed in actions, we can rightly judge that there is insufficient oversight, protection and most likely an inability to intervene appropriately, to mitigate risk for children and their families.

Within my first six months, I have been able to witness these positive attributes across all of the interactions I have been party to, and I can offer

back to the Lead Safeguarding Partners that I am assured that there is a culture of openness, of constructive enquiry and a willingness to be both challenged, and to offer challenge to practice and policy in return, across all statutory partners.

There is an evident healthy inquisitiveness and desire to learn and improve services and the management of those services. Clear oversight and assurance are provided through the quality assurance processes employed by the partnership, again, involving all agencies.

In addition, my direct experience of locally commissioned reviews, reveals positive relations with direct evidence of challenge and inquiry as to how agencies performed, and where improvement is required.

All the above gives confidence of the partnership's effectiveness and of the oversight of that practice, and this gives further assurance for the year to follow. Clear progress has been made in governance, learning and collaboration, which has created strong foundations. Looking to the future, there is a clear focus for 2026-27 to:

- Further evidence real impact on children's outcomes
- Strengthen data and performance analysis
- Embed learning, equity and children's voices consistently

Overall, the partnership is well aligned, more reflective and increasingly outcome focused, and further work is underway to achieve further sustained, and measurable improvement. As the Independent Scrutineer, I look forward to witness how the partnership rises to these challenges. ”

Rob McCulloch-Graham

Appendix 1 - Child Death Review Activity

The Child Death Review (CDR) process continued to provide multi-agency scrutiny of child deaths in Waltham Forest during 2025-26.

Of the 92 child death notifications received across the Pan-London system, 14 related to Waltham Forest, including nine expected and five unexpected deaths. Six of the deaths involved neonates, with treatment withdrawn the most common mode of death, and the majority categorised as perinatal or chromosomal and genetic, reflecting complex medical needs.

During the year, 23 deaths were reviewed, with increased panel capacity supporting progression, particularly in the final quarter. Reviews often remained open for 10–18 months due to case complexity and the need to align with parallel processes. Learning from reviews continues to strengthen multi-agency understanding, health collaboration and wider safeguarding assurance, informing prevention and improvement activity across the partnership.

The CDR process continues to provide robust, multi-agency oversight and learning, ensuring that child deaths are reviewed systematically and with appropriate professional scrutiny. Increased panel capacity supported the timely progression of reviews despite ongoing complexity.

The predominance of perinatal and medically complex cases has reinforced the importance of strong multi agency collaboration with health partners and continued focus on understanding contributory factors, family experience and system learning. Learning from reviews informs wider safeguarding, assurance and prevention activity across the partnership, supporting continuous improvement and strengthening the collective response to child death and sudden unexpected death in childhood.

Appendix 2 – Managing allegations

The table below provides an overview of referrals received by the Local Authority Designated Officer (LADO) in relation to concerns / allegations made against people working with children.

	April 24 - March 25	***April 25 – March 26***
LADO referrals	**177**	**184** *(94 related to school staff + 23 related to early years staff)*
LADO Consultations	**339** *(201 with schools / colleges + 36 with early years providers)*	**365** *(218 with schools / colleges + 26 with early years providers)*
Complaints	**50** *(40 in relation to schools via Ofsted)*	**82** *(55 in relation to schools via Ofsted)*

Referral sources were as follows:

27% Primary schools

21% Secondary schools

5% Special schools

4% Colleges

5% Nurseries / Early Years

7% Children's Social Care / Local Authority employees

11% Police

5% Other Local Authorities / external agencies

8% Other sectors

Appendix 3 - Funding and Resources

The ICB, Police and Local Authority have a legal responsibility to fund the Partnership, ensuring that resources are allocated to the development and delivery of safeguarding initiatives, training, and response mechanisms. In addition to statutory partners, some relevant agencies also provide financial support.

These collective contributions enable the Strategic Partnerships Unit to carry out the work of the Safeguarding Partnerships (covering adults and children) to coordinate local safeguarding efforts and drive continuous improvements in service provision, alongside the other partnerships.

Strategic Partnerships Team Income	**£328,300**
NHS NEL Integrated Care Board	£100,000
North East London Foundation Trust	£10,000
Barts Health NHS Trust	£10,000
Police *(Nationally agreed)*	£10,000
National Probation Service *(Nationally agreed)*	£1000
London Borough of Waltham Forest	£100,000+ £97,300

Strategic Partnerships Team Expenditure	**£328,300**
Strategic Partnership Unit Staff	£295,700
Independent Scrutiny *(from December 2025 and based on 40 days per year across adults and children)*	£8,000
Professional Services (Reviews)	£15,800
Professional Services (Other – Neglect toolkit)	£2800
Miscellaneous other	£6000