Safeguarding Children Annual Report 2025-26

1.0 Introduction and context

1.1 The Children Act (1989 and 2004) and Working Together to Safeguard Children (2025) specify that the Trust Board has a legal responsibility to safeguard and promote the welfare of children and young people, and all staff within the organisation have a statutory responsibility to safeguard and promote the welfare of children.

1.2 The purpose of this report is to update the committee on the work of the safeguarding children's team so that it can be assured that systems and process are in place to ensure the safety and welfare of children and young people in the Trust. The report provides an overview of the performance across the safeguarding children agenda and key developments, identified service risks, learning and improvement. The appendices set out the detail of the activity. The report highlights the drive for high quality practice, which is effective, efficient and continually improving. Despite a number of challenges, the team have maintained a responsive and comprehensive service input to meet the needs to those that are identified as vulnerable and in need of support.

2.0 National and Local Context

2.1 2025-26 has been a busy year in relation to the safeguarding of children. Highlighted below are several key pivotal safeguarding children related matters, both at a national and local level that influence and shape our safeguarding agenda and responses.

2.2 The Children's Wellbeing and Schools Bill 2024 was introduced to Parliament on 17 December 2024 and aims to change the law to better protect children and raise standards in education and sets out a proposed statutory framework for the social care reforms. DHSC and DfE are involving NHS England for elements that involve or impact health strategy or service provision. There is a duty on the Local Authority to set up MACPTs (Multi-Agency Child Protection Teams) and a duty to cooperate placed upon health and the police. Early discussions have been undertaken with the local partnership to determine the local service model. There is a clear expectation that health, via either the children's safeguarding team or community universal services are part of the membership and a core requirement.

2.3 Working Together to Safeguard Children has undergone a revision in 2026. The updated guidance aims to foster a "joined-up family help model". This is through a stronger focus on supporting families through early help, reducing the need for child protection intervention by keeping children at home and safe. From a practice perspective key changes emphasise kinship care support, a stronger focus on children's mental health, strengthened guidance on child sexual abuse, online risks, and coercive control. There is a renewed focus on the requirement for clearer accountability for safeguarding partners, with new "Lead Safeguarding Partner" (LSP) roles for strategic decisions within the local safeguarding arrangements. The LSPs for safeguarding partners are: Chief Executives of Local Authorities, Chief Executives of the Integrated Care Board (ICBs), and Chief Officers of police forces.

2.4 ICBs hold statutory duties under the Children Act 2004 to ensure commissioned health services protect children and promote their welfare. ICBs must establish robust safeguarding systems, appoint designated professionals, and collaborate with local authority partners to address child safety, special educational needs (SEND), and looked-after children's health needs. ICBs in England are undergoing major, mandatory financial restructuring, with a directive to cut their running costs both staffing and administration. ICBs are forming "clusters" or merging to share leadership and being re-focused as "strategic commissioners" rather than administrative bodies, with a push to move more, or all, of their functions into provider collaboratives. The Trust will need to be cognisant of any changes in relation to safeguarding roles and function in the new revised arrangements. This is an area that will be monitored closely as we move into 2026-27.

2.5 The Southport Inquiry, established in April 2025 is a statutory investigation into the July 2024, knife attack in Southport that killed three girls and injured many others. The inquiry found that missed opportunities, systemic failures by public agencies, and parental inaction could have prevented the attack, noting the perpetrator had a long-term fixation on violence. The inquiry found that multiple agencies missed opportunities to stop the attacker, who had a history of carrying knives and making threats. The perpetrator had three failed referrals to the "Prevent" program, as his fixations were not properly identified as ideologically dangerous. Whilst some interagency referrals and discussions took place at various panels, these were not effective in terms of actions. Prevent awareness remains core to our mandatory training. Information sharing between agencies is only as good as effective actions and outputs. This is an area that is constantly at the forefront when staff attend any interagency meeting and ensuring that actions result from discussions. Interagency strategy meetings and case panel meetings and improving expectations of health will be taken forward as part of our modular approach to safeguarding children training in the coming year.

2.6 The statutory Independent Inquiry into Grooming Gangs in England and Wales was established following a June 2025 audit by Baroness Louise Casey, addressing systemic failures in protecting victims. Chaired by Baroness Anne Longfield, the inquiry focuses on group-based sexual exploitation, is expected to last three years, and aims to hold institutions accountable

for past failures. The issue of grooming is widespread across the country. A BBC investigation reported in February 2026 revealed the significant extent of child sexual exploitation and grooming of girls across London; with the head of the child exploitation team for the Metropolitan Police in Lambeth and Southwark estimating that 60 children are being exploited across the two boroughs. One of the team attends the Southwark Extra-Familial Harm (EFH) panel and has provided anecdotal feedback that although children at risk of child sexual exploitation are discussed at panel, most young people discussed are male and victims of child criminal exploitation, suggesting a potential hidden harm for girls in the community. Whilst known cases can be discussed at the EFH panel and a plan agreed, there will be many more children who are not yet on the radar of services and remain at risk. It is therefore important that health professionals, including school nurses, know how to use the child sexual exploitation (CSE) risk matrix tool and that sexual health clinics in the community are using a specific young person's assessment template to identify any vulnerabilities, particularly given that GSTT no longer offer a specific young person's sexual health clinic. There is a link consultant for safeguarding children within GSTT sexual health services, and the team receive monthly supervision from the acute safeguarding children team.

2.7 A revision on our local arrangements for harm outside of the family has been undertaken. The new Multi Agency Risk Outside the Home meeting (MAROTH) is responsible for monitoring, evaluating and improving the effectiveness of all multi-agency activity related to the risk's children face outside the home including child exploitation, violence affecting young people and children who go missing. Reporting to the Local Safeguarding Children Partnership (LSCP) the work of the meeting is focused on processes, trends, groups, and locations rather than case specifics. The terms of reference and the meeting have been updated to align itself with the learning and recommendations of HMRCFRS (His Majesty's Inspectorate of Constabulary and Fire and Rescue Service) and to ensure best practice is identified through the London MACE chairs network meeting. The MAROTH will take a child first approach and be underpinned by the belief that children cannot consent to their own exploitation. The MAROTH will take a Victim, Offender, Location, Themes (VOLT) approach to its meetings, its response and collection of data. The Head of Nursing Safeguarding Children or nominated deputy will be the Trust representative.

2.8 The Lambeth LSCP has been updating our local partnership online safety policy and guidance. We have contributed to this guidance. This local guidance will support our Safeguarding Commissioning Assurance Toolkit (SCAT) submission. The SCAT is submitted to NHS England in terms of our compliance with core safeguarding requirements. One question in the SCAT relates to having a policy regarding internet and social media use which addresses safeguarding. The Trust does have an overarching internet and social media policy. Although it does not specifically reference safeguarding, the policy is based on the premise of safety and protection. To promote online safety, partner agencies delivered a public warning to parents that online offenders will exploit the school holidays to engage in criminal acts with young people when they know less support is readily available. Material has been cascaded to service leads to promote this campaign in their areas.

2.9 Universal services play key role in the identification and follow through of vulnerable children and young people. Lambeth Commissioners have outlined their intent to significantly disinvest the financial budget for universal services; this reduction will be over this financial year. Various workstreams have been set up to review and agree a new model of working for the 0–19-year service. It is planned that this will change to a 0-11 and a 11–19-year service. A safeguarding workstream continues to meet to discuss potential pathways for vulnerable children within the community, however there is no confirmed model at present and the projected timeline for enacting any change is not yet determined. Changes to how universal services will work will invariably mean a change to how the safeguarding children community teamwork. This naturally causes some anxiety with staff when they move from an established way of working to a new revised model and approach. It is anticipated that the safeguarding children community team will have some patient facing activity and case holding which is not in their current model of working.

2.10 In July 2025 NHS England provided further guidance in relation to the roll out of Phase 2 of CP-IS (Child Protection Information System). We have previously successfully implemented CP-IS in the emergency department and maternity departments. The new directive is in relation to scheduled care with NHS England strongly advising all NHS providers currently using CP-IS to urgently integrate the system into all services that may encounter children, to support holistic and timely safeguarding. The proposed roadmap and timescale from NHS England for Community paediatric departments, sexual health and sexual assault centres, health visiting and school nursing is by August 2026. Local planning is in place with joint meetings scheduled with King's College Hospital to implement.

2.11 We have submitted an escalation letter via the Lambeth ICB to Lambeth Children's Social Care to highlight ongoing challenges in multiagency child protection work. It is hoped this letter helps create the momentum for positive change. The letter outlines several areas where the current system is not functioning as intended:

- Multiagency partnership working: Routine processes are not always followed, which can create uncertainty and potential risk for children.
- Clarity of roles and professional expertise: Health input is sometimes overlooked, which can delay or prevent appropriate medical assessment.
- Communication and information sharing: Timely updates and shared critical thinking are essential for safe decision making, but this is not happening consistently.
- Shared understanding of thresholds: Different interpretations of risk and thresholds are leading to repeated escalations and unnecessary tension between agencies.

- Use of escalation pathways: Health colleagues are escalating concerns frequently due to delays or lack of progress, which creates anxiety and takes time away from direct work with families.
- Governance and audit processes: Multiagency audits are not always resulting in shared learning or agreed changes, and health perspectives can feel marginalised.

The letter emphasises that these issues are systemic rather than individual, and that we are committed to working collaboratively to improve the experience and safety of children and families. However, this has been an opportunity to review some health areas that needed to be developed such as ensuring some health leads being clear on the meaning of escalation and channels to appropriately escalate. The escalation route to Directors of Children's Social Care (CSC) has been inappropriately used in some instances when a case discussion with respective managers has been needed. A productive meeting was held with senior leadership to discuss the concerns and how we work going forward. We have reintroduced a health and social care meeting, and communication channels. Education to Social Workers and police regarding children's chronic health needs is planned for Q1 of 2026-27. This education will assist in enabling Social Workers and police to have greater understanding of children's health needs when medical neglect is raised as a safeguarding concern and what agencies need to consider when placement searches are underway. A task and finish group has been set up following the physical abuse case audit to explore process issues.

3.0 Governance and corporate standards

3.1 We continue to fulfil our Section 11 requirements with no significant changes. A Section 11 audit has been completed for Southwark LSCP at the end of April 2026. Whilst this is for Southwark LSCP, the core standards and evidence will be applicable across the safeguarding children's partnership that we are members of (Lambeth LSCP; Kensington and Chelsea LSCP). It is anticipated that a 'challenge panel' will be convened whereby the LSCP Chair and executive leads will provide scrutiny and challenge.

- A safeguarding children policy (updated March 2026) and procedures (updated February 2024 and due renewal 2027) are in place. The overarching policy and procedures are supported by additional guidance, including Domestic abuse policy; Female Genital Mutilation policy; Safeguarding children supervision policy; Therapeutic and restrictive intervention guidance; Allegations policy.
- The Trust sexual safety policy and chaperoning policy have been developed and revised in 2025-26.
- The safeguarding training strategy is due a renewal and plans have been in place to update. This had been delayed due to the anticipated publication of the revised Intercollegiate document (2025) Safeguarding children and young people and

children and young people in care: Competencies for health care staff. This was published at the beginning of November 2025. A draft training proposal has been developed and is currently undergoing review by relevant stakeholders.

3.2 A dedicated safeguarding team is in place. There has been some turnover of staff in the team over the year. There has been successful recruitment to the five vacant posts and new staff have commenced employment and have had a period of induction. The Southwark Named Nurse for Community Safeguarding left their post at the end of August 2025. This post is a statutory requirement and essential for leadership. Despite recruitment attempts this post remained vacant until February 2026. Operational management and team oversight was maintained during this period.

3.3 The safeguarding children team has been affected by high sickness levels over the year. Although these are not directly attributed to work related stress, it is important to note that the nature of safeguarding work can affect physical and or other life stressors that an individual experiences. Dedicated psychology and reflective practice time had been embedded for the team; this is highly valuable. The psychology input will not be able to be replicated in 2026-27 due to changes in the psychology team. However, plans are in place to provide reflective practice and restorative supervision for team members. The level of work and the nature of safeguarding means it is easy for staff to become overwhelmed and burnt out and therefore, pastoral care for the team is a priority.

3.4 Safeguarding children training compliance has been circa 80-82% for the majority of 2025-26. There has been a positive trajectory and Q4 compliance has increased to circa 89%. This is due to revision of training profiles, direct communication with individuals and their managers and also increased training provision. Training compliance is covered further in the report.

3.5 Level 4 safeguarding training is available for all safeguarding children practitioners. Safeguarding supervision training has been sourced via the NSPCC for safeguarding nurse specialists as part of the education and training commissioning requirements. This has commenced at the end of 2025-26.

3.6 There were 15 allegations in relation to the safeguarding of children over the year. These have all been appropriately managed.

- 10 cases were in relation to the staff members professional life and 5 cases were in relation to their personal lives.
- The categories include 7 physical abuse, 5 information governance breaches, 1 misconduct and 2 sexual abuse/ harassment.
- 4 cases were referred by the LADO
- The staff groups included 2 Admin, 3 Doctors, 7 Midwifery and Nursing and 3 Other Staff Groups.

