



Lambeth
Safeguarding
Children
Partnership

Annual Report

2025/2026





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Foreword from our Independent Scrutineer

When I read this report, I do so with one test in mind: would a child in Lambeth feel the difference? That is the sole measure that ultimately matters, and it is the standard against which we ask partners to judge themselves.

There is a great deal in this year's report to be proud of. Ofsted judged children's services to be good, with services for care leavers judged outstanding, and His Majesty's Inspectorate of Probation judged our youth justice service to be good. Those judgements are not the work of a single agency; they reflect years of persistence by social workers, nurses, midwives, health visitors, police officers, teachers, designated safeguarding leads, youth workers and voluntary sector colleagues who have kept going through sustained pressure. Alongside that external assurance, the partnership has strengthened its own foundations: decision making at the front door has improved, our Anti-Racist Charter has been launched, the Education Safeguarding Portal has given schools a single trusted source of guidance, risk registers have made operational pressures visible to leaders, and more practitioners than ever have accessed our learning offer.

I want to be equally clear about where our challenges lie in the year ahead.

First, engagement. Operational safeguarding in Lambeth is strong, but strategic contribution is not yet consistent. Attendance at some groups, and the timeliness of agency returns to audits, reviews and reporting, fell short of what children deserve. Delay in a review is not an administrative inconvenience; it is learning that reaches practice later than it should.

Second, data and intelligence. We have adopted a multi-agency dataset, but it is still weighted towards one partner's information. Until health and police data sit alongside it, and until we have the analytical capacity to interpret it, we will continue to describe activity rather than evidence impact.

Third, disproportionality. Black children remain over-represented in our statutory safeguarding pathways and appear less visible in the early help and emotional wellbeing pathways that might have prevented escalation. Publishing a charter is a start; changing that pattern is the work we must all do.

Fourth, the voice of children and families. Individual agencies can demonstrate some strong examples, but the partnership itself cannot yet evidence a systematic mechanism of its own. The introduction of Young Scrutineers during 2026/27 must deliver real scrutiny, with the power to change what we do, rather than acting as another consultation exercise.



Running through all of this is reform. The Families First Partnership Programme, multi-agency child protection arrangements and the Children's Wellbeing and Schools Act represent the most significant reshaping of children's social care in a generation. I am clear that we must drive these reforms forward rather than let them drift into a paper exercise. Reform done well will place help earlier, keep families together where it is safe to do so, and sharpen the protection we offer where it is not. Reform done badly, or done late, will simply add process to an already stretched system.

I do not underestimate what we are asking of partners. This year has seen restructuring and cost reduction across the integrated care board, difficult choices in policing, and continued budget pressure on the local authority. Vacancies, sickness and difficulty retaining experienced staff have been felt in every agency, including our own business unit. Those pressures are real, and I will keep naming them honestly to those who set budgets and policy nationally. They are the context for our challenges; they are not an alibi for them. Where capacity is genuinely at risk of compromising the protection of children, I will say so, publicly and without hesitation.

My commitment, and the commitment of the safeguarding partners, is to continue this improvement journey. We will keep asking difficult questions of ourselves, keep testing whether our activity has changed anything for a child, and keep listening to the families who experience our services. Lambeth's children and their families remain at the centre of everything this partnership does, and they will remain the measure of whether we have succeeded.

Jim Gamble QPM

Independent Safeguarding Children and Young People Commissioner





At a Glance

Our Purpose

The Lambeth Safeguarding Children Partnership (LSCP) brings together local authority, health, police, education and wider partners to work collectively to safeguard and promote the welfare of children. During 2025/26, our focus was on strengthening safeguarding fundamentals, tackling disproportionality and becoming more data-informed in our decision making.

Lambeth in Numbers

54,633 children
aged 0-18



63% of children —————
from Global Majority Backgrounds

13,338 contacts received
by Children's Social Care

- **600 children** subject to a Child Protection Plan across the year
- **356 Children** Looked After
- **618** Care Leavers supported
- **3,621** CAMHS referrals
- **768** MARAC referrals involving 570 children
- **33,482** children attending Lambeth schools





Our Priorities

Back to Basics - strengthening safeguarding fundamentals including:

- Information sharing
- Escalation and challenge
- Threshold application
- Safeguarding practice
- Quality assurance

Active Anti-Racism - developing more equitable safeguarding arrangements by:

- Launching our Anti-Racist Charter
- Embedding anti-racist learning
- Increasing focus on disproportionality
- Challenging adultification and bias

Data-Driven Activity - using data and intelligence to:

- Understand need and demand
- Identify emerging risks
- Measure impact
- Improve decision-making

Key Achievements

- ✓ Ofsted judged Lambeth Children's Services Good
- ✓ Ofsted judged Care Leaver Services Outstanding
- ✓ HMIP judged Lambeth Youth Justice Service Good
- ✓ New LSCP Website launched
- ✓ Anti-Racist Charter launched
- ✓ Online Safety Policy launched
- ✓ Education Safeguarding Portal launched
- ✓ Multi-agency dataset established
- ✓ Strategic and operational risk registers introduced
- ✓ 2,488 practitioners accessed LSCP learning and development opportunities
- ✓ 13 seven-minute briefings and 24 learning resources produced



Learning and Improvement

During 2025/26 the LSCP:

- Completed 1 Rapid Review
- Completed 4 Cases for Consideration
- Published 3 Child Safeguarding Practice Reviews
- Completed a thematic audit into physical abuse
- Undertook a partnership-wide Section 11/175 assurance exercise
- Mobilised a thematic audit into risk outside the home

Recurring themes included:

- Neglect
- Professional curiosity
- Voice of the child
- Think Family practice
- Educational safeguarding
- Information sharing
- Anti-racist practice

What Difference Did It Make?

- Greater multi-agency involvement in safeguarding decision-making.
- Improved quality of referrals and information sharing.
- Stronger oversight of missing children and exploitation risks.
- Expanded opportunities for children and families to influence services.
- Increased evidence that learning from reviews, audits and training is influencing practice.
- Strong external assurance from inspection and scrutiny activity.

Challenges we must Address

- ⚠ Inconsistent partner engagement and attendance.
- ⚠ Delays to audit, review and reporting processes.
- ⚠ Limited maturity of multi-agency data and intelligence.
- ⚠ Growing workforce and capacity pressures.
- ⚠ Need for stronger partnership-level child and family participation.
- ⚠ Continued disproportionality in safeguarding interventions.



Our Priorities for 2026/27

- **Strengthening partnership effectiveness** - improving governance, engagement, escalation and information sharing.
- **Embedding children's voices and tackling disproportionality** - establishing Young Scrutineers and strengthening partnership-wide participation.
- **Improving safeguarding practice** - focusing on neglect, safe sleep, pre-birth safeguarding, Think Family practice and risk outside the home.
- **Developing a stronger learning culture** - expanding learning opportunities beyond traditional training.
- **Supporting adolescence and transition** - strengthening responses to exploitation, contextual safeguarding and transition into adulthood.

Overall Assessment

LSCP arrangements are effective, strengthening and increasingly reflective. While challenges remain around capacity, engagement, data maturity and evidencing impact, partners continue to demonstrate a strong commitment to learning, improvement and working together to improve outcomes for Lambeth's children and families.



Introduction

This report will provide transparency and accountability for how safeguarding partners in Lambeth worked together to safeguard and promote the welfare of children during the period 01 April 2025 to 31 March 2026. It will evaluate the effectiveness and impact of local safeguarding arrangements, highlight key learning and achievements, and identify priorities for further improvement.

It is broken down as follows:

- Section 1: provides an overview of the roles and responsibilities of the LSCP, who our members are, how we are organised, what we are responsible for and how we are scrutinised and supported to discharge our statutory duties.
- Section 2: looks at the Lambeth context and the needs of our population to help understand why we prioritised what we did this year.
- Section 3: details our activity this year and examines what difference it made.
- Section 4: scrutinises the training and support we offered to the workforce this year and the impact this had.
- Section 5: reflects on whether our arrangements were effective, and where we still have work to do.
- Section 6: looks forward to the year ahead and our priorities.

Across the sections, we use the following terms:

- Activity: what did we do?
- Impact: what difference did it make?
- Evidence: how do we know it made a difference?

A note on language: throughout this report, we use the term 'child' to refer to all individuals under the age of 18. Whilst we respect that not everyone under 18 would identify, or describe themselves, as a child, we intentionally use this language as an important reminder that the duty to safeguard applies to all individuals under 18. Where we use the term 'young people', this includes care leavers and young adults with special educational needs and disabilities (SEND) who continue to receive support, services, and additional statutory entitlements beyond their 18th birthday.

A note on acronyms: throughout this report, whilst we explain what acronyms stand for as these are first used, we do not consistently explain these across every section. A table of acronyms is included in Appendix A for support.



Roles & Responsibilities of the LSCP

What are we meant to do and how do we do this?



1.1 What do we do?

The Lambeth Safeguarding Children Partnership (LSCP) was established by the Children and Social Work Act 2017, which places a shared and equal duty on the local authority, police and health services to work together to safeguard and promote the welfare of children.

The detailed expectations for how safeguarding partners should discharge these responsibilities are set out in the statutory guidance Working Together to Safeguard Children¹ and our complementary local arrangements are set out in [Lambeth's Multi-Agency Arrangements to Safeguard Children](#) (which were last updated in December 2024).

Our work is summarised as delivering:

- Strategic leadership: delivering and monitoring multi-agency priorities and procedures to protect and safeguard children.
- Meaningful engagement: ensuring education and other relevant voices have a voice at strategic and operational levels.
- Information sharing: ensuring effective information sharing arrangements between agencies.
- Learning from reviews: delivering learning from serious child safeguarding incidents.
- Training and development: providing appropriate safeguarding training and professional development.
- Child and family voice: seeking and responding to feedback from children, young people and families.



¹ Although Working Together to Safeguard Children was updated at the very end of the reporting period, the 2023 version remained the framework that governed the partnership's activity for the year. Consequently, the work described in this report reflects the arrangements, responsibilities and expectations set out in Working Together 2023.



1.2 Why do we do this?

The value of what we do goes beyond our legal duties; we do this because of our shared vision of achieving the best possible outcomes for Lambeth's children through collaborative and effective safeguarding practices.

This is underpinned by our principles and commitment to:

- Prioritising children and families: ensuring the best possible outcomes for children and families by providing the right services in a coordinated and timely manner.
- Strengthening safeguarding practice: continuously improving safeguarding practice across all partner agencies to positively impact the lives of children.
- Promoting collaborative learning: facilitating shared learning opportunities for frontline staff across all partner agencies.
- Enhancing accountability: embedding peer challenge as a key process for learning, improvement, and mutual accountability among agencies.
- Improving information sharing: sharing information effectively to ensure accurate and timely decision-making for families.
- Delivering effective safeguarding: upholding the highest standards of safeguarding practice through:
 - Robust governance structures
 - Effective quality assurance and intelligence gathering
 - A culture of continuous learning and improvement.





1.3 Who does this?

The partnership is led by our three statutory safeguarding partners:

- Lambeth Council
- Metropolitan Police Service (MPS)
- South East London Integrated Care Board (SEL ICB)

Education continues to be recognised locally as a fourth safeguarding partner.

A Lead Safeguarding Partner (LSP) sits in each statutory partner, who can speak with authority and take decisions on behalf of their agency, as well as hold them to account.

Our LSPs are:

- Ian Davis - Chief Executive, London Borough of Lambeth
- Matt Twist - Assistant Commissioner, Metropolitan Police Service
- Andrew Bland - Chief Executive Officer, SEL ICB

A Delegated Safeguarding Partner (DSP) also sits in each statutory partner, to whom many functions are delegated including the delivery of local arrangements.

Our DSPs are:

- Andrew Carter - Corporate Director: Children, Families & Education, Lambeth Council
- Andrew Eyres - Corporate Director: Integrated Health and Adult Social Care, SEL ICB & Lambeth Council
- Chris Heathcote - Detective Superintendent: Public Protection, Central South BCU (AS) (Lambeth & Southwark), Metropolitan Police Service

Together, our DSPs form the core membership of the LSCP Executive Board, alongside Lambeth's Independent Safeguarding Children and Young People's Commissioner (ISCYPC) and Lambeth's Director of Education.





Our partnership further includes subject matter experts and leaders across the following statutory partners and relevant agencies:

Local Authority

- Adult Social Care
- Child Friendly Communities
- Children's Social Care (CSC)
- Commissioning
- Early Years
- Education
- Housing
- Public Health
- Safe Taskforce
- SEND
- Violence Reduction Unit
- Youth Justice & Youth Engagement

Health

- SEL ICB
- Guy's & St Thomas' NHS Foundation Trust (GSTT)
- King's College Hospital NHS Foundation Trust (KCH)
- Lambeth Primary Care Providers
- South London & Maudsley NHS Foundation Trust (SLAM)

Police & Enforcement

- Public Protection
- Probation

Education Providers

- Ashmole School
- City Heights E-Act Academy
- Herbert Morrison School
- Lansdowne School
- Liberty Academy Trust
- Nursery Federation
- Oasis Southbank Academy
- St Gabriel's College
- Woodmansterne School

VCS

- Better Start
- Gaia Centre
- Home Start Lambeth



1.4 How do we do this?

Our members all feed into our governance structure, which is organised as follows:

Executive Board

Members 5
Frequency Quarterly
Purpose To hold the partnership accountable for the safety of children, identify priorities, oversee strategic risk and agree funding.



Partnership Board

Members 30
Frequency Quarterly
Purpose To scrutinise the work of the subgroups, ensure effective implementation of strategic decisions and make recommendations on policy and practice.