3.7 A new Local Authority Designated Officer (LADO) stakeholder steering group has been set up in Lambeth. This enables partners of health, police, Social Care and education to collectively review best practice. This has included the formulation of children's leaflets to share with children and their parents; a professional leaflet for those invited to an Allegation against Staff and Volunteer (ASV) meetings, and a 7-minute guide to LADO remit to share with professionals. These documents will be made available to staff and any service users.

3.8 A review of the Trust's domestic abuse services has been completed in the year. Historically the Trust has had two separate services, with Reach providing a service to the Emergency Department and Mozaic providing a service to women's services. This led to an inequitable service offer to those in need of support across the organisation. Each service had separate funding streams and reporting structures. The in-house, Reach service has come to a natural end with the retirement of the post holder at the end of Q3. Notice has been served to the Mozaic service and the contract ended at the end of April 2026. Plans are underway to recruit to a newly formed internal service. This will take the form of an initial domestic abuse screening and risk assessment and onward referral to local services. There will be a continuation of adult and children safeguarding teams input for adult and children at risk. Further consideration will be needed in the future to explore a fuller trust wide service model.

3.9 A Safeguarding Children Operational Committee has been in place to take forward key aspects of the safeguarding children agenda. The terms of reference have been updated. To ensure that maternity safeguarding is fully encapsulated in the committee the committee has changed its title to Children and Maternity safeguarding Operational Committee.

3.10 The team have noticed an increase in the number of complaints which have a safeguarding component. The themes from this include information sharing without consent, access to child related information when parents are estranged and a higher proportion of complex and challenging safeguarding cases with a pattern of opposition to medical advice and complex FII type presentations.

4.0 Activity

4.1 2025-26 has been a busy year with significant levels of activity and vulnerabilities identified. The full activity is depicted in table and graph format in the appendices. Activity numbers will provide an outline of the level of contacts regarding children of concern; however, this does not fully represent some of the complexities of cases and level of input required. Some cases will be short lasting activity with identification during an acute episode, initial response and referral to partner agencies and

discharged to ongoing providers. However, some acute cases require longer term involvement such as children with concerns about fabricated and or induced illness, delayed discharge due to identification to appropriate placement and or support package. Maternity cases will invariably span the pregnancy with periods of ongoing risk assessment and planning. Community paediatricians will be involved for a short period of time with case discussions with partners and then a child protection medical. Universal services, and in particular health visiting will have ongoing case involvement as part of a targeted service delivery to vulnerable children.

4.2 There are an increasing number of cases that pose a challenge in terms of management. These cases often are not 'pure' safeguarding or mental health and often families with deemed challenging behaviours, whether overt or passive aggression. This can impact in the clinical team's ability to deliver safe and effective care. The Director of Nursing, Evelina London is convening a deep dive meeting to explore issues and possible strategies going forward.

4.3 Hospital based activity. (See Tables 1-3 and Charts 2-12 in the appendices).

- Total referrals across the Trust have been comparable with the previous year with a total of 2273 referrals received. There was a peak of 613 referrals in Q1, and other quarters ranging between 541-575.
- Q2 saw a 55% drop in referrals from the Royal Brompton Hospital (RBH) site. This may be attributed to reduced safeguarding presence on the RBH site and case dialogue and early identification. Staffing capacity was a contributing factor, in which CNSs have been unavailable to provide regular onsite days at the RBH site. The Named Doctor and Deputy Named Doctor for Safeguarding Children and the Senior CNS have been working to actively support clinicians on the RBH site and have provided regular site visits to increase visibility.
- Neglect remains a prevalent feature of cases with 261 identified over the year through hospital activity; this increases to 508 when 'was not brought' is added to the figures equating to 22.3% of all referrals to the hospital team.
- Childhood mental health concerns relate to 329 referrals to the safeguarding children team; this equates to 14.4% of the total referrals. A further 285 referrals (12.55) referrals were generated in relation to either parental mental health concerns or behaviours that could impact on their child.
- The number of cases that has required both internal and external legal advice is on the increase Two separate Treatment Order were required to be sought due to parents being unable to follow medical plans which posed a risk to the child. We are seeing an increase in the number of staff that are required to be preparing statements and or attending family Courts as witnesses. This can be onerous for staff. Support is provided through the safeguarding leads, internal and external legal teams as required.

4.4 The number of contacts for safeguarding maternity support remains significant. (See Table 4-6 in the appendices).

- The team received 3326 contacts and or enquires for 1250 women over the year. Of these 461 referrals were generated to Children's Social Care for assessment of need. Due to being under maternity services from maternity booking to birth of the baby it is inevitable that there will be ongoing contacts at periodic episodes throughout the pregnancy.
- The highest number of referrals and contacts for support related to women already known to Children's Social Care (212 women), domestic abuse (205 women) and mental health (185 women).
- Issues in terms of homelessness and or unsuitable accommodation is steady through the year with 118 women referred to the maternity safeguarding team.
- The Mozaic domestic abuse service commissioned by Women's services supported 119 women who disclosed domestic abuse.

4.5 The number of Child Protection Plan (CPP) in Lambeth has increased from 254 at the start of the year to 285 at the close. Southwark has also increased from 214 CPP to 259 in the same period. During the year there has been month on month variation (See Chart 13). This notable uplift indicates a shift in presenting risk and safeguarding demand, signalling increased complexity and a higher volume of concerns requiring statutory oversight as the year concluded. It is not unusual to see fluctuation month to month in terms of CPP figures; variations include new children being made subject to CPP or previous children stepped down to Child in Need Plans as progress has been made in terms of case management and risk mitigation. Emotional abuse tends to be the prevailing category of abuse with circa 40% of cases, followed by neglect with approximately 35% of cases. Approximately 2/3rd of all CPP are for school age children.

4.6 A significant proportion of community safeguarding activity is in relation to the acquisition and sharing of information for various multi-agency case discussions. This includes MASH (Multi Agency Safeguarding Hub) enquiries and strategy meetings.

- Q4 saw a significant increase in strategy meetings in Lambeth, with 202 strategy discussions convened by Children Social Care (CSC), rising from 153 in Q3. This continues the upward trajectory observed earlier in the year (166 in Q2 and 202 in Q1), indicating a sustained period of heightened safeguarding demand rather than a temporary fluctuation. Many of these discussions progressed to Section 47 enquiries, reflecting the seriousness of presenting concerns. A key factor driving this increase was the rise in Non-Accidental Injury (NAI) and Child Sexual Abuse (CSA) concerns, alongside a noticeable uplift in domestic abuse and neglect strategy referrals. The overall rise in strategy activity appears to correlate with the increase in children subject to CPP during Q4. Southwark average 200-220 strategy meetings attendances per

quarter. However, the Southwark safeguarding team (Doctors and Nurses combined) attended 25% fewer strategy meetings in 2025/26 compared to 2024/25.

- 1 WTE post is dedicated to MASH enquires in each borough. Safeguarding activity within MASH remained consistently high throughout Q4, with 175 cases discussed in Lambeth MASH involving 299 children. This represents a sustained level of demand and an increase of 86 children (40%) compared with the 213 children linked to cases in Q3. Within Southwark there is year on year increase in requests for health information with a 37% increase in Q4 2025/26 compared to Q4 2024/25.
- Child protection medicals undertaken by the Lambeth team are steady with attendance of appointments ranging between 73 in Q1 to 89 in Q4 and a total of 294. However, of note is that these figures do not include those children that have been determined at a strategy meeting to require a child protection medical and then do not attend; 111 children did not attend due to various factors such as no consent or deemed no longer necessary. Within Southwark there were on average 46 child protection medicals each quarter and a total of 184; the non-attendance rate is less than Lambeth with 56 appointments not attended. (See Charts 14-15). Attendances are comparable to the previous year.
- 39 child sexual abuse examinations were undertaken across the boroughs of Lambeth and Southwark.

5.0 Key priorities

5.1 Getting child protection right

5.1.1 Safeguarding procedure guidance can be lengthy due to the breadth of the safeguarding subject matter. Full guidance is in place and available to staff via the policy pages on the intranet. To ensure that guidance is accessible 'Safeguarding quick reference guides' have also been updated to enable staff to have key salient points to note and guide practice. These have been supported by the circulation of two 'Question and Answer' documents, the Safeguarding of Children and deprivation of liberty in relation to 16- and 17-year-olds.

5.1.2 Safeguarding children supervision is vital for support for practitioners and also in terms of quality assurance and oversight of vulnerable caseloads. A revised safeguarding children supervision policy has been approved and champions a cultural shift towards group supervision where appropriate and a whole-family working approach. This new model and approach need to be further embedded in the next year with the allocation of supervisors to families and the embedding of this model into daily practice. As with any organisational change, there are barriers, particularly where staff work differently according to their individual work plans and service demands. As community teams go through reorganisation as part of the 0-19 service there will be a need to maintain safeguarding supervision at the forefront of practice and oversight.

5.1.3 Some concerns have been expressed regarding access to safeguarding children on the Royal Brompton and Harefield (RBH) sites. A review of staffing was undertaken, and the staff have been centralised into one acute hospital team. Service cover remains present and not removed. The Named Doctors for Safeguarding Children are working to actively support clinicians on the RBH site and have provided regular site visits to increase visibility and provide advice. As inpatient services move from the Royal Brompton site to the Evelina London site in May 2026, access to safeguarding support should be timelier.

5.1.4 The community medical team have updated the referral form for child protection medicals. Delays had been experienced in offering child protection medicals due to insufficient information and or consent. This revised form will ensure that the right information is shared as part of the referral with the aim of ensuring that children with injuries or marks are seen within 24-48 hours, in line with RCPCH guidance. Social care and police partners are supportive of this change, as it will strengthen assessment processes. A key barrier remains the timely acquisition of consent for medicals. Work is underway to streamline and clarify consent processes.

5.1.5 The timeliness of child protection medicals being offered within 24 hours is generally positive. (See Chart 14-16 in appendices). However, there is a notable difference between both Lambeth and Southwark in terms of overall activity; Lambeth had 390 appointments offered in 24 hours out of a total of 399 (97.7%). Of these total appointments 294 children attended. Comparatively Southwark had 164 appointments offered in 24 hours out of a total of 184 (89.1%). Of these total appointments 184 were attended. Whilst Lambeth has higher numbers of appointments this does not necessarily translate into the number of children seen; Lambeth invariably has higher numbers of missed appointments due to consent issues and or non-attendance.

5.1.6 The number of appointments attended does have an impact on the completion and distribution of the child protection medical reports. The team have taken several steps to avoid scheduling child protection call for our residents just before night shifts, annual leave or zero days. This, along with increased supervision is enabling some progress with meeting the 10 working days target. In Q2 the Lambeth team were able to complete and share reports with Children's Social Care (CSC) within the specified timeframe in 75.3% of cases. This is an improvement from 57% in January 2025. However, this dropped to 64.5% in Q4. Within Southwark, the range of completed reports range from 78.7% in Q1 to 97.9% in Q4. (See Chart 17 appendices). Reports relating to child sexual abuse (CSA) are particularly delayed due to the need for external peer review to support clinical opinion and diagnosis. This quarter, several cases required CSA peer review. Due to IT issues, DVDs could not be shared online, and this has been escalated. Until digital sharing is restored, doctors have been manually transporting DVDs between Lambeth and Southwark to facilitate peer review.

5.1.7 The Neglect Toolkit has been available in Lambeth since 2024-25. This has now been rolled out to Southwark in 2025. The consistent use of the Neglect Toolkit during health assessments is being actively reinforced through safeguarding supervision sessions, ensuring that practitioners are equipped to identify and respond to neglect more effectively. Consideration to be given to adding the Neglect Toolkit to EPIC, for ease of use (and compliance reporting) when completing referrals to CSC where neglect is identified.

5.1.8 Was Not Brought (WNB) or Did Not Attend (DNA) appointments can be an indicator of neglect. The acute WNB process has now been reviewed. WNB cases are now easily identifiable on EPIC allowing the team to move away from the use of a manual spreadsheet for recording activity. In Q1 it was identified that there was an EPIC issue in which referrals made against an episode marked as a DNA cannot be seen in the notes and do not appear in the safeguarding inbox. This was escalated to the EPIC team and addressed.

5.1.9 In January 2026 a new process was agreed and finalised for Chain of Evidence samples within the community settings. The Child Development Worker or Child Protection administrative staff will no longer be required to transport samples as they will be collected by GSTT Transport department. We have used the service since the agreement was made and there have been no issues or concerns raised.

5.1.10 Following discussions over the last couple of years about the Evelina Community non acute, non-forensic CSA service, the CSA lead clinicians across Lambeth and Southwark have recently submitted a position statement to the Joint Heads of Service and the Clinical Director/Deputy Medical Director identifying current risks and suggesting further steps.