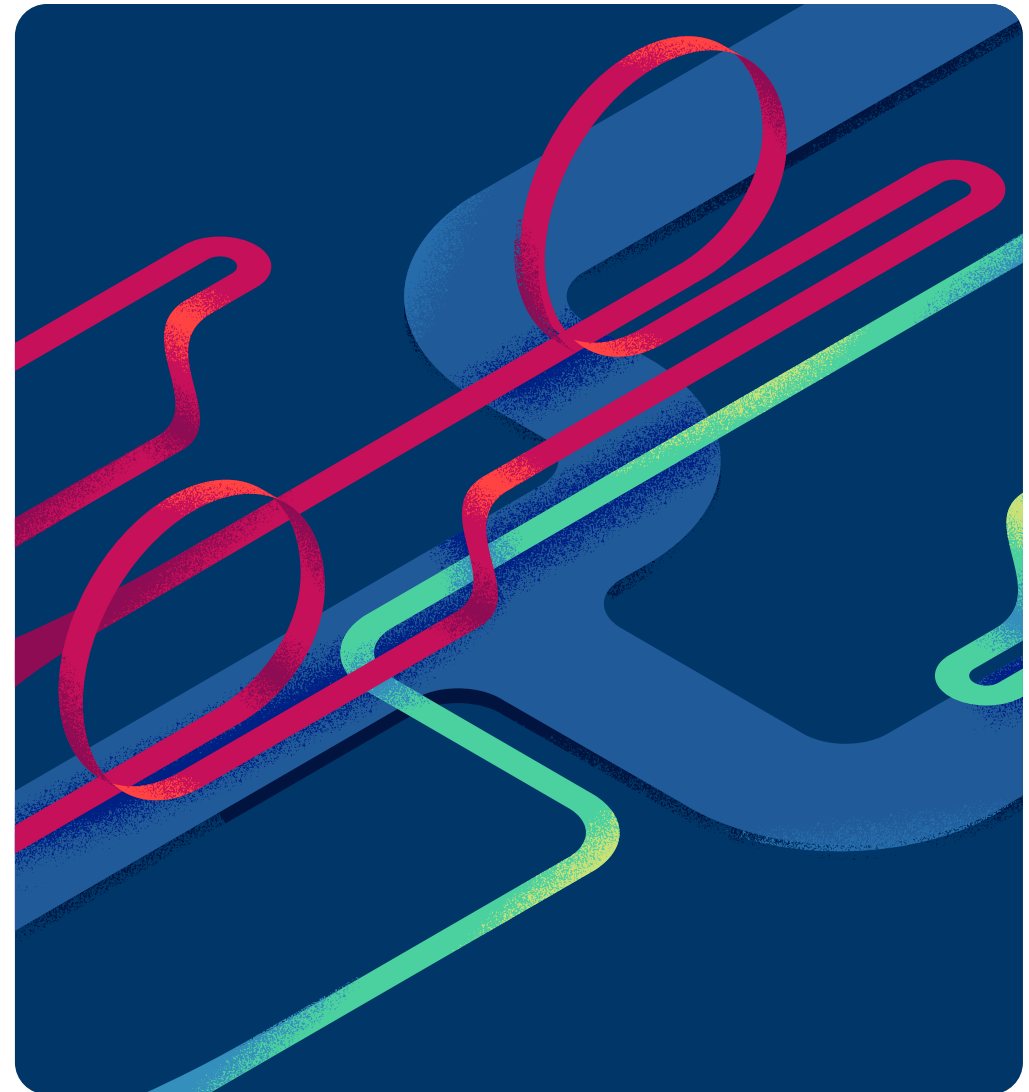
Subgroups

Group	Purpose	Frequency	Members
Case Review Subgroup (CRSG)	To facilitate rapid reviews, scrutiny of other cases presented for consideration and oversee Child Safeguarding Practice Reviews (CSPRs).	3 monthly	23
Contextual Safeguarding Strategic Oversight Group (CSSOG)	To set the strategy to safeguard children against extra-familial harm and address wider determinants.	6 monthly	17
Early Help & Family Support (EHFS)	To track the progress and impact of the Early Help Strategy.	3 monthly	23
Education Safeguarding Advisory Committee (ESAC)	To champion safeguarding across all education systems and provide a communication channel to share information.	Termly	24
Learning & Improvement Subgroup (LI)	To oversee delivery of multi-agency training programme and support learning dissemination.	3 monthly	17
MASH Strategic Oversight Group (MASHSOG)	To ensure services are working effectively to respond to children's needs at the earliest opportunity and at the right level.	6 monthly	16
Performance Challenge Impact Subgroup (PCI)	To monitor the impact and outcomes of partner activities, overseeing the quality assurance framework and implementation of recommendations, and to develop policy and procedure.	Quarterly	18



Oversight, challenge, decision-making and coordination are achieved across our governance structure against our arrangements to **ensure that we deliver:**

- **Quality assurance and performance scrutiny:** a combination of multi-agency audits, data analysis, performance monitoring, agency assurance reports and operational & strategic risk management help us to understand how effectively agencies are working together and whether children are receiving the right help and protection. Learning from this activity is translated into action plans and improvement work across the partnership.
- **Reviewing and learning from and responding to serious child safeguarding incidents:** the partnership undertakes Rapid Reviews, commissions CSRs where appropriate, and additionally considers cases which do not meet the serious incident notification threshold but still merit local attention. This supports continuous improvement and helps strengthen safeguarding practice for children and families, with recommendations leading to action to improve systems and practice.
- **Training & workforce development:** we commission and deliver a programme of multi-agency safeguarding training informed by local priorities, emerging risks, audit findings and national learning. Training is supported by training needs analysis and evaluated to assess its impact on practice and outcomes for children.
- **Communication and engagement:** we seek child and family feedback and engage our workforce through forums and consultations to ensure that services are shaped by local need and that our workforce feels engaged and supported to deliver our arrangements. We deliver monthly newsletters and a maintained website to support safeguarding practice.
- **Escalation pathways:** we support professional challenge and escalation by overseeing and owning the multi-agency escalation pathway.
- **Strategic development:** we produce multi-agency strategies, policies, procedures and guidance to support local delivery and additionally respond to national reforms and guidance.





1.5 Who scrutinises and supports this?

All of this work is subject to Independent Scrutiny via appointment of an Independent Safeguarding Children and Young People Commissioner (ISCYPC). Jim Gamble QPM is responsible for:

- Quarterly meetings with the DSPs and Lambeth Council's Chief Executive.
- Chairing our Executive Board to add an independent perspective.
- Chairing our Partnership Scrutiny Board, CRSG, CSSOG and MASHSOG.
- Advocating for and on behalf of children in Lambeth.
- Assisting in the resolution of disagreements between agencies.
- Reviewing partnership arrangements via evaluation of effectiveness.



Across the year, our work was supported by the LSCP Business Unit, which comprises:

- A professional advisor: supporting development and delivery of the business plan & overseeing local learning reviews.
- A training & development manager: supporting design and delivery of the multi-agency training and workforce development offer.
- A business support officer: supporting administration and finances of the partnership (role vacant from September to November 2025).
- A projects & improvement officer: supporting policy development and implementation of recommendations from reviews (role vacant from June 2025 to January 2026).

Together, these arrangements enable the partnership to provide leadership, oversight, challenge and continuous improvement across the local safeguarding system. They ensure that our work is informed by evidence, strengthened by independent scrutiny and focused on improving outcomes for children and families. To understand how these arrangements are applied in practice, it is helpful to understand the context in which they operate. The following section therefore explores Lambeth's local profile, needs and safeguarding challenges.

Lambeth Context

What is it like to live and access services in Lambeth?



2. Lambeth Context

What is it like to live and access services in Lambeth?

Effective safeguarding arrangements are rooted in a strong understanding of the children they serve. To identify priorities, target resources and evaluate impact, it is important to understand not only who lives in Lambeth, but also the strengths, needs and experiences of local children and families.

This section provides an overview of Lambeth's local context through three distinct lenses

- Who lives in Lambeth – looking at the borough's population, diversity and demographic profile.
- Local need and service demand - drawing on data from across the safeguarding partnership to understand the needs of our children and families.
- Inspection activity – and what this tells us about the effectiveness of local services.

Taken together, these insights help build a comprehensive picture of the environment in which the partnership operates and provide important context for the remainder of this report.



2.1 Who lives in Lambeth?

Lambeth is one of London's most vibrant, diverse and dynamic boroughs, shaped by the rich experiences, cultures and identities of its residents. This section gives some headlines about our residents and child population.



Lambeth is home to:

- 317,600 residents including:
 - 54,633 children aged 0-18
 - 38,686 young people aged 19-25
- 130 spoken languages
- A highly mobile population, with approximately 21% population turnover annually
- The largest LGBTQ+ population in London, at 22,200 residents
- A globally connected and culturally rich community, with over a third (38.6%) of residents born outside the UK



Our borough has a diverse child population and several overlapping vulnerability factors which drive our local approaches:

Data	Safeguarding Relevance
63% of children are from Global Majority backgrounds (compared with 21% nationally). When looking at individuals aged 0-20, this is broken down as follows: • 35% identify as Black • 16% identify as Mixed Heritage • 27% identify as White British • 10% identify as White Other • 6% identify as Asian • 6% identify as Other	Requires anti-racist and inclusive practice, with continued analysis of disproportionality.
45% of primary school aged children and 39% of secondary school aged children do not speak English as a first language (compared to national averages of 22% and 18%).	Additional considerations are needed to ensure children's views, wishes and feelings are heard and understood.
43% of children live in poverty after housing costs, with evidence of increasing inequality across the borough.	Poverty, housing instability and family stress are recurrent contextual factors requiring attention.
7.4% of pupils have an Education Health and Care Plan (EHCP), 16% receive SEND support in school.	Children with SEND may experience additional vulnerability, communication barriers and service coordination needs.
Approximately 21% population turnover annually.	Mobility creates challenges for continuity, information sharing and joined-up support.



2.2 What was the local need for help and protection?

This section draws on data from across the safeguarding partnership to understand the challenges, vulnerabilities and pressures affecting children and families living in Lambeth across the year.

Headline	Detail	Insights
CSC contacts & referrals - demand within Lambeth's Integrated Referral Hub (IRH) – the 'front door' of CSC remained unchanged, with 13,338 contacts received this year (compared to 13,339 last year)	- Who were contacts coming from? - Police - 27% - Health services – 27% - Schools – 16% - Other – 30% - What were the main areas of need? - Domestic abuse – 11% - Families in acute stress – 11% - Physical abuse – 6% - Housing & homelessness – 5% - Parental mental health – 5% - What were the outcomes? - No further action – 49% - Social work assessment – 19% - Early Help – 13% - Other - 8%	- There was little variation between males and females - Black children were disproportionately overrepresented in contacts (43% compared to 35% of local population) - White British children were disproportionately underrepresented in contacts (9% compared to 27%) - There was a marked increase in the number of contacts discussed at the Multi-Agency Safeguarding Hub (MASH): rising from 94 in Q2 to 183 in Q4, with a total of 890 children discussed at 550 MASH meetings across the year.



Data	Detail	Insights
Early Help & prevention – there was a strong demand across targeted early help, children's centres and holiday activity programmes.	• 360 children across 167 families were receiving targeted Early Help at the end of the reporting period. • Children's Centres continue to demonstrate strong engagement, with 98% of parents reporting satisfaction with services • The Holiday Activities and Food (HAF) programme provided 50,609 funded places and 68.170 meals to vulnerable children	• Demand for targeted early help led to waiting lists across the year.
Child in Need (CIN) - 468 children were subject to a CIN Plan on the 31st of March, with 1,368 children subject to a Plan at some point during the year	• 44% had abuse or neglect as the primary area of need • 22% as a family in acute stress • 12% for family dysfunction • 8% due to child's disability	• There were more males than females subject to CIN (54% to 45%) • Black children were disproportionately overrepresented (52% compared to 35% of local population), as were Mixed Heritage children (22% compared to 16%) • White British children were disproportionately underrepresented (10% compared to 27%) • 17% of children had a recorded disability



Data	Safeguarding Relevance	Insights
Child Protection (CP) – 266 children were subject to a CP Plan on the 31st of March, with 600 children being subject to a Plan at some point during the year.	- As of 31st March 2026, reasons for plan were recorded as: - Emotional abuse – 37% - Neglect – 33% - Physical abuse – 26% - Sexual abuse – 4%	- Family dysfunction, family acute stress, parental mental health difficulties and homelessness / housing instability are frequent presenting needs - Rates of children subject to CP remain above the London average, but comparable to statistical neighbours - There were more males than females subject to CP (52% to 47%) - Black children were disproportionately overrepresented (43% compared to 35% of local population), as were Mixed Heritage children (22% compared to 16%) - White British children were disproportionately underrepresented (11% compared to 27%)
Care proceedings and pre-proceedings – as of 31st March 2026, there were 58 open care proceedings	- Care proceedings issues have increased by 17% in cases and 20% in children compared to the previous year - The total open proceedings have reduced from 63 to 58 cases (a 7% decrease) and 101 to 96 children (a 5% decrease).	45% of children made subject to final court orders were Black, higher than their representation within the wider population.



Data	Detail	Insights
Children Looked After (CLA) - as of 31st March 2026, there were 356 Children Looked After	• These figures included 48 Unaccompanied Asylum Seeking Children (UASC) and 12 newly arrived UASC in the previous 6 months • Adolescent children (13-17) represent 60% of new entries into care • 282 children live with foster carers (79%) • Only 43 children had experienced three or more placement moves within the previous year (12%) • 95.6% of children are placed within 20 miles of Lambeth • 346 Children Looked After were supported by health services through statutory health assessments and care planning across the year	• There were more males than females subject to CLA (53% to 47%) • Black children were disproportionately overrepresented (52% compared to 35% of local population), as were Mixed Heritage children (26% compared to 16%) • White British children were disproportionately underrepresented (7% compared to 27%) • 17% of children had a recorded disability
Care leavers – as of 31st March 2026, 618 care leavers were being supported through Lambeth's Leaving Care Service	• 112 care leavers were former UASC • 37 care leavers were in custody	• 18% of care leavers had a disability
Missing episodes – continue to impact a vulnerable subgroup of adolescent children.	• There has been a significant decrease in the number of missing persons reported to the police, which corresponds with the introduction of Local Missing Hubs in June 2025 (153 in May 2025, 65 in March 2026: whilst available performance data combines both adult and child missing persons, it provides important context regarding vulnerability and safeguarding demand across the boroughs) • 87.7% of Return Home Interviews (RHI) were completed within 72 hours	• Criminal exploitation was identified in 18% of missing episodes • The primary reason for missing episodes was reported as a desire to spend some time with peers (66%) • Missing persons data shows that those reported missing are predominantly Black, and that a slightly larger proportion of men than women are reported missing



Data	Detail	Insights
Domestic abuse and Multi-Agency Risk Assessment Conferences (MARAC) - 768 MARAC referrals were discussed involving 570 children.	School-aged children represented approximately 70% of all children discussed through MARAC throughout the year.	General Practitioner (GP) referrals to MARAC increased from 5% to 9%
Young carers – 305 young carers received support across the year	133 young carers were known to CSC (44%) 45 new referrals for young carers were received across the year	
Education – 33,482 children attend Lambeth Schools..	- Average school attendance is 93.8% (above the national average of 93.5%) - Persistent absence is 8.3% (above the national average of 18.1%) - Severe absence is 1.7% (below the national average of 2.1%) - As of 31st March 2026, 254 children were electively home educated (EHE) and 17 children were missing education (CME)	01 schools and colleges and 51 nursery providers operate in Lambeth 94% of settings are graded good or outstanding 67% of EHE children are of secondary school age
Special educational needs and disabilities	- As of January 2026: 5,386 children in Lambeth Schools received SEN support and 2,506 children in Lambeth Schools were in receipt of an EHCP - As of 31st March, Lambeth CSC's 0-25 Disabilities Service were supporting: 71 allocated children and 258 children receiving short breaks	



Data	Detail	Insights
Emotional wellbeing & mental health needs - A total of 3,621 children were referred to Lambeth Child and Adolescent Mental Health Service (CAMHS) this year	• The majority of referrals came from GPs, Schools, Child Health Services and Accident & Emergency Departments (A&E) • The median waiting time – from referral to assessment (either by telephone, face to face or e-consultation) was 4 weeks • The average CAMHS caseload across the year was 3,010 open cases each month (these are children who are allocated to a care co-ordinator following assessment who maintains contact whilst awaiting intervention and oversees delivery of intervention), there was a steady increase in demand rising from 2,819 open cases in April 2025 to 3,160 in March 2026	• Increasing demand for Attention Deficit Hyperactivity Disorder (ADHD) assessments continues to place pressure on specialist services • While information relating to additional needs is reliant on manual updates, available data indicates that autism was the most commonly additional need among children allocated to CAMHS • More males than females were referred to CAMHS (54% to 45%) • Black children were disproportionately underrepresented in referrals (31% compared to 35% of local population), as were Mixed Heritage children (2% compared to 16%)
Safeguarding in hospitals and primary care – across acute healthcare services 6,543 referrals were made to hospital safeguarding teams	• KCH managed 3,020 safeguarding referrals • GSTT managed 2,273 safeguarding referrals through hospital services • GSTT managed 1,250 maternity safeguarding referrals • Primary Care Safeguarding teams provided over 100 safeguarding consultations to Lambeth Practices	• The most common safeguarding concerns related to emotional harm, neglect and domestic abuse. • A continued rise in children presenting in mental health crisis was observed, particularly amongst 12–15-year-olds attending the Emergency Department. • Domestic abuse remained a significant feature of safeguarding work, both directly affecting children and through wider family vulnerabilities.



Data	Detail	Insights
Public protection – demand remained high with significant increases in Violence Against Women and Girls (VAWG), and improvements in positive outcomes rates.	- London-wide domestic abuse offences increase by 11% compared to the previous year, whilst the positive outcome rate improved to 14.1% (representing an increase of 5.7 percentage points) - London-wide VAWG offences increased by 5%, with the positive outcome rate improving to 12.4% (an increase of 4.8 percentage points) - London-wide rape offences reduced by 9.2%, with positive outcomes increasing significantly to 21.3% (representing a year-on-year improvement of 14.1%) - Within Lambeth and Southwark, domestic abuse offences increases by 202 offences year to date and domestic abuse related VAWG offences increased by 181 offences. - Lambeth generates around 70-80 referrals to the police public protection unit every week, with around 75%-85% of these being 87A safeguarding referrals, with many meeting the threshold for formal safeguarding intervention	Overall, within Lambeth and Southwark VAWG offences increased by 138 offences demonstrating sustained and growing demand on safeguarding services and partnership arrangement supporting vulnerable victims.