<u>Areas for development and identified service risks</u>

5.1.11 Safeguarding supervision compliance data within the community is not optimal. This is of particular concern in Southwark for Q3 and Q4. (See Table 8 appendicees). Recorded supervision has ranged between 46-71% for school nurses and 46-97% for health visitors. Allocation of supervisees has been reviewed and there is a plan in place to target practitioners who may have avoided safeguarding supervision over multiple reporting quarters. The fall in compliance may also be due to ineffective recording of when supervision sessions have been completed, and it is expected that with a combined approach of targeted work and better recording systems, compliance will steadily improve over the next quarter. Safeguarding supervision for clinical teams within hospital teams needs to be refocused as some teams have not had regular sessions due to some scheduling and capacity issues. However, the team continue to have an open-door policy and ad hoc and case discussion is available.

5.1.12 A sample of children on child protection plans has been reviewed and showed that health visitors were seeing the children on child protection plans and appropriately discussing in supervision. Of the school-aged children subject to child protection plans reviewed, a significant proportion have been discharged from the school health service with 'no identified health need requiring school nurse input' provided as the rationale for discharge. The current pattern and step-downs in school nursing raises concerns about whether a single Initial Health Needs Assessment is sufficient to understand the holistic health needs of vulnerable children. A one-off assessment may not fully identify unmet health needs, particularly where risks are dynamic or where emotional, developmental, behavioural or chronic health issues emerge over time. None of the school-aged children audited had been discussed at safeguarding supervision. Given that many child protection plans remain open for 12+ months and evidence that children and young subject to child protection plans have poorer health outcomes, further exploration as part of the universal service redesign needs to be undertaken to quantify the school nurse role and offer to children subject to a child protection plan. The Named Nurses safeguarding community are undertaking further work and putting systems in place to monitor and determine that compliance is also added in terms of children subject to a child protection plan being discussed at supervision

5.1.13 There remain concerns regarding the uptake of child protection medicals in Lambeth. Several appointments are wasted due to various factors. Q3 63.9% children offered appointments attended compared to 77% in Q4. The reasons are usually around parental no consent. Children should not be kept waiting for more than 10 working days from the point of referral, unless there are clear mitigating factors agreed by all parties. Where police investigation or protection from harm is required, they need to be completed within 24 hours. Although the team have the capacity to see children within 24 hours, this has proven challenging due to delays in appointment confirmations, often due to CSC processes or parental constraints such as work commitments. When there is a delay between disclosure and the child protection medical assessment, this is clearly documented to ensure accurate interpretation of any absence of physical findings. This impacts on physical findings on examination.

5.1.14 Several incidents have been reported whereby the child and family demographic details on EPIC are out of date and or wrong. In some instances, this has meant that the biological parent has been contacted when the child has been removed from the parent to foster care. This poses an inherent risk that the child's whereabouts and details are known when they should not be. This appears to be linked to changes on the NHS spine and how this is linked to the record and how legal guardians are recorded on the system. A working group has been reviewing this situation as a priority to mitigate. Staff have been using legal guardian and parental responsibility interchangeably when they have separate meanings. The default letter function has been removed from the legal guardian field.

5.2 Violence agenda (inclusive Domestic Abuse/ FGM/ Serious Youth Violence/ Child Sexual Exploitation)

5.2.1 The Trust domestic abuse policy is in place. This was last reviewed in 2023 and due renewal no later than November 2026. However, this will be revised sooner to include revised pathways following the agreement to change the domestic abuse services in the trust.

5.2.2 A review of the Trust's domestic abuse services has been undertaken over the year. The Trust has had two distinct services, Reach service for the Emergency Department and Mozaic for Women's services. Each had separate funding streams and reporting structures leading to some governance concerns. Various options for service reconfiguration have been proposed with the preference for one trust wide service. This option is not currently viable. The Reach service has come to a natural end with the retirement of the post holder. Notice has been served to Mozaic which was externally commissioned. The contract ended on 30 April 2026. We are currently in the process of advertising for domestic abuse support officers for our newly revised internal service model. This will provide services for ISM and the Women's and Children Clinical Groups. This new team will report to the Head of Nursing Safeguarding Children. The working model will be of an initial response, assessment and onward referral to local domestic abuse services as opposed to longer term case management. Further work will be undertaken to look at the preferred option of a trust wide service. All trust patients continue to receive a responsive safeguarding service for those adult and children at risk.

5.2.3 The Women's Safety Alliance has launched as the new Violence Against Women and Girls (VAWG) service in Southwark, which includes domestic abuse services. This service is being delivered by Bede House and will tackle wider VAWG issues beyond domestic abuse including sexual assault/rape, child sexual exploitation, FGM, honour-based violence and forced marriage amongst others. A meeting has been set up with the service and the Southwark safeguarding team to discuss the service offer and discuss effective partnership working.

5.2.4 Over the reporting year Mozaic received 119 referrals in total; these were primarily from Women's service; 117 of these continued to have input from Mozaic following the initial contact. Comparatively the hospital safeguarding children team received 124 referrals in relation to domestic abuse from areas outside of Women's services and where there was concern about the impact of domestic abuse to a child in the family. It would be expected that there would be higher numbers of referrals based on patient episodes of care at the Trust. One key issue is that domestic abuse questions are not regularly being asked or identified amongst patients. Domestic abuse is now being discussed within supervision to mitigate this risk, and the team are looking at developing specialised domestic abuse training as part of our training strategy. Only 1 MARAC

referral was made by Mozaic in the year; this is surprisingly low for a service that supports high risk domestic abuse clients. Reach service data is incomplete for the latter part of the year due to sickness within the service.

5.2.5 Issues had been raised within Southwark of the health MARAC sharing processes and governance during Q2 and therefore, MARAC made the decision that they would not be sharing full details and minutes with health. The MARAC coordinators were concerned that information may be stored on systems in an unrestricted manner that is not controlled and that staff are conducting welfare checks on families as a standard process, rather than on a case-by-case basis that accounts for individual need/ risk. Some changes to processes have been made within the community safeguarding nursing team to ensure that the team operate under best practice standards, the Information Sharing Agreement and GDPR guidance. MARAC conference attendance has now been resumed. As outputs of the meeting, specific targeted health actions will now be generated as opposed to a generic health visitor follow up requests being made. This will make actions purposeful and measurable. There is a plan for any health actions from MARAC to be agreed and discussed within the conference itself to ensure an individualised approach, and that all partner agencies are aware of work being undertaken by health.

5.2.6 Compliance on routine enquiry within maternity is showing improvement on EPIC but requires further work. The domestic abuse template is not always used, particularly on the postnatal areas, where information is documented in narrative form. A member of the Maternity Digital Team is supporting clinical midwives to address this. Within maternity services, compliance for routine enquiry on domestic abuse (DA) at booking is reported as 87% in Q4, an increase from 81% in Q1, but down from 97% reported on pre-EPIC system. Staff are being supported to use the DA template, rather than free text, to support compliance reporting and monitoring.

5.2.7 The Trust's Female Genital Mutilation (FGM) policy is in date and last renewed in May 2024. New FGM risk assessment tool build has been agreed and is ready for implementation March 2026.

5.2.8 Over the reporting year there were 187 pregnant women who were identified as having FGM. This included Type 4 x 2; type 3 x 30; type 2 x 34; type 1 x 72 and 49 unknown type. 104 female babies were born to these mothers. FGM risk assessments were completed fully in all cases, and all women offered an appointment with the Consultant Midwife for public health. All FGM-IS alerts on the national spine have been confirmed.

Areas for development and identified service risk

5.2.9 Further work needs to be undertaken to quantify that routine enquiry in relation to domestic abuse is embedded into health visiting practice. An audit in Q4 provides partial assurance, with improvement required in consistency, safe-practice compliance, and documentation quality. While practitioners generally demonstrated appropriate judgement in recognising when conditions were not safe or private for domestic abuse enquiry, there was limited evidence of follow-up planning when enquiry could not be completed. Feedback from MARAC has highlighted that no referrals were made to Southwark MARAC by GSTT services in Q4, however MARAC data indicates that 26 children under 5 years old were identified as the child of either a victim or perpetrator discussed at conference in Q4. Therefore, there needs to be consideration as to whether the quality of routine enquiry undertaken is sufficient to identify high risk victims of domestic abuse and whether appropriate actions are taken if a disclosure is made.

5.3 Mental health

5.3.1 Local delivery plans for children's services for 2026 have been developed accompanied with an implementation plan. These include:

- Reducing the time children and young people spend in inappropriate care environments through consistent use and regular review/ revision of the Evelina Escalation Pathway based on feedback and learning from case reviews. To deliver this, we will continue to audit LOS (hours) in PED/ CSSU so that we can retrospectively review cases and report impact.
- In 2026 work will start with colleagues in the GSTT digital team to develop how to embed our existing children's mental health pathway for children, which provides clear guidance on caring for children and young people with acute mental health concerns who are inpatients, into EPIC. This would make information accessible for staff across all sites to enable consistent, high-quality care to be delivered. This pathway is due for review by the end of July 2026, so we aim to deliver this work before this date. At present only the risk assessment and rapid tranquillisation aspects are available on EPIC.
- Following the HSIB report on children and young people with acute mental health challenges cared for in acute children's inpatient settings (HSIB, 2024) we have reviewed the recommendations and identified actions required which will be reported through the Evelina Clinical Governance group in 2026, and form part of the assurance report to GSTT Mental Health Group starting in mid-2026. The areas identified by the report include:
    - Risk of absconding
    - Checklist for safety in side rooms
    - Access to mental health services
    - Escalation/shared ownership of risk across the system

- Work with adult colleagues on enhanced care provision, to ensure the Enhanced Care Team (ECT) receives appropriate training to support the cohort of children and young people, once the team has been fully recruited.
- Ongoing work with security colleagues to ensure the Paediatric Nurse Practitioner (PNP) team receive advanced training on specialist management and use of appropriate techniques to lead safe restraint of children and young people and enable the delivery of the revised restraint/ clinical holding policy for children.
- Continued ambition to engage with and hear from service users, including cohorts of children and young people who have experienced care at Evelina whilst in acute mental health crisis and we will continue to look for opportunities alongside our CAMHS and patient experience colleagues.
- In 2026 our training plans will focus on ensuring teams deliver trauma-informed practice. This includes developing expertise within our established PNP service, alongside all children's inpatient areas, including critical care services. A programme of rolling education will be delivered by our CAMHS education partners alongside our existing multiprofessional education.
- Within 2026, we will undertake a planned review with our GSTT colleagues, looking at current and future pathways of care for 16/17-year-olds who attend our emergency services in acute mental health services, learning from recent cases. This follows a recent review of children and young people with physical health needs, led by the Evelina Deputy Medical Director and the Evelina Head of Nursing for Site.

5.3.2 A revised formal escalation pathway for Children and Young People with mental health illness and/or complex safeguarding concerns who require a Child and Adolescent Mental Health services (CAMHS) inpatient admission or an agreed safe discharge plan to the community setting has been developed. This is in draft format and is currently being reviewed by relevant stakeholders. The purpose of this pathway is to provide staff with guidance on the escalation process and actions required to ensure the children and young people is managed in a safe environment and a safe discharge plan is agreed. This pathway involves collaboration between the Paediatric Emergency Department (PED), CAMHS and safeguarding team and other relevant services to facilitate safe and effective care transitions. Delayed discharges is an area of concern across the Southeast network and conversations have been held in terms of best practice and how to address. A memorandum of understanding is being proposed across the partnership to address the issues.

5.3.3 It has been identified that the SLAM CAMHS Liaison Service based at St. Thomas Hospital are commissioned to provide a service to the Guy's site. The Lead Consultant Psychiatrist for the team has been tasked with developing a Standard Operating Procedure to deliver this service. Until the SOP is completed and plans to extend CAMHS Liaison cover to the Royal Brompton Hospital and Harefield Hospital sites have been put on hold. This is due to CAMHS are not currently fulfilling their core commissioning responsibilities to provide a service to the STH/ELCH/Guys site; this needs to be addressed and

resolved before taking on extra responsibilities (at an additional cost). Mitigations against the current situation are that the mental health nurses at Royal Brompton Hospital and Harefield Hospital sites will see 16-17-year-olds if necessary and liaise with CAMHS. Any under 16s or 16 and17 year olds requiring emergency mental health assessment will be conveyed to the local ED for assessment by the local CAMHS service (CNWL). There is also a paediatric psychology service on the Royal Brompton site and adult psychology cover 16-year-olds and over. No under 16-year-olds are admitted to the Harefield site and under 17s only in an emergency. However, from May 2026 inpatient services for paediatric services currently at the Royal Brompton site will transfer to the st Thomas site and have access to CAMHS service that in place.

5.3.4 In the first 3 quarters of the year there were 322 children that attended the PED that required an acute mental health assessment. Numbers per month average approximately 34, with a peak to 46 in November. The reasons for presentation remain suicidal ideation/ alcohol/ substance misuse and depression. The number of mental health presentations do include a significant and increasing number of children and young people, once assessed are deemed not to have an acute mental health presentation or no mental health concerns, but have an acute behavioural problem. This group are distinctly more difficult to move to their next destination or placement as this becomes wholly reliant on Social Care intervention.