This data presents a complex picture of need across Lambeth, with demand remaining high across safeguarding, early help, education, mental health and wider family support services.

A particularly significant theme emerging from the data is the differing patterns of access and intervention experienced by children from different ethnic backgrounds. Black children are consistently overrepresented in statutory safeguarding interventions; in contrast, the available data suggests that Black children are less likely to be represented within pathways for help and wellbeing support (such as CAMHS). This contrast suggests a pattern of Black children being more visible within safeguarding and protection systems and less visible in specialist or therapeutic support systems, which raises important questions about whether all children and families are able to access support at the earliest opportunity and whether barriers may exist in accessing emotional wellbeing and preventative services before needs escalate. While the data does not indicate causation, it does highlight the importance of continuing to understand the experiences of Black children and families, ensuring services are culturally responsive, inclusive, accessible and trusted,

and considering whether opportunities exist to strengthen early intervention and wellbeing support before concerns reach statutory thresholds.

Alongside these findings, family stress, domestic abuse, parental mental health difficulties, housing instability and family dysfunction continue to be prominent factors underpinning referrals and statutory intervention, demonstrating the interconnected social and economic pressures affecting many families. Demand for CAMHS, SEND services, MARAC processes and early help provision further illustrates the breadth of need experienced by children across the borough.

Overall, the data points to a safeguarding system responding to significant and often complex need, whilst also highlighting the importance of understanding disproportionality, access to support and lived experience. These findings reinforce the LSCP's commitment to equity, early intervention and ensuring that support is available at the right time, in the right place and in ways that are accessible to all of Lambeth's diverse communities.



2.3 Recent inspections

While demographic information and service demand data help us to understand the needs, experiences and pressures affecting children and families in Lambeth, they provide only part of the picture. It is equally important to understand how effectively local services are responding to these needs and where opportunities for improvement have been identified. Inspection findings provide valuable insight into our strengths, areas for development and priorities for improvement.

This year marked a significant milestone for the partnership when, in March 2026, Ofsted published the findings from their Inspection of **Local Authority Children's Services (ILACS)** in Lambeth. Lambeth achieved an overall judgement of Good, with Ofsted recognising the dramatic improvements made since previous inspections (2022: Requires Improvement; 2018: Requires Improvement; and 2015: Inadequate). The Inspection identified significant progress across services, strong leadership and improved outcomes for many children and young people.

Key strengths identified included:

- **Leadership and governance:** leadership was noted to be strong and ambitious with a clear vision, effective corporate and political support was noted and leaders demonstrated a good understanding of strengths and areas requiring improvement.
- **Children in care:** children benefited from stable relationships, strong fostering services, effective permanency planning and good health and education outcomes.
- **Care leavers (outstanding):** care leavers receive highly effective support, strong participation opportunities, trusted relationships and good outcomes around housing, education, training, employment and emotional wellbeing.

- **Early help & multi-agency working:** well established Children's Centres and Early Help services, effective partnership working, timely assessments and improved support.
- **Children with disabilities:** significant improvements within the 0-25 Disabilities service, with better transition planning into adulthood and strong co-production with children and families.

Areas for improvement identified included:

- **Front door screening and decision-making:** a need to improve screening and decision making for children who are presented to IRH where safeguarding concerns are not immediately evident
- **Responses to homeless 16 and 17 year olds:** a need to strengthen assessment and support arrangements for young people who present as homeless
- **RHIs:** a need to improve the quality and consistency of RHIs for children who go missing from care.

Additionally, in January 2026 His Majesty's Inspectorate of Probation (HMIP) published the findings from their **Inspection of youth justice work with children and victims in Lambeth**. Achieving an overall judgement of Good this also demonstrated a marked improvement from previous inspections (2019: Requires Improvement; 2015: Inadequate). Areas of strength included the trauma-informed approaches to children and practitioners working alongside children to ensure their voices and opinions were heard and informed the work undertaken with them. The primary area for development was the support required to ensure that victims had a high profile in the service and that their needs and wishes were considered consistently by all staff across the organisation.

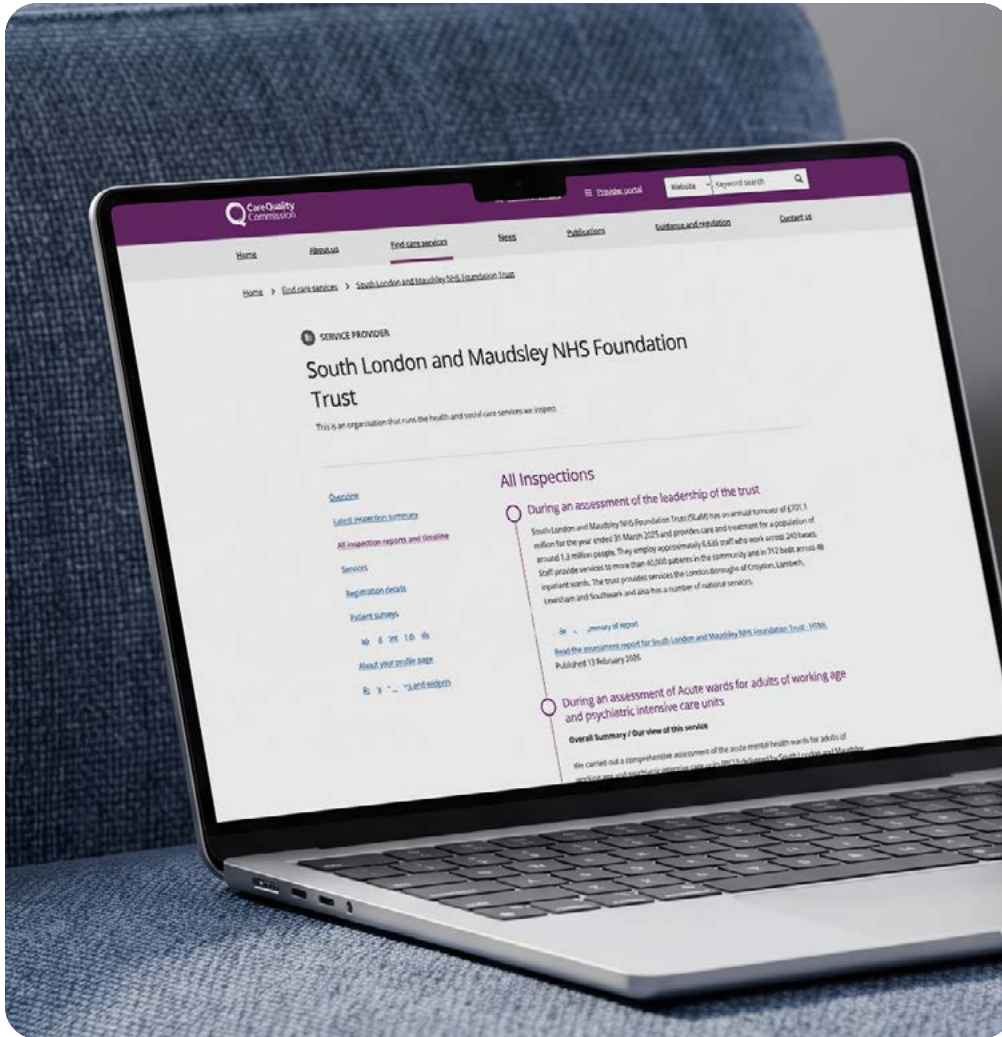


Across the health economy, various Inspections also took place:

GSTT: An unannounced Care Quality Commission (CQC) Inspection of Urgent & Emergency Care Services at St Thomas's Hospital took place in March 2026. The outcome of the overall inspection was that services were outstanding, noting that the service had a proactive and positive culture of safety, based on openness and honesty. People were cared for in a safe environment and protected from avoidable harm.

KCH: participated in several inspection, assurance and regulatory review processes, including CQC inspections and associated improvement activity across Child Health and Maternity Services. Outcomes of these inspections include:

- Positive assurance regarding safeguarding leadership and partnership working, with evidence of strong collaboration between safeguarding teams, Child Health, Maternity and Neonatal Services in preparation for and response to inspection activity.
- Improved alignment of safeguarding practice across Child Health services through strengthened governance arrangements, increased attendance at child health governance forums and enhanced multidisciplinary oversight.
- Identification of opportunities to improve safeguarding capability and consistency across Child Health services, leading to the development and delivery of bespoke Level 3 Safeguarding Children training for paediatric and neonatal staff.
- Enhanced safeguarding supervision and oversight arrangements within paediatric, neonatal and maternity services, including regular multidisciplinary supervision and case discussion forums.
- Continued strengthening of safeguarding governance and learning systems, including the publication of safeguarding bulletins, learning briefings, webinars and dissemination of local and national safeguarding learning.
- KCH have since updated the Trust safeguarding policies for children and maternity.



SLAM: A CQC Inspection took place in SLAM's community adult mental health services and in-patient mental health services in June 2025, which included children's wards and perinatal mental health services. The outcome of the overall inspection was that services required improvement, although child and adolescent in-patient services and perinatal services both received a rating of good. The primary areas for change were around high numbers of staff vacancies and not all staff receiving regular one-to-one supervision.

Overall, inspection activity during 2025/26 provided strong assurance that services across Lambeth are continuing to improve, with major inspections of CSC and youth justice both achieving Good judgements and recognising significant progress in leadership, partnership working and outcomes for children. While inspections also identified areas requiring further development, the findings provide a clear framework for ongoing improvement and help shape LSCP priorities moving forward.



2.4 Our priorities throughout the year

To understand which priorities we were working on this year, it is important to recognise that the LSCP entered these from a period of significant organisational change. During 2024/25, safeguarding arrangements were restructured and mobilised to align with the requirements of Working Together to Safeguard Children 2023. As a result, the LSCP was still in the early stages of its renewed structure, with activity focused on embedding new governance arrangements.

Against this backdrop, toward the end of 2024 we set three priorities for our work:

- 1. Back to basics:** getting the safeguarding fundamentals right, covering themes like information sharing, escalation and robust responses.
- 2. Active anti-racism:** a commitment to eradicating racism which causes harm and negatively affects the opportunities for some children to thrive.
- 3. Data driven activity:** utilising multi-agency data to measure the effectiveness of safeguarding responses and inform the work of the LSCP.

This report will provide an open reflection on how we have progressed against our priorities and where we are now. The remainder of this report will reflect on the activity undertaken to address local need and priorities, and evaluate the effectiveness of this activity.

Year in Review

What activity went on this year and what difference did it make?



This section outlines:

- 1. Reform and statutory change:** an overview of national changes which required local activity.
- 2. Contributions from safeguarding partners:** a look at what our partners did and the difference this made.
- 3. Education as a key partner:** shining a spotlight on how education contributed to strategic and operational working.
- 4. Activity across the partnership:** summarising what we did as a collective and the difference this made.
- 5. Quality assurance and scrutiny:** an overview of how we sought assurance that agencies were effectively working together, what we found and what we did.
- 6. Data and information sharing:** exploring what data we had access to and how we used this to inform our work.
- 7. Learning from serious incidents:** a look at what we learnt from incidents where children were fatally or seriously hurt this year.
- 8. Child and family feedback:** summarising how child and family voice was captured and used.
- 9. The role of independent scrutiny:** an overview of the impact of independent scrutiny this year.
- 10. Funding, resources and value for money:** information about our financial contributions and expenditure.



3.1 Reform and statutory change

This section looks back on what changed nationally, and what we needed to do locally in response.

The reporting period was characterised by substantial system-wide change, requiring partners to balance the delivery of everyday safeguarding responsibilities whilst preparing for significant reform programmes. We were expected to begin preparations for implementing the Families First Partnership Programme (FFPP), which represents the most significant reform of children's social care in a generation. The primary needs this year were to develop our local plans to reshape early help, family support and child protection arrangements in readiness to begin implementing these during 2026/27.

Alongside this, we needed to:

- Implement and respond to the SEND and Alternative Provision Reforms introduced through the 2023 Improvement Plan, whilst also preparing for further changes anticipated under the incoming Government's wider programme of SEND Reform by engaging with national consultation ahead of the publication of the Schools and SEND White Paper in February 2026.
- Work towards embedding Family Hubs as accessible locations for families to obtain advice, support and referral to services under the Best Start for Life Programme.
- Support development of Integrated Neighbourhood Working to strengthen place-based, multidisciplinary support to improve health outcomes for children and families.

The breadth and pace of change is not taking place in isolation. Reform is happening against a backdrop of NHS restructuring and cost reduction initiatives, local government budget pressures and wider policing reform under the Metropolitan Police's Tough Choices Programme.

Consequently, leaders across the partnership have needed to balance immediate operational pressures with longer-term transformation, ensuring that statutory safeguarding responsibilities continue to be delivered effectively whilst reshaping services for the future. The capacity required to lead and implement change has therefore become an increasingly important consideration across all agencies during the year.

Against this context, activity across the year has focussed on preparation, planning and laying the foundations for future implementation including:

- Strengthening Early Help & Family Hub provision.
- Expanding family group conferencing and kinship support.
- Enhancing support for children with disabilities and care leavers.
- Developing more integrated responses to contextual safeguarding risks.
- Establishing a Families First Programme Lead to work closely with pathfinder areas and key stakeholders to begin the design phase.
- Establishing the Neighbourhood Operational Delivery Group (NODG) with dedicated workstreams for Family Help, Multi-Agency Child Protection Teams (MACPTs) and Family Group Decision Making (FGDM).
- Early discussions were undertaken to determine the local service model, establishing 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.
- Fact-finding visits were undertaken to pathfinder areas, and engagement with national briefings was facilitated.

As many of the reforms remain in the design or mobilisation phase, it is too early to evidence measurable impact for children and families. There will be ongoing activity throughout 2026/27 to mobilise reform and measure impact.



Other national changes requiring a local response included:

- **Child Protection Information System (CP-IS):** in July 2025, NHS England provided further guidance in relation to the roll out of Phase 2 of CP-IS, advising all NHS providers using CP-IS to urgently integrate the system into all services that may encounter children. Local planning began to implement the roadmap for all community paediatric departments, sexual health and sexual assault centres, health visiting and school nursing systems to implement the change by August 2026.
- **Intercollegiate training guidance:** in November 2025, the Safeguarding Children Intercollegiate Document was revised, prompting health services to revise training strategies to include more variety via a modular approach to revalidating Level 3 safeguarding competencies.
- **Operation Encompass requirements:** in response to updated statutory guidance published in November 2025, significant work was undertaken by the police to enhance the CONNECT Domestic Abuse decision tree, including an operational notice reminding officers of their responsibilities when recording children linked to domestic abuse incidents with mandatory prompts including requirements to record all children in the household and including their education details and associations (regardless of whether the children witnessed the incident).

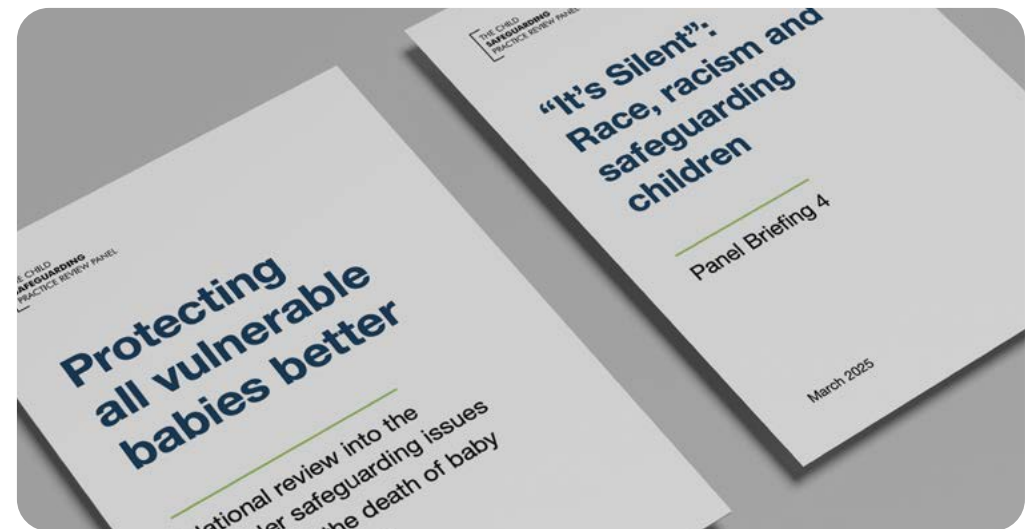
Alongside this, the LSCP has taken action to implement learning from two National Reviews published during this reporting period: *It's Silent* (May 2025) and *Protecting All Vulnerable Babies Better* (Feb 2026):

- Our Anti-Racist Charter was launched in December 2025, complemented by a training offer.
- Training material has been updated and strengthened at both single- and multi-agency levels, ensuring that principles of equity and inclusion are central across all training.
- Seven-minute briefings were produced and published on our website.