5.3.5 Rolling programmes of CAMHS training and education continues to be provided to PED staff delivered by Evelina Mental Health Champion and SEL Education Lead. Mountain ward has recently taken part in multidisciplinary team education on improving care and the experience of care for children and young people with eating disorders, working with the Swift Targeted Admission Reduction Team (START) from the Maudsley Centre for Child and Adolescent Eating Disorders. Under the Mental Health Training Framework and Skills Passport for Adult Nurses (Pillar 5: MH in Specialism) work stream, Capital Nurse is arranging a meeting with providers in NWL and SEL ICS to discuss developing standardised approaches to Mental Health CYP training that is based on existing good practice trainings/initiatives.

5.3.6 To mitigate the risks of staff not all trained in mental health, RMNs are used via Trust bank and agency as there is no current mental health expertise to support day to day care of children and young people requiring a high level of care and supervision, which has been particularly high in Q2, utilising 10.35 WTE. In Q2, one-to-one RMN care has been required on Savannah ward for a six-week admission of a young person requiring RMN care to meet their acute mental health needs, a result of the neurological condition they presented with. RMN usage reduced to 2.66 WTE for the period between October to January.

5.3.7 A Radar incident review took place regarding one incident that occurred in PED in September involving a 16-year-old with chronic substance misuse psychosis arriving at the department during daytime hours. The young person was brought in by police with a 3-day history of induced psychosis and erratic behaviour, becoming agitated, requiring sedation. They needed

care in resus for 34 hours, and during their stay, they became violent, breaking the glass in the resus room door. Learning from this incident demonstrated good communication with the CAMHS team, consultant input and the de-escalation was managed well and illustrated the known risk of the lack of a designated room to manage paediatric patients in acute mental health crisis.

Areas for development and identified service risk

5.3.8 Two risks in relation to children's mental health are currently on the Risk Register.

i. Risk of injury to staff, child and others resident within inpatient area. No designated environment available for children and young people presenting with acute mental health care needs within Evelina London. Significant numbers of children and young people admitted to inpatient areas (including CSSU) with violent and challenging behaviour who with their families are disruptive and could be at risk due to the environment and to others. Paediatric trained staff have limited mental health training, so potentially harm could occur to the children or young person or staff due to delivering care without specialist mental health training. The use of nursing assessment tool is in place to inform level and type of nursing care required. All RMN agency requests are escalated to and approved by the Director of Nursing. Individual risk assessments are undertaken for each child to minimise the risk of harm to them. For inpatient areas, children are cared for in a side room on wards to minimise stimulation. One-to-one care is usually delivered but is often dependent on the supply of temporary RMN staff. The enhanced care team is asked to support the care of children and young people where needed and any training/support needs for this cohort of staff will need to be considered once recruitment is complete.

ii. Delay in placing children in the appropriate environment to receive care. The cohort of complex children and young people often have challenging home social circumstances and may experience an unnecessarily prolonged stay in the emergency department while a discharge destination is organised in collaboration with Social Care and families. The cohort is unpredictable in presentation, is extremely resource-intensive in both providing care and managing escalation with Social Care to expedite transfer of care to a more appropriate. Presentations of children and young people resident out of the local area, presenting challenges to existing communication pathways with local providers. A revised escalation pathway has undergone multi-professional team review.

5.4 Children Looked After (CLA)

5.4.1 Key performance metrics are in place and measured each month. (See Table 9 appendicees). The Southwark team is consistently seeing 100% of children for Initial Health Assessments (IHA) within 20 days of receipt of referral in the last 6 months. This drops to 73.7% when the metric of being seen within 20 days of being looked after is applied. Within Lambeth 90.8% of children are seen for IHA within 20 days of receipt of referral; this drops to 80.6% when seen within 20 days of being looked after. When there is an increase in being looked after (BLA) to referral time, the first appointments were offered within 20 days of BLA for most referrals but a higher-than-average DNA for IHA rate meant that subsequent appointment offered was outside of the 20-day limit.

Areas for development and identified service risk

5.4.2 Review Health Assessments (RHA) 56.5% were seen by due date in Lambeth; 89.6% were seen by due date in Southwark. Late RHA referral date continues to impact on capacity. This has been escalated within health, social care and designate roles.

5.4.3 Immunisation rates remain lower than target but there has been improvement over the year. To improve the uptake for the immunisation schedule there are ongoing extra nurse led clinics which are being maintained. There is ongoing work with Universal Services and Public Health around signposting to other clinics in the community and how the CLA population can be specifically supported. The CLA nurses are now fully trained in vaccinations. Doctor immunisation training is paused currently as doctors see children and young people attending for IHA, when opportunistic immunisation may not be appropriate. Additionally, doctors see mainly children under 5 for RHA and consent from those with PR prior to the appointment would be needed.

5.4.4 The process for Adult health is still not available on EPIC. Adult Health for adoption, fostering and Special Guardianship Order (SGO), is currently stalled awaiting Trust approval of consent to access Adult Health records. This is being taken forward by the Medical Advisor. Dual processes of paper and electronic records could lead to potential risk that information to inform decisions and plans is not readily available. This should be mitigated once the process is live on EPIC.

5.4.5 The DNA rate is a focus of the service. The DNA rate is historically higher with 15-17-year-olds and the complexity of children entering care late is increasing. Mitigation includes administrative colleagues to ensure reminders occur for all appointments

the day before, flexibility to meet needs with out of service hours offers Monday to Friday alongside offer of home visit/virtual appointments, feedback from social workers/ care staff where it can be elicited.

5.4.6 Drop in receiving ED/ Admission/ Discharge notification for CLA children and young people who attend acute care. This has an impact on health care planning and opportunity to offer timely enhanced health reviews. Exploration is underway in terms of the feasibility of automatic notifications via EPIC when children attend GSTT or KCH. Email communication has been sent to other London safeguarding acute care teams to raise awareness and need for notifications. Invariably Lambeth and Southwark CLA will attend out of borough hospitals due to placements out of borough.

6.0 Learning and Development

6.1 The safeguarding children training strategy is currently under review and a draft has been circulated to key stakeholders for consultation ahead of submission for approval. The revised Safeguarding Children Intercollegiate Document was published at the end of November 2025. This latest version is less prescriptive in the number of taught hours, whilst maintaining a focus on key content and requirements. The guidance supports an adult learning focused, and training geared towards individual needs based on roles, experience and training needs analysis. Based on this we propose a modular approach whereby staff undertake a couple modules, depending on their area of interest post initial core and foundation training. We are also exploring with our safeguarding adult colleagues in relation to a life journey approach, i.e. combined children and adult training for some subject matters such as domestic abuse and level 2 updates. It is anticipated that the revised training strategy will be ready for approval at the end of Q1.

6.2 Previous reports have highlighted the challenges of maintaining appropriate levels of safeguarding children training compliance. For the majority of 2025-26 the compliance has been circa 80-82%. Training compliance has been variable across clinical groups and staff groups. (See Tables 10-12 in appendices). To address this, we put in several measures to aid compliance. This included a revision of staff profiles to ensure that they were correct; direct communication with individuals and their managers; sought Clinical Director and Directors of Nursing support and engagement. In addition to training sessions that were already planned, a boost of additional training was facilitated over a concentrated period. This included 8 additional sessions, primarily for the emergency department staff, but open to all staff; full day 'masterclass' for the emergency department medical staff; condensed block of training over a 2-week period from 23.02.2026-05.03.2026 with 3 sessions per day (1 morning and 2 afternoon sessions) on 5 days. All of these measures have been successful and training compliance for Level 3 child protection at the end of March is 87.82% and compliance for Level 2 is 87.72%. Trust wide Level 3 compliance for nurses and midwifery staff is 91.56% and 76.43% for medical and dental staff.

6.3 The new entrants to Community Paediatrics have accessed Child Protection Level 3 through the Community Paediatrics Course. The Virtual Child Protection Simulation and Debrief course for new community paediatricians starters took place on 15 October 2025.

6.4 All maternity practitioners attending this year's Maternity Child Protection Level 3 training programme from October 2025 to July 2026 are being trained in the use of Lambeth LSCP's Neglect strategy and toolkit, with awareness training also on infant abduction and EPIC safeguarding issues/ referrals. Midwives will be rostered to attend this mandatory training. By July all midwives, excluding those on long term leave, should be compliant with Level 3.

6.5 Monthly shared learning meetings have been launched for all the Trust's safeguarding teams (adult, maternity, acute children's and community children's teams); this will provide a opportunity for our teams to become further integrated, to learn from each other's expertise and to really embed a 'Think Family' approach into our practice as a wider safeguarding team.

6.6 The Business Support Manager for Safeguarding Children is currently developing bitesize training videos for the safeguarding department on various safeguarding topics that can contribute towards CPD learning.

6.7 The safeguarding team members are co-designing and delivering training on chronic medical needs with other LSCP partners. This follows learning from an incident when partner agencies did not fully understand the health need of a child when they enacted an emergency removal of a child with diabetes from the home. Additionally, termly induction training is delivered to new social workers in Southwark introducing them to the Child Protection medical. The last session was held in February 2026. The Named Nurse has had an initial discussion with Social Care colleagues to offer a similar termly session for social work students and newly qualified Social Workers around the role of 0-19 universal children's health services, so that the role of the health visitor and school nurse as part of the multi-agency partnership is better understood.

6.8 An infant abduction drill was carried out in August 2025 to test midwifery and customer care teams' response in the event of an attempted baby abduction, or removal of a baby from a ward prior to an agreed discharge. Appropriate challenge and response were observed, and the 'mother and baby' were returned from the foyer to the ward area.

6.9 HOPE memory boxes are now available to offer to mothers/ parents where care proceedings have commenced and /or there is a likelihood that a mother and baby will be separated following birth. The boxes are in pairs - one for the mother and one for the baby's carer, both with meaningful items to create special memories and support connection, recognise grief and loss, and reduce trauma. The Maternity Safeguarding Team, Tower and PNMH midwives completed training in August 2025 and

will support midwives in their use, and boxes are stored in Maternity Safeguarding Office. Further information is available via link: Giving Hope and Minimising Trauma. The full project will be completed by end of October 2025. Alongside this, mothers will be encouraged to accept referrals in pregnancy to Flourish (Lambeth) and Pause (Southwark/ other LAs) specially trained social workers (not involved in care proceedings), to support them through the process and empower them to make positive changes in lifestyle going forward.

6.10 Southwark community paediatrics had 3 articles published online in the Archives of Disease in Childhood Education and practice supplement in 2025:

- QI short report - Improving Communication in Child Protection
- Best Practice - Fifteen-minute Consultation - An approach to the child protection medical assessment - a focus on non-technical skills
- Epilogue - If it's not a bruise what else could it be?

6.11 Several audits have been completed in the year and a new audit programme planned for 2025-26. This is both singular Trust audits and multi-agency audits with the safeguarding children partnership.

i. Compliance for routine enquiry on domestic abuse (DA) at maternity booking and follow on episodes of care. Compliance has been variable and figures have been impacted by EPIC data reporting. In Q4 quarter, routine enquiry at booking remained at 87%, and at 33-36 weeks gestation decreased from 72% to 68%. This is the second compliance report on DA that has being available since EPIC was introduced and shows approximately 17% less compliance than reported on previous maternity system. Compliance data is unavailable for routine enquiry in the postnatal period prior to discharge home and is most likely due to free documentation (rather than lack of enquiry), and lack of familiarity with EPIC system to record more appropriately. The prompt to complete it is at end of a discharge list. A request has been submitted to move it to beginning of list and consider it being a mandatory task.

ii. Understanding and compliance of routine enquiry within health visiting. Audit findings reveal that routine enquiry is generally taking place when safe to do so. Of those not asked, the rationale was noted that neither parent was seen alone. While practitioners generally demonstrated appropriate judgement in recognising when conditions were not safe or private for domestic abuse enquiry, there was limited evidence of follow-up planning when enquiry could not be completed. This represents a key practice gap, as routine enquiry should be revisited at the next safe opportunity and clearly documented. Further training and supervision has been put in place to address any gaps.

iii. A multi-agency physical abuse audit has undertaken with the Lambeth Safeguarding Children Partnership. Whilst this highlighted some good standards and application there were several learning points that the partnership is addressing. This includes need for more consistent application of procedures; need to balance voice of child, medical findings and parental accounts in substantiating harm; need to consider use of review strategy meetings; need to improve trauma-informed responses to children and need to ensure effective escalations. A task and finish group has been set up to take forward the findings and strengthen practice.

iv. A multi-agency audit in relation to Risk Outside the Home has been undertaken with the Lambeth partnership. The audit found that professional curiosity was not consistently evident in initial threshold-decision making and vulnerability factors were not always sufficiently weighted, resulting in examples where opportunities for early intervention were missed and responses were instead incident-led at points when risks had already escalated. Once multi-agency responses were initiated, procedures were followed and there was evidence of good-multiagency collaboration and risk management.

v. Following a previous audit on school nursing and Think Family audit an action plan was developed to take forward some of the learning. The audit revealed that there were missing elements of the Assessment Framework and Think Family approach. As a result of this the health needs assessment template has been updated and now includes all domains of the assessment and been incorporated into EPIC from September 2025.