- Multi-agency briefing events to share and reflect on key learning were held, alongside targeted forum engagement.
- An update to our pre-birth protocol has been identified as a future workstream.

Towards the end of the reporting period, we had begun to respond to the targeted Working Together update which was published on 18th March 2026.

Taken together, these changes illustrate the LSCP is operating within a rapidly evolving policy and practice landscape. Throughout the year, partners have worked collaboratively to balance immediate safeguarding responsibilities with the planning and redesign necessary to prepare for future reforms, creating the foundations for implementation during 2026/27 and beyond.





3.2 Contributions from our statutory safeguarding partners

This section looks at the efforts across the partnership to deliver our arrangements and improve outcomes for children and families.

Children's Social Care (CSC)

"Children's services in Lambeth have been significantly strengthened since the last inspection in 2022, when they were judged to require improvement. Sustained commitment and strategic focus from senior and political leaders have led to clear and measurable improvements across many aspects of children's services. Leaders are ambitious for children and have fostered a strong, family focused, child centred organisational culture."
(Ofsted ILACS, Jan 2026)

Across the year, CSC delivered a substantial programme of activity within the context of both ongoing operational demand and preparation for Ofsted inspection. While continuing to meet its statutory responsibilities to children and families, the service undertook a range of improvement activity across a range of areas.

Improvement activity was informed by a comprehensive quality assurance framework which included:

- A programme of multi-layered audits undertaken by managers, senior leaders and the Quality Assurance Service, including targeted thematic audits.
- Regular oversight was maintained for children subject to long-term intervention.
- Performance and practice quality were scrutinised through a combination of weekly performance surgeries, management oversight meetings and Practice & Performance Review Panels.
- Power BI dashboards and routine performance reporting enabled leaders and practitioners to monitor key indicators across the safeguarding system, including demand, timeliness, outcomes, permanence, missing episodes, SEND and transition pathways.
- Performance information was made accessible at all levels of the organisation, supporting a culture of transparency, accountability and learning.
- Learning from complaints and compliments: 160 Stage 1 Complaints were received (an increase from 102 in the previous year), with 20 progressing to Stage 2 and 5 to Stage 3. 15 complaints were referred to the Local Government and Social Care Ombudsman, of which 2 were upheld. 29 compliments were received across CSC Services.
- Multi-agency safeguarding audits, Section 11 assurance reviews and Child Safeguarding Practice Review activity.
- Significant emphasis was placed on understanding the voices and experiences of children and families, feedback was gathered through early help satisfaction surveys, CP conference evaluations, the Children in Care Council, Bright Spots surveys, Family Group Conferences (FGC), advocacy services, foster carer and care leaver feedback mechanisms, and Young Inspectors activity.



Drawing on this learning, activity focussed on multiple themes:

Strengthening front door decision making – this was identified by Ofsted as a priority area and remedial action was implemented immediately following inspection, increasing opportunities to strengthen screening and decision making for contacts received where safeguarding concerns were not immediately apparent:

- **Activity** – a review of historic No Further Action (NFA) decisions was undertaken; mechanisms for enhanced Assistant Director (AD) oversight of NFA decisions were introduced; additional management capacity was brought into IRH; targeted training was delivered to the team.
- **Impact** – increased focus on professional curiosity, cumulative harm and children's lived experiences within screening processes; improved management oversight and quality assurance of decision making; greater consistency in threshold application and recording; enhanced scrutiny of contacts requiring further assessment.
- **Evidence** – Multi-agency collaboration on front-door decision making via MASH doubled (rising from 94 cases in Q2 to 183 in Q4). The percentage of contacts which led to NFA without any intervention, including signposting advice, fell from 12% in Q1 to 5% in Q4.





Early Help and prevention – quality assurance activity identified the need for further strengthening of transitions between Early Help and statutory services to ensure seamless support for children and families:

- **Activity** – provided targeted Early Help support; maintained Children's Centre services; strengthened step-up and step-down arrangements between services; reinforced guidance promoting earlier intervention and coordinated support for families; maintained strong partnership working across children's centres, schools, health services, housing, community organisations and voluntary sector providers.
- **Impact** – improvements within the step-up and step-down pathways are emerging, but not yet established. Early Help services continue to operate a waiting list. Families reported increased confidence, resilience and improved family functioning following support.
- **Evidence** – 360 children from 167 families received targeted Early Help, with feedback collected from Early Help audits demonstrating that children and families felt listened to, supported and empowered. In the borough-wide Children's Centre satisfaction survey, 89% of parents reported being very satisfied with services and a further 9% reported being satisfied. Families highlighted the quality of support available through children's centres, parenting programmes, early years services, employment support and family interventions.

Improving responses for missing children – reviews identified variable quality of RHIs and the need for stronger oversight of children who repeatedly go missing:

- **Activity** – developed new guidance and training resources for practitioners; introduced additional management oversight for missing episodes and RHI completion; strengthened multi-agency Missing Panel arrangements; introduced reporting requirements for social workers to record direct discussions with children who decline independent RHIs.
- **Impact** – improved tracking of missing episodes and contextual safeguarding risks; better multi-agency understanding of vulnerability and exploitation risks.
- **Evidence** – 87.7% of RHIs completed within 72 hours, criminal exploitation identified in 18% of missing incidents.



**Strengthening support for homeless 16 and 17 year olds:
learning from Audits and Ofsted highlighted the need for a more
coordinated response for children presenting as homeless:**

- **Activity** – a review of the joint pathway of Housing and CSC was undertaken leading to the introduction of a “One Front Door” approach; enhanced oversight by the 16/17 Homeless Coordinator; undertook a senior management review of all cases proposed for closure without intervention.
- **Impact** – Improved multi-agency coordination and assessment processes; increased management scrutiny and oversight of decision-making; greater consistency in support offered to vulnerable children.
- **Evidence** – “One Front Door” Pathway established.

**Child protection and risk management: audit findings identified
opportunities to strengthen multi-agency contributions to
safeguarding processes.**

- **Activity** – increased engagement with health partners and safeguarding midwives; strengthened quality assurance of Section 47 enquiries and CP Conferences; continued ongoing scrutiny of children subject to long-term CP Plans.
- **Impact** – improved timeliness and quality of CP activity and increased attendance and multi-agency participation with processes.
- **Evidence** – 97% of Core Groups completed within timescales; 100% of CP Reviews completed within timescales; 94.7% of Initial Child Protection Conferences (ICPC) / statutory visits completed within timescales; 92% of conferences were quorate during the reporting period; parents frequently reported that they felt respected, listened to and able to participate in planning for their children.



SEND and children with disabilities: learning from audits, family feedback and inspection activity informed further development of the 0-25 Disabilities Service:

- **Activity** – strengthened transitions planning from age 14 onwards; implemented monthly drop-in sessions for social workers and SEND (facilitated by the Designated Social Care Officer (DSCO)); enhanced oversight of short breaks and support packages.
- **Impact** – improved social care contributions to EHCP processes; sustained improvement in performance and quality of practice; timelier transition planning and improved outcomes for children with disabilities.
- **Evidence** – Ofsted identified significant improvements in the 0-25 Disabilities Service and stronger transition arrangements; greater satisfaction from families accessing services.

Embedding the voice of the child: quality assurance activity consistently identified the importance of ensuring children's experiences shape assessments and plans:

- **Activity** – delivery of targeted training on direct work and tools; expanded Young Inspectors, Children in Care Council and Bright Spots engagement; developed child-friendly resources and participation opportunities.
- **Impact** – increased use of direct work tools and participation activities; improved quality of assessments and plans; enhanced child participation in service development.
- **Evidence** – audit activity demonstrated stronger evidence of children's voices within assessment and plans; increased participation of children in service design; feedback influenced developments within the 0-25 Disabilities Service, Autism Strategy, Carers Strategy and transition arrangements into adulthood.