6.12 Several Safeguarding Reviews have been undertaken that have required input from the safeguarding children's leads.

i. Following the death of an 8-year-old girl a Rapid Review was undertaken. The child presented at hospital due to being unwell and minutes after arrival she went into cardiac arrest. At the time of death, a Section 47 investigation was open due to her having a wound on her arm and had undergone a recent child protection medical. The criteria for a CSPR had not been met and that sufficient learning had taken place during the Rapid Review process. There is no clear indication that the injury or abuse was linked to the child's death. There was not seen to be any failing by any agency.

ii. A Rapid Review was undertaken following an allegation of a serious incident of sexual abuse of a child in care at a Children's Home. The young person was aged 15 years of age, with diagnoses of autism and ADHD. During her time in the care of the Local Authority, she has had periods subjects to DOLS as well as a period in secure accommodation. Whilst there was some good practice identified, the review highlighted several areas where improvement was needed. It is important for professionals to use appropriate non-victim blaming language when providing referral information to any other agency. The Comprehensive Health Assessment Tool (CHAT) which is used for young people in secure units

does not give the child a voice in the same way as an Initial or Review Health Assessment can. Health professionals should consider this when reviewing the CHAT information.

iii. A tabletop review was undertaken following an incident when a young 12-year-old girl ran away from her placement and subsequently reported a sexual assault. The intersectionality of race, gender, child looked after status and autism significantly increased her vulnerability to exploitation. Linked to this are concerns about adultification and how professionals talk about and to children and young people and the impact this has on support for them. DoLS was used appropriately when necessary and the ongoing oversight of its use was well managed. There is a need to regularly review the work undertaken across the partnership with children with autism and neurodiversity regarding extra familial harm, their sexuality, and supporting their parents. Addressing the safeguarding of young people using technology and supporting parents and placements remains an area to continue to develop. It is important that social media use is discussed in various contexts including during health assessments. The incident was responded to promptly and appropriately by all relevant agencies.

iv. A London borough is currently undertaking a review involving two children who previously lived in Lambeth who have experienced chronic neglect and prolonged exposure to domestic violence. At the point of being in Lambeth the family were deemed to be requiring a universal health visiting service. There was timely and appropriate midwifery and health visiting engagement following birth, with all mandated developmental reviews completed. Escalation pathways for missed contacts with universal services could be strengthened to ensure children remain visible, especially during periods of reduced face-to-face contact. It needs to be acknowledged the impact of COVID-19 on accessibility of clients to services and how this could have impacted on ensuring needs were fully recognised and understood.

v. In April 2025, an out of London borough Multi-Agency Partnership convened a Rapid Review following a suspected non-accidental injury (NAI) involving a pre-school-aged child. Although the incident did not lead to a Local CSPR, several areas of learning relevant across multiple agencies and local authorities were identified. The child had not been brought to several scheduled appointments with Lambeth Health Visiting Services. However, the organisation's 'Was Not Brought' (WNB) policy was not followed, and the opportunities to assess and address emerging concerns were missed. This was particularly concerning given that the family had recently been stepped down from Universal Plus to Universal provision, reducing the level of professional oversight. The review also identified the importance of recognising and responding to unexplained bruising in young children, where there may be limited ability for the child to communicate.

vi. A new CSPR has been undertaken following the death of a young person by shooting. This young person had chronic health needs, emotional vulnerabilities, and emerging safeguarding concerns. While individual professionals demonstrated commitment and persistence there were gaps in how his identity, voice, and broader context were understood and addressed. Clear treatment options were provided to him and attempts to manage his chronic medical condition were made. The team persevered when there was noncompliance. Contextual harm risks were known and understood to community health; this enabled active participation in safeguarding processes and liaison with specialist health teams.

vii. A new CSPR has been agreed to be undertaken in relation to a four-year-old child that suffered a significant physical assault by his mother. This family was known to services due to mother's alcohol addiction. The children were under a Supervision Order. Once the Terms of Reference are determined an IMR will be undertaken.

viii. A Rapid Review has been undertaken in relation to a young person with complex medical needs. This young person had not been able to leave home for long periods of time due to anxiety. This led to care being sub optimal and contacts only being made virtually or through her parent. Whilst virtual appointments are beneficial in some circumstance they do have some limitations. It is not possible to care for her through only video or phone appointments as examination and investigations are essential. The voice of the child can be lost in virtual or telephone contacts. Despite several measures, no desired sustained change was brought about. This cumulated in a home visit being undertaken by a paediatrician, outside of normal practice, and immediate actions being undertaken.

ix. A Rapid Review was undertaken following the death of a premature baby at 21 days of age, who was born following a concealed and or unbooked pregnancy. Other children in the family were subject to child protection plans due to chronic neglect. The mother had outlined to health staff that she may have been in the early stages of pregnancy when she attended hospital and GP services. This information was not shared with CSC due to the early stage of pregnancy and her outlined intent to not carry on with the pregnancy. It would be expected that she should have booked for maternity care from 12 weeks onwards after a confirmed pregnancy. This would have been through referral from GP or self-booking to maternity. Maternity safeguarding assessments and pathways would have then followed from her maternity booking.

x. A Rapid Review has been undertaken following a death by apparent suicide of a young person. The case highlighted the invisibility of children removed from mainstream education or educated otherwise. It raises questions about parental

capacity to home educate and whether home education should trigger safeguarding checks, particularly where vulnerabilities exist.

xi. A Rapid Review has been undertaken by an out of borough safeguarding partnership. A CLA is implicated as a perpetrator in the death of another person. The young person had been in receipt of CLA health assessments which appropriately identified their vulnerabilities.

xii. A Rapid Review has been undertaken following a significant serious youth violence incident. The young people involved in the review transcend three boroughs. Prior to the acute events, health had limited information and or contact with the named individuals. It is only more latterly that complex strategy meeting has brought some of the information and linkages together.

xiii. A Rapid Review has been undertaken in Southwark in relation to maternal mental health concerns and the impact on their child. The mother had a long history of mental health and had a pattern of brief crisis admissions, rapid stabilisation, quick discharge, short Home Treatment Team involvement and return to community. The review highlighted that the child's lived experience was absent from adult mental health records. As a result of this a Review and refresh the Multi-Agency Protocol on Parental Mental Health and include risk assessments, joint safety planning and parental mental health triggers will be undertaken.

xiv. A Rapid Review has been undertaken following the death of a 17-year-old by apparent hanging. She had a late diagnosis of autism and struggled to accept it and was largely isolated. The Trust's involvement was limited due to her previously attending out of borough schools. Partnership learning included the need to streamline and prioritise neurodiversity (autism) assessments for young people with complex mental health needs to inform support and intervention. Further work is being undertaken with the partnership regarding exploring and monitoring online activity and digital risks and providing parents with up-to-date advice on online safety.

xv. PSII initiated following the Sudden Unexpected Death in Infancy (SUDI) in a child with previous contact with GSTT service. Mother found 9-month-old child wedged between bunk bed and the wall lifeless. The family was known to health visiting service. They were identified as requiring a targeted health visiting pathway but only received contacts on a standard universal health visiting pathway. This review was undertaken using a system and service review of health visiting pathways and caseload management. However, this methodology and approach have not assisted in determining specifics regarding practice re this child. A separate case review will now be undertaken.

xvi. A LeDeR review is being undertaken following the death of a Southwark young person. This young person died at 19 years of age from a medical condition. They had been a CLA until 18 years of age. The LeDeR process will look the young person and family experience of being in care along with diagnosis and care.

xvii. A Child Safeguarding Practice Review has been recommended to be undertaken in Lambeth following the death of a 10-month-old baby. The causation of death is not yet established. However, the mother of the baby was previously a CLA, and mother and baby were living in semi-independent accommodation at the time of death.

6.13 Recommendations and resulting actions from learning reviews are monitored through the Safeguarding Children Operational Committee. There are several legacy actions that need to conclude with the required evidence to demonstrate completion. As a result of some of the reviews and audits undertaken several actions have been taken internally as well as with the partnership. These include:

- Factsheet – variation of bail (as recommended by Physical Abuse Audit)
- Factsheet – substance use problems (as recommended by Baby Ethan)
- 7-minute-briefing – physical abuse audit
- 7-minute-briefing – self-assessment audit
- 7-minute briefing – Barton family
- Guidance – understanding statutory partners

7.0 Priorities going forward

- Team building and developing and enabling staff supported by compassionate leadership and a collaborative approach. A development programme for staff members to be implemented in 2026.
- Service transformation and alignment to adapt to the new universal service redesign and Families First for Children. Delivery of a change and transition programme to the community safeguarding teams.
- To strengthen quality assurance activities, particularly in relation to audits, learning from reviews, and ensuring that this learning is effectively shared through team briefings.
- Domestic abuse:
  - Revised Trust service provision to be implemented. Agree pathways and processes.
  - Ensuring that staff have the right skills to be able to recognise and risk assess in relation to domestic abuse. This includes embedding routine enquiry within universal services.

- Raise awareness of domestic abuse and implications for victims aged 16-18 years of age.

- Training:
  - Revision of the safeguarding children training strategy.
  - Improving and sustain compliance with Child Protection Training at Levels 2 and 3.
  - Rolling out training to specialist nursing and midwifery teams in use of neglect toolkit to help identify neglect cases.
- Ensuring that the most vulnerable children are seen and provided targeted and or enhanced service.
  - Revised safeguarding supervision model and approach to be embedded into practice.
  - To continue to work with the school nurse leadership team to ensure that the health needs of vulnerable children and young people are assessed and that this monitored as part of new KPI measure.
- Process issues
  - Improving the turnaround time of child protection medical reports to meet the standard timeframe of 10 days.
- CP-IS phase 2 implementation.

8.0 Assurance statement

8.1 The Trust is able to demonstrate evidence and compliance with the standards of Section 11 of the Children Act. This includes having a dedicated safeguarding team, policies and procedures and training in place. The one standard that remains a challenge is in relation to GSTT Level 3 training compliance. All the identified risks have mitigation plans to reduce the risks and further resolution strategies are in place and being monitored.

8.2 The Trust will continue to review and challenge the arrangements in order to support safe and consistent practice, adhere to its statutory duties and will respond positively and assertively to the changing guidance and national reviews. The safeguarding team's main priority is to ensure that children's safeguarding arrangements are safely maintained and that the Trust continues to develop a competent and capable workforce in relation to recognising and appropriately responding to safeguarding concerns.

Appendix: Safeguarding activity

Index

Hospital Safeguarding data:

Table 1: Safeguarding children referrals per quarter				
	Q1 2025/26	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Total referrals	613	541	575	544
Top five reasons for referrals- excluding mental health presentation (GSTT)				
Neglect	78	56	71	56
Not Brought to Appointment	66	63	54	64
Domestic abuse	37	26	32	29
Alcohol intoxication/Drug use of child (recreational)	26	27	12	26
Physical injuries*	29	33	34	22
*This category includes bruising/lacerations/bite marks unexplained, burns/ scalds, dog bite, unexplained fractures & explained fractures, head injury and physical injuries.				

Chart 1: Safeguarding Children Referrals Breakdown for GSTT & RBH Sites

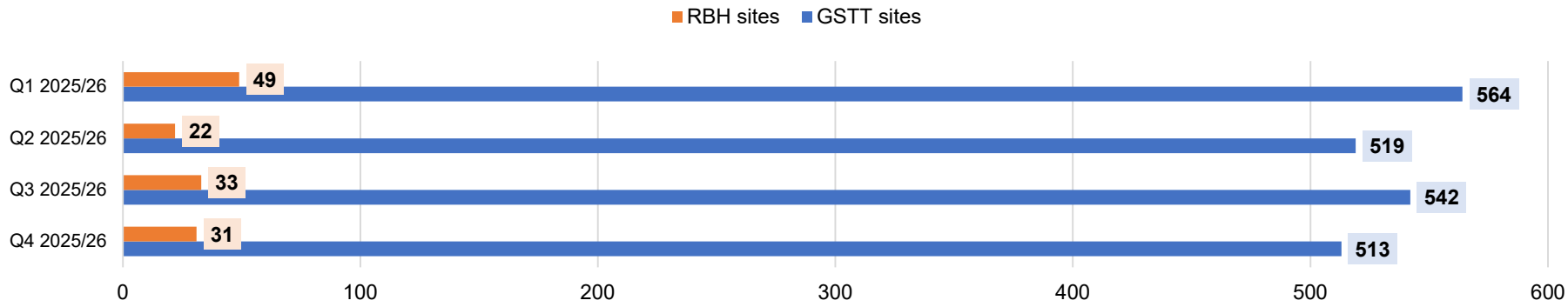


Table 2: Local authority area				
Borough	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Q4 25/26**
Barking and Dagenham	2	4	2	2
Barnet	6	1	3	0
Bexley	0	0	0	0
Bromley	7	6	11	2
Croydon	17	17	15	21
Essex	5	5	11	12
Greenwich	16	13	15	18
Hertfordshire	5	10	6	6
Hillingdon	1	5	4	3
Hounslow	4	3	4	4
Kensington & Chelsea	2	5	3	4
Kent	36	41	40	35
Lambeth	112	110	111	108
Lewisham	23	31	27	35
Other London Boroughs	61	45	36	37
Out of London	83	56	87	84
Overseas	0	1	0	0
Southwark	153	128	133	114
Surrey	10	12	9	10
Sussex	16	11	9	18
Wandsworth	20	13	20	14
Westminster	22	17	19	9
NFA/ Unknown	12	7	10	8

Chart 2: Referrals by Borough- Q4 2025/26

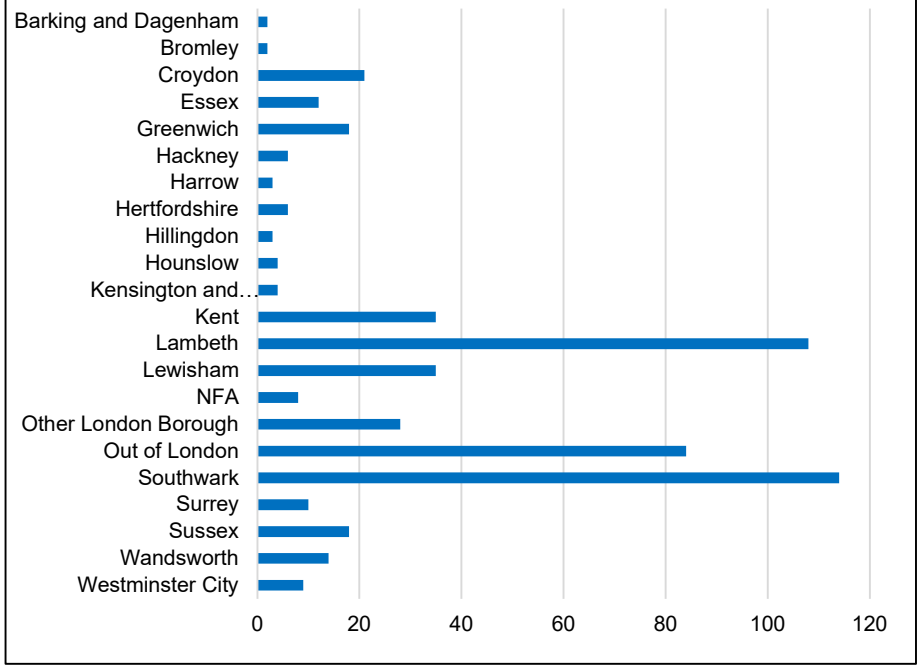


Table 3: Areas of referral				
Ward/Dept.	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Q4 25/26**
Adult ED	93	100	89	75
Adult Inpatients & Outpatients	14	19	19	15
Paeds ED & UCC	214	229	239	217
Paeds Outpatient/ Non-Admissions	224	147	173	167
Paeds Inpatients	61	46	55	69
Maternity (child related)	7	0	0	1

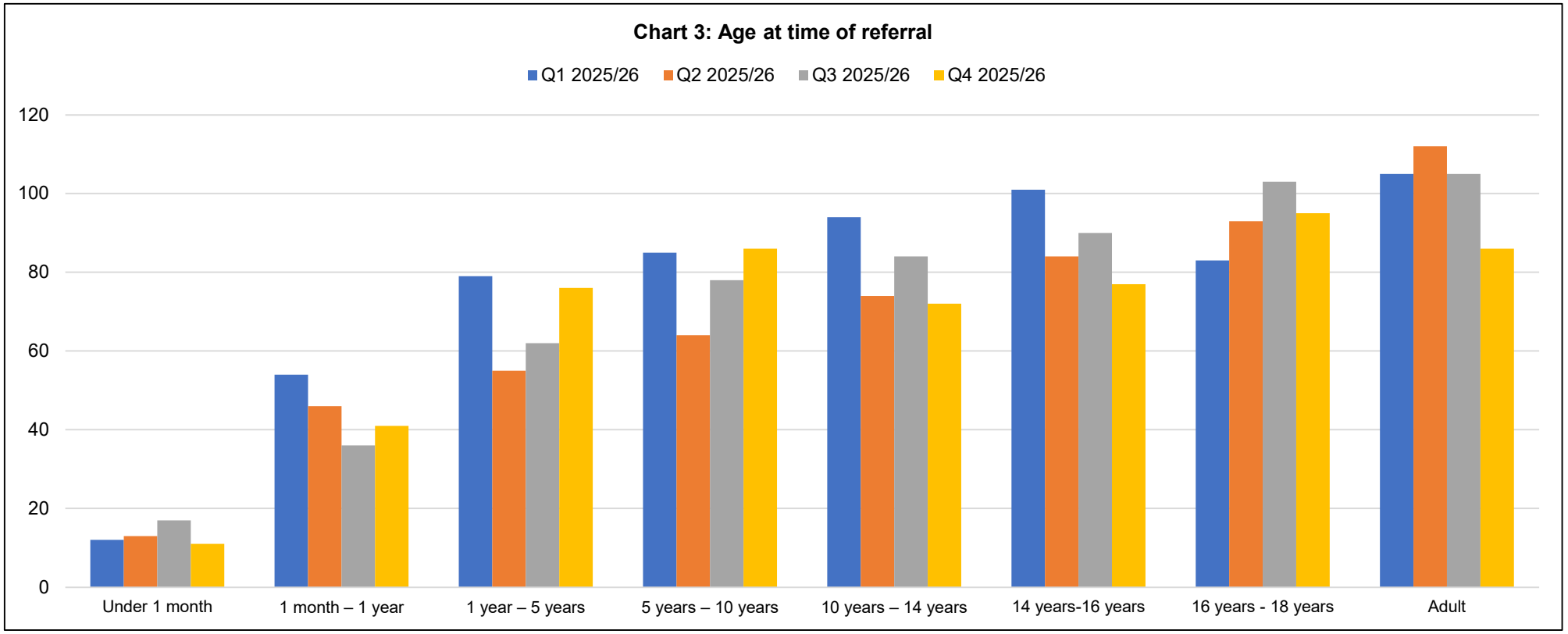


Chart 3: Age at time of referral
Q1 2025/26
Q2 2025/26
Q3 2025/26
Q4 2025/26
120
100
80
60
40
20
0
Under 1 month
1 month – 1 year
1 year – 5 years
5 years – 10 years
10 years – 14 years
14 years-16 years
16 years - 18 years
Adult

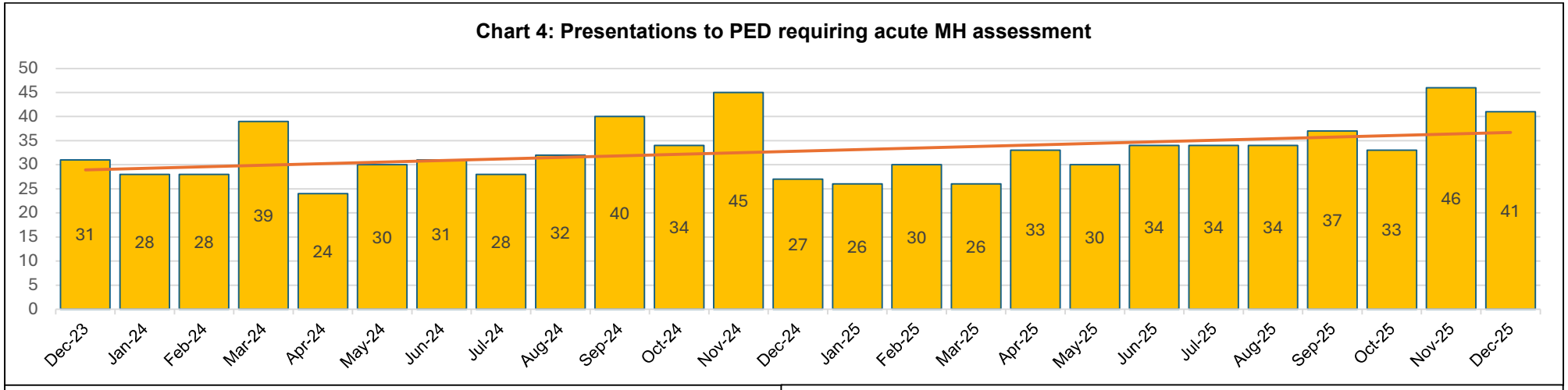


Chart 4: Presentations to PED requiring acute MH assessment
50
45
40
35
30
25
20
15
10
5
0
31
28
28
39
24
30
31
28
32
40
34
45
27
26
30
26
33
30
34
34
34
37
33
46
41
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25

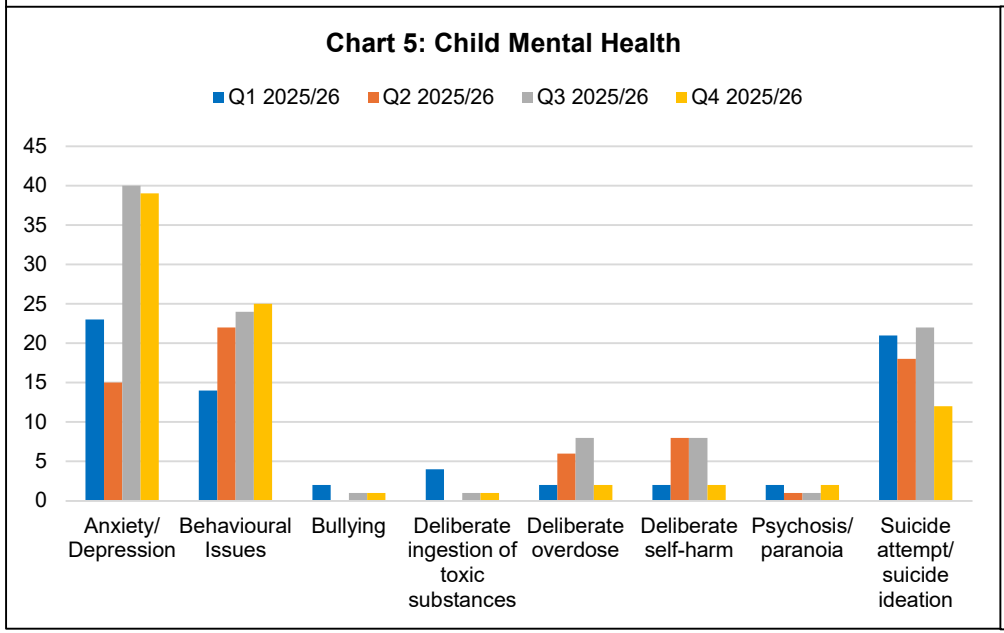


Chart 5: Child Mental Health
Q1 2025/26
Q2 2025/26
Q3 2025/26
Q4 2025/26
45
40
35
30
25
20
15
10
5
0
Anxiety/ Depression
Behavioural Issues
Bullying
Deliberate ingestion of toxic substances
Deliberate overdose
Deliberate self-harm
Psychosis/ paranoia
Suicide attempt/ suicide ideation

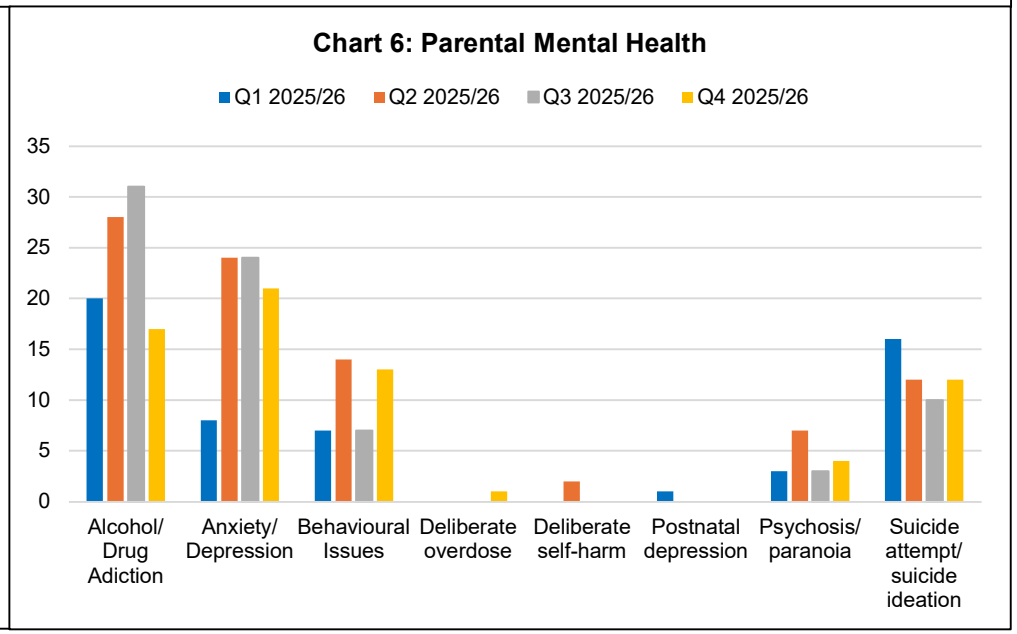
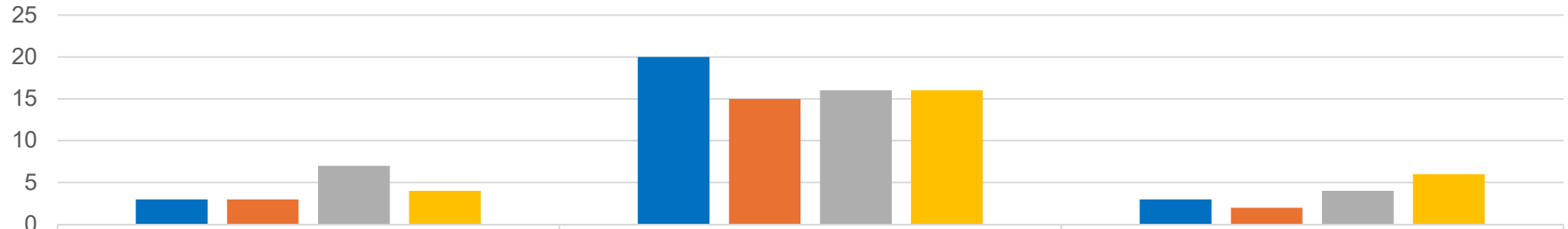


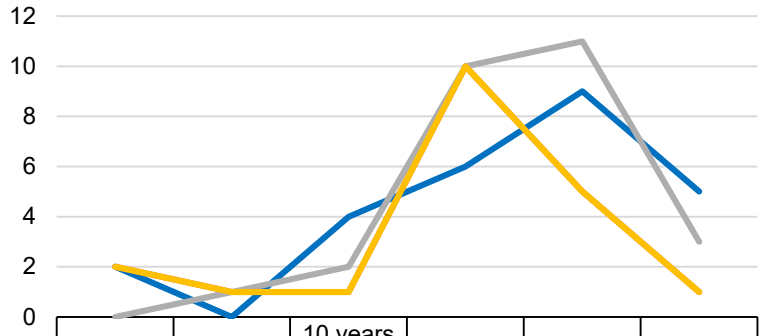
Chart 6: Parental Mental Health
Q1 2025/26
Q2 2025/26
Q3 2025/26
Q4 2025/26
35
30
25
20
15
10
5
0
Alcohol/ Drug Adiction
Anxiety/ Depression
Behavioural Issues
Deliberate overdose
Deliberate self-harm
Postnatal depression
Psychosis/ paranoia
Suicide attempt/ suicide ideation

Chart 7: Recorded attendances with violent related injuries



	Child Criminal Exploitation	Physical harm (assault)	Stabbing Injury
Q1 2025/26	3	20	3
Q2 2025/26	3	15	2
Q3 2025/26	7	16	4
Q4 2025/26	4	16	6

Chart 8: Reported age range of attendances with violent related injuries



	1 year – 5 years	5 years – 10 years	10 years – 14 years	14 years - 16 years	16 years - 18 years	Adult
Q1 2025/26	2	0	4	6	9	5
Q2 2025/26	2	1	1	10	5	1
Q3 2025/26	0	1	2	10	11	3
Q4 2025/26	2	1	1	10	5	1

Chart 9: Reported ethnicity of attendances with violent related injuries (Q1-Q4)

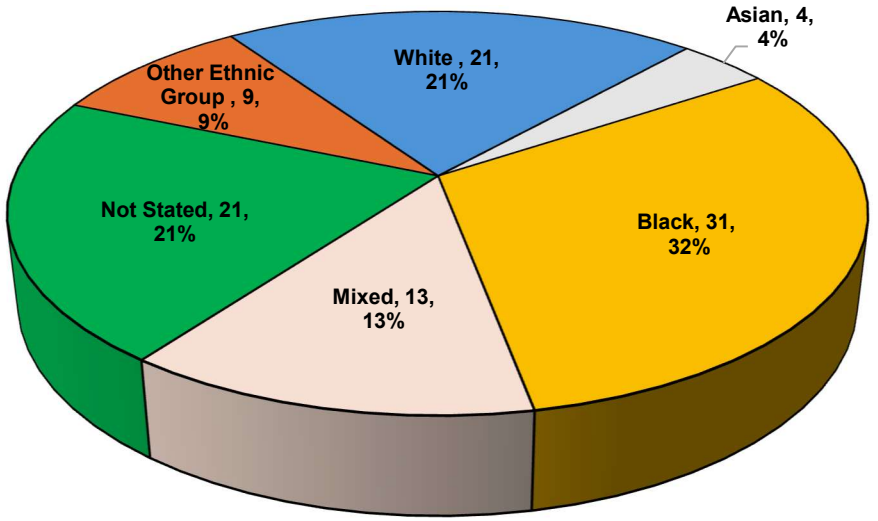
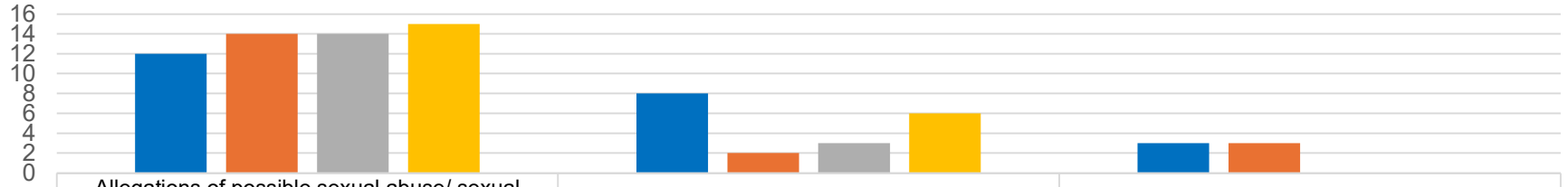
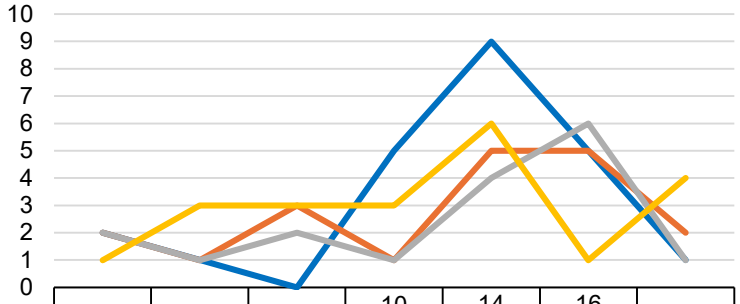


Chart 10: Recorded attendances related to child sexual abuse concerns (incl. exploitation & sexual health)



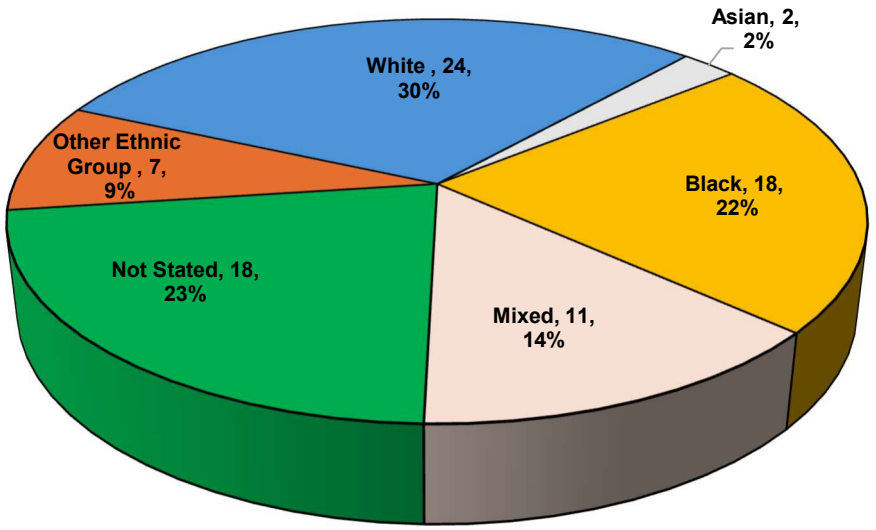
	Allegations of possible sexual abuse/ sexual health concerns	Child Sexual Exploitation	Teen Pregnancy
Q1 2025/26	12	8	3
Q2 2025/26	14	2	3
Q3 2025/26	14	3	0
Q4 2025/26	15	6	0

Chart 11: Reported age range of attendances related to child sexual abuse concerns



	Under 1 year	1 year – 5 years	5 years – 10 years	10 years – 14 years	14 years- 16 years	16 years - 18 years	Adult
Q1 2025/26	2	1	0	5	9	5	1
Q2 2025/26	2	1	3	1	5	5	2
Q3 2025/26	2	1	2	1	4	6	1
Q4 2025/26	1	3	3	3	6	1	4

Chart 12: Reported ethnicity of attendances with child sexual abuse concerns (Q1-Q4)



Maternity Safeguarding Data:

Table 4: Reason for referrals				
	Q1 2025/26	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Children's Social Care involved	213 (54)	154 (51)	134 (54)	110 (53)
Domestic abuse	150 (58)	102 (42)	131(52)	157 (53)
Maternal Mental health	126 (60)	103 (37)	126(49)	91 (39)
Homeless / housing	85 (35)	52 (29)	81 (29)	50 (25)
Poor antenatal care (late, unbooked, DNA, concealed)	78 (34)	78 (28)	109 (30)	89 (32)
NRPFs	3 (3)	3 (2)	9 (3)	8 (3)
Substance misuse	62 (17)	52 (21)	50 (15)	73 (20)
Teenage pregnancy	34 (8)	23 (7)	20 (6)	6 (2)
Learning disability / difficulty	0 (0)	3 (1)	3 (2)	16 (4)
Physical disability	0 (0)	(0)	1 (1)	(0)
Paternal mental health	26 (12)	40 (17)	66 (26)	47 (17)
Aggressive behaviour	33 (3)	3 (2)	(0)	8 (2)
CSE	7 (2)	(0)	(0)	(0)
Family concerns	46 (12)	37 (17)	25 (14)	80 (31)
Asylum Seeker	27 (14)	20 (9)	5 (2)	9 (2)
Other**	43 (17)	53 (26)	99 (39)	67 (27)
Total	**933 (*329)**	**723 (*289)**	**859 (*322)**	**811 (*310)**

**The main number indicates the total number of contacts to the Maternity Safeguarding Team, whilst the figure in brackets denotes the actual number of women referred to the Maternity Safeguarding Team.*

Table 5: Maternity Referrals to Children's Social Care				
	Q1 2025/26	**Q2 2025/26**	**Q3 2025/26**	**Q4 2025/26**
Total Number	111	103	121	126
Data collection is more accurate since using EPIC to send all MASH referrals.				

Table 6: Domestic Abuse (Hospital)				
	MOZAIC			
	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Number of total referrals	37	26	34	22
Number of referrals that have children in family	34	21	27	17
Total number of children in families	57	32	39	21
Initial engagement from victim	37	26	34	22
Follow-up post discharge/ ongoing work	36	26	33	22
Number of referrals to MARAC	1	0	0	0

There was a decrease by 12 referrals to the Maternity Domestic Abuse Advocacy service (MOSAIC) in quarter 4.

The MOSAIC service has been serviced their notice with services terminating the end of April 2026.

Domestic abuse routine enquiry at booking in maternity was 87% in quarter 4 and 53 women disclosed domestic abuse, similar to previous period, although the number of contacts for support increased from 131 in quarter 3 to 157 in quarter 4.

Safeguarding Community Data:

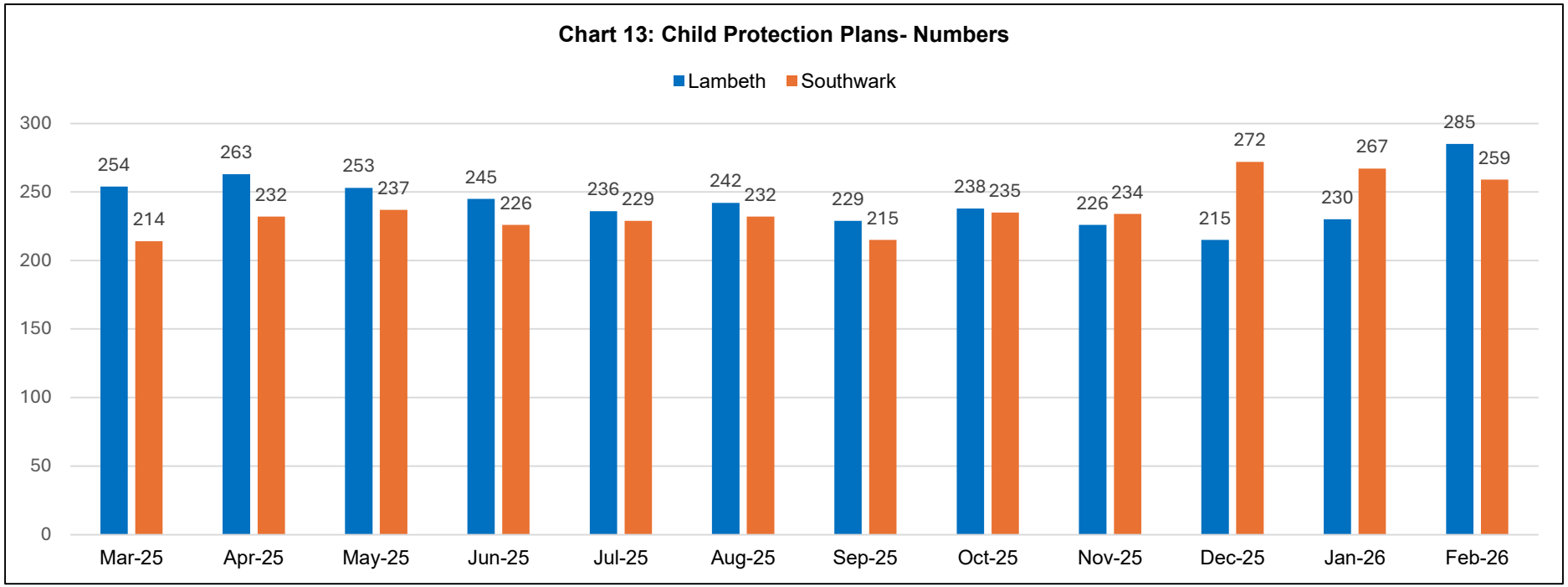


Table 7: Case conference attendance by HV/SN									
	Lambeth					Southwark			
	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26		Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Initial conferences	34	52	53	52		Not available	71	61	48
Attendance	34/34 (100%)	52/52 (100%)	52/53 (98%)	52 (100%)		Not available	70/71 (98%)	60/61 (98%)	48/48 (100%)
Review conferences	67	47	70	50		Not available	54	59	44
Attendance	59/67 (88%)	44/47 (93%)	60/70 (86%)	46 (92%)		Not available	51/54 (94%)	58/59 (98%)	41/44 (93%)

Table 8: Safeguarding Supervision												
	Q1 2025/26			Q2 2025/26			Q3 2025/26			Q4 2025/26		
	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
HV Supervision: Lambeth	83%	89%	93%	100%	96%	70%	80%	90.5%	92%	90%		
HV Supervision: Southwark	92%	97%	100%	94%	Not available	46%	67%	73%	86%	97%	83%	69%
SN Supervision: Lambeth	89%	100%	92%	100%	87%	100%	100%	100%	100%	85%		
SN Supervision: Southwark	92%	100%	92%	90%	Not available	46%	50%	50%	50%	71%	62%	50%

Chart 14: Child Protection Medicals- NAI

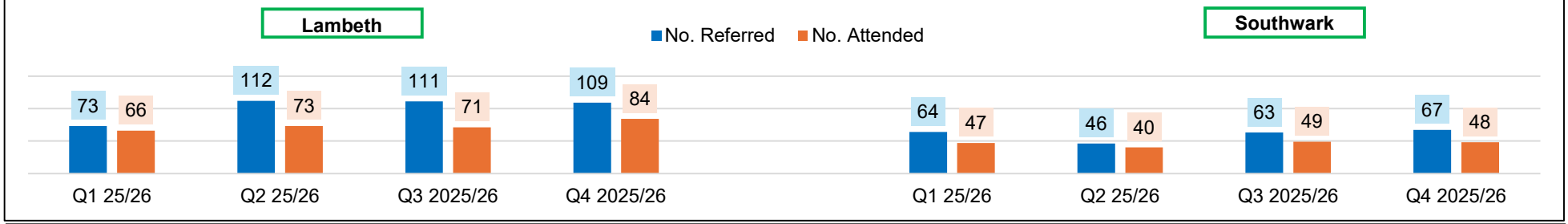


Chart 15: Child Protection Medicals- CSA

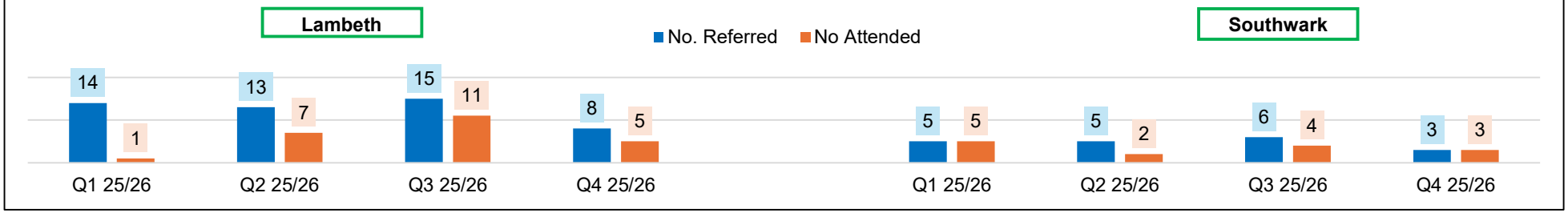


Chart 16: Child Protection Medicals- Timeliness

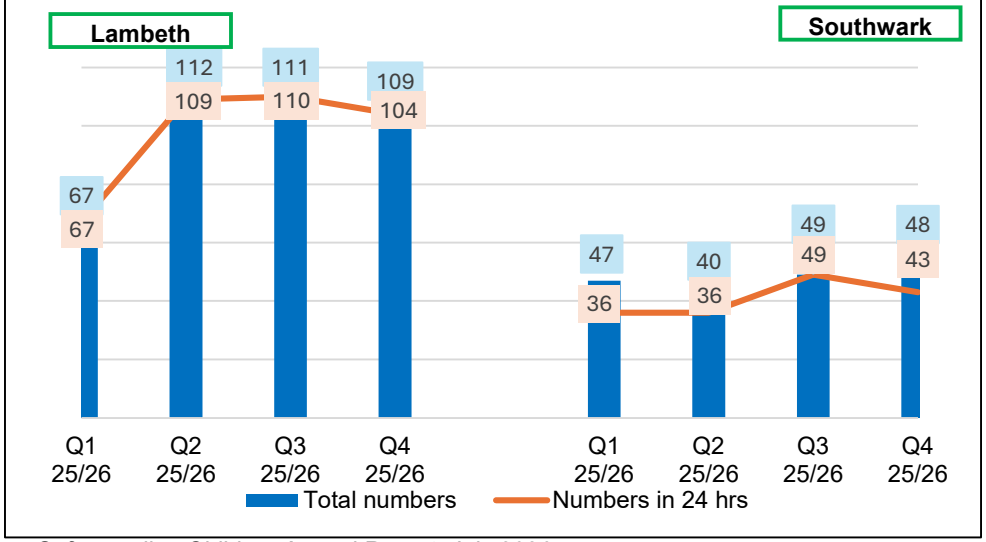


Chart 17: Child Protection Medicals- Reports

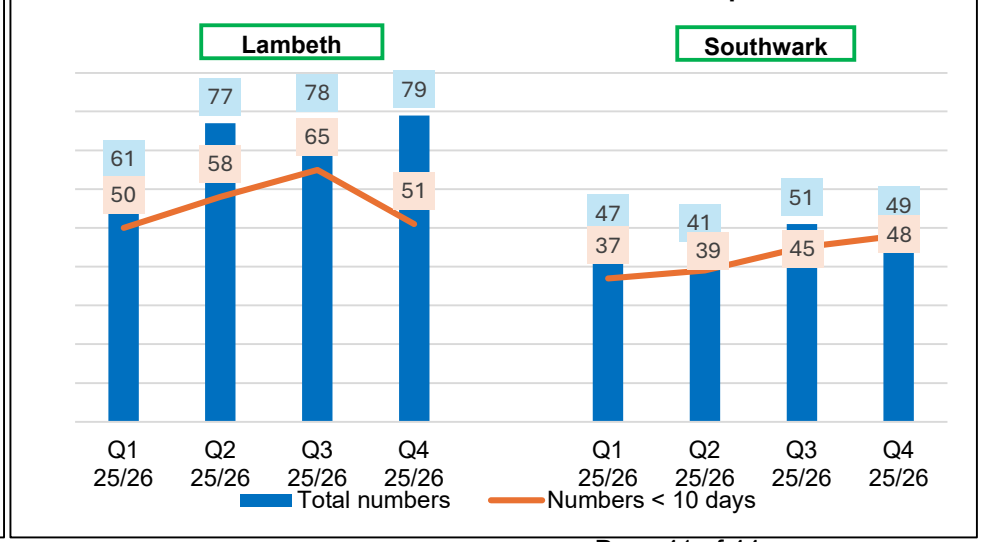


Table 9: Looked after Children

		Q3 2025/26						Q4 2025/26					
		Sep 25		Oct 25		Nov 25		Dec 25		Jan 26		Feb 26	
CLA Metric		Lambeth	Southwark	Lambeth	Southwark	Lambeth	Southwark	Lambeth	Southwark	Lambeth	Southwark	Lambeth	Southwark
IHA													
Seen within 20 days of referral	**98%**	80% (12/15)	100% (13/13)	100% (15/15)	100% (17/17)	82% (14/17)	100% (9/9)	93% (13/14)	100% (10/10)	92% (12/13)	100% (10/10)	100% (13/13)	100% (6/6)
Seen within 20 days of BLA	**50%**	67% (10/15)	69% (9/13)	94% (15/16)	85% (11/13)	76% (13/17)	89% (8/9)	93% (13/14)	70% (7/10)	77% (10/13)	60% (6/10)	77% (10/13)	67% (4/6)
Seen by due date	**90%**	60% (12/20)	94% (31/33)	63% (12/19)	93% (28/30)	53% (10/19)	84% (27/32)	52% (11/21)	91% (20/22)	61% (17/28)	90% (26/29)	50% (12/24)	85% (23/27)
Completed IHA and RHA Part C returned to social care within 10 days of being seen for assessment	**80%**	91% (31/34)	88% (46/52)	86% (31/38)	70% (30/43)	87% (46/53)	67% (31/46)	81% (26/32)	61% (31/44)	78% (31/40)	84% (31/37)	75% (24/32)	79% (22/28)
DNA – GSTT Nurses (RHAs)	**15%**	18% (4/22)	17% (6/35)	17% (4/24)	11% (3/27)	29% (6/21)	0% (0/33)	54% (7/13)	22% (5/23)	8% (2/24)	16% (5/31)	12% (2/17)	14% (3/21)
DNA – CLA Doctors (IHAs and RHAs)		10% (3/29)	12% (3/26)	9% (3/34)	19% (8/42)	11% (3/27)	11% (2/19)	0% (0/29)	13% (3/24)	13% (4/30)	0% (0/23)	11% (4/35)	6% (1/18)

Table 10: Safeguarding training: year to date as of 31 March 2026			
	Total number to train	**Numbers compliant**	**Overall Trust compliance**
Level 2	10619	9315	87.72%
Level 3	3613	3173	87.82%

Table 11: Level 3 child protection training by area			
Area	**Staff Count**	**Compliant**	**% Target = 90.00**
Evelina London	**2694**	**2394**	**88.86%**
• Evelina Central	77	71	92.21%
• Evelina Children Cardio Respiratory & Critical Care	718	589	82.03%
• Evelina Children Community	381	365	95.80%
• Evelina Medicine and Neonatology	779	705	90.50%
• Evelina Surgery, Theatres and Anaesthesia	341	295	86.51%
• Evelina Women's Services	392	363	92.60%
Inpatient services (SNP)	43	39	90.70%
Acute & General Medicine	283	238	84.10%
Dental	110	104	94.55%

Table 12: Level 3 Child protection training by staff groups						
	Child Protection Level 2			Child Protection Level 3		
Staff Requiring this training:	10619			3613		
Staff Groups	**Required**	**Trained**	**Percentage**	**Required**	**Trained**	**Percentage**
• Add Prof Scientific and Technic	589	510	88.12%	186	161	88.17%
• Additional Clinical Services	1421	1274	92.96%	162	143	90.74%
• Administrative and Clerical	140	114	82.14%	55	44	80.00%
• Allied Health Professionals*	1212	1074	93.32%	208	177	89.90%
• Healthcare Scientists	262	223	88.17%	104	96	93.27%
• Medical and Dental	2343	1668	72.90%	789	594	76.43%
• Nursing and Midwifery Registered	4652	4147	92.22%	2109	1858	91.56%

Table 13: Prevent (WRAP) training: year to date as of 31 March 2026			
	Required	**Trained**	**Percentage**
Evelina London	**3178**	**2989**	**94.05%**
• Evelina Central	177	169	95.48%
• Evelina Children Cardio Respiratory & Critical Care	715	656	91.75%
• Evelina Children Community	483	476	98.55%
• Evelina Medicine and Neonatology	834	788	94.48%
• Evelina Surgery, Theatres and Anaesthesia	366	352	96.17%
• Evelina Women's Services	586	531	90.61%