Children in care, permanency and family network planning – audits identified the value of earlier family involvement and stronger permanence planning:

- **Activity** – expanded Family Group Conferencing (FGC); strengthened Permanency Board oversight; increased focus on kinship and connected-person care.
- **Impact** – improved permanence planning; greater use of family network solutions; reduced delay in care planning; improved stability for children looked after.
- **Evidence** – Ofsted ILACS judged services to Children Looked After as outstanding; FGC referrals increased by 41%; families participating in FGCs reported feeling respected, listened to and empowered to develop solutions within their wider family networks; placement stability remained strong with only 43 children experiencing three or more placement moves within the past year (12% of children); 95.6% of children were placed within 20 miles of Lambeth; 79% of all Children Looked After live with foster carers.



Care Leavers - remained a key priority due to the ongoing vulnerabilities many young people experience as they transition to adulthood without the levels of family support available to most of their peers:

- **Activity** – redesigned pathway plans with care leaver input; developed the Life Skills Hub and wider local offer with care leaver input.
- **Impact** – care leavers were directly involved in service improvement and design.
- **Evidence** – Ofsted ILACS judged services to care leavers to be outstanding; 618 Care Leavers were supported; feedback from the Bright Spots survey highlighted areas of strength, whilst also identifying the continued importance of addressing loneliness, social support and trusted relationships.

Learning from complaints and compliments – the key themes included communication, delays, families not understanding decisions that had been made, concerns regarding service responsiveness and timescales, requests for great clarity around rights and historical complaints relating to care experiences, special guardianship arrangements and entitlements:

- **Activity** – strengthened management oversight and monitoring of complaints and service responses; weekly complaints reports shared with managers and senior leaders; complaints training delivered; more accessible information and guidance created; greater promotion of advocacy services.
- **Impact** – improved accountability, timeliness and complaints handling; strengthened a learning culture; increased focus on communication, record keeping and timely completion of statutory duties.
- **Evidence** – evidence is emerging and not fully established.



This year marked a significant milestone for CSC, achieving a good judgement from Ofsted regarding the quality of children's services in Lambeth. The extensive improvement activity demonstrates a strong culture of learning, reflection and continuous improvement. Moving forward, the next steps for CSC include:

- Continue to focus on strengthening front-door screening and threshold decision making.
- Embed and evaluate the "One Front Door" arrangements.
- Strengthen step-up and step-down pathways between Early Help and statutory services.
- Reduce waiting times within targeted Early Help services.
- Improve the quality, consistency and effectiveness of RHIs, ensuring children's experiences and risks are fully understood and recorded.
- Continue to strengthen practitioners' direct work skills to ensure children's lived experiences remain central to decision-making.
- Increase the use and quality of life-story work for children in care.
- Continue development of kinship care, connected-person and family network approaches.
- Address issues identified through Bright Spots feedback, including loneliness, social connectedness and access to trusted relationships.
- Strengthen transition planning into adulthood.





Health Partners

Lambeth's health economy is extensive and encompasses a wide range of services and professional disciplines that contribute to keeping children safe and promoting their wellbeing. The health contribution to the LSCP is delivered through a collaborative partnership involving SEL ICB Designated Professionals, Primary Care Safeguarding Services, MARAC Health Services, CLA Health Services, GSTT, KCH and SLAM. Collectively, these services play a critical role in identifying need, recognising vulnerability, sharing information and responding to safeguarding concerns at every stage of a child's journey. Many of these organisations operate across multiple local authority boundaries and therefore contribute to several safeguarding children partnerships. This provides valuable opportunities to share learning, expertise and innovation across local systems, whilst also requiring partners to navigate differing governance arrangements, priorities and assurance requirements.

The SEL ICB acts as the strategic health partner within the safeguarding arrangements. Through its Designated Professionals, the ICB provides strategic leadership, expert advice, assurance and professional scrutiny to ensure safeguarding responsibilities are understood and discharged effectively across the health system. During the reporting period, SEL ICB commenced the implementation of the nationally mandated organisational restructuring and cost reduction programmes. Whilst place-based leadership arrangements remain unchanged, reductions in Designated Professional and Named GP safeguarding capacity are expected to have a significant impact on safeguarding leadership, quality assurance, professional advice, training, supervision and system influence across Lambeth. The LSCP recognises the need to mitigate the risks associated with the loss of safeguarding expertise, organisational memory and clinical leadership at a time of increasing demand and complexity across children's safeguarding services.

Improvement activity was informed through a comprehensive quality assurance framework which included:

- Multi-agency safeguarding audits, Section 11 assurance reviews and CSPR activity.
- Safeguarding supervision, complex case discussions, safeguarding committees and Trust governance arrangements.
- Analysis of safeguarding referrals, MARAC activity, MASH discussions, CP medicals, conference attendance and training compliance data.
- Learning from complaints, incidents, inspections, Rapid Reviews and national safeguarding developments.
- Feedback from children and families through health assessments, patient experience surveys, CLA feedback, CAMHS participation activity and community engagement mechanisms.



Drawing on this learning, activity focused on several key themes:

Strengthening multi-agency safeguarding and information sharing: health services continued to strengthen their contribution to multi-agency safeguarding arrangements:

- **Activity** - health partners actively participated in MASH, MARAC, CP conferences, strategy meetings, legal planning meetings and LSCP learning and governance structures; work was undertaken to strengthen escalation processes, improve referral quality and enhance information sharing across agencies; KCH delivered targeted training to their workforce on the quality and consistency of safeguarding referrals.
- **Impact** – improved partnership working; stronger safeguarding decision-making; more coordinated responses to children experiencing harm or vulnerability.
- **Evidence** – KCH received feedback from MASH colleagues on the quality of a referral submitted; GSTT community health services:
 - contributed to 550 MASH discussions involving approximately 890 children;
 - contributed to 768 MARAC referrals involving 570 children;
 - achieved a 99.5% attendance rate at ICPC, with Review Child Protection Conference (RCPC) attendance averaging 89%;
 - observed improvement in quality of safeguarding referrals evidenced by a reduction in NFA outcomes.

Responding to domestic abuse and family vulnerability: domestic abuse remained one of the most significant safeguarding themes across health services:

- **Activity** – targeted domestic abuse training; MARAC participation; routine enquiry processes within maternity and community services; enhanced safeguarding responses for families experiencing domestic abuse were implemented; GSTT health needs assessment template updated to incorporate Think Family approach; KCH reviewed and updated safeguarding policies and procedures and strengthened responses to domestic abuse, exploitation and serious youth violence through partnership working with specialist services including Solace, Victim Support and Redthread.
- **Impact** – improved identification of domestic abuse; increased professional confidence; strengthened multi-agency safety planning for children and families.
- **Evidence** – MARAC activity involved 768 MARAC referrals discussed relating to 310 families and 570 children; GP referrals to MARAC increased from 5% to 9%; 18.6% of referrals to the GSTT Hospital Safeguarding Team originated from adult hospital services, demonstrating effective implementation of the Think Family approach.



Supporting children experiencing mental health difficulties and crisis: health partners identified increasing mental health need as a significant safeguarding challenge:

- **Activity** – introduction of CAMHS ADHD waiting list initiatives including use of external care providers and greater transparency around waiting times; a CAMHS ADHD nurse prescriber lead was funded; CAMHS stakeholder event with parents and carers was completed; CAMHS Non-Violent Resistance (NVR) offer expanded and extended to include neuro-developmental pathway cohort; introduction of CAMHS consultant psychiatrist consultation with primary care providers; increased CAMHS prescriber capacity via recruiting pharmacists.
- **Impact** – improved access to assessment; reduced long waits for first contact; increased support for children with complex emotional wellbeing needs.
- **Evidence** – Lambeth CAMHS received over 3,600 referrals, maintained a median waiting time of four weeks for first meaningful contact and demonstrated a significant reduction in children waiting more than 52 weeks for support; CAMHS caseloads continued to increase, reflecting sustained demand; high rates of ‘was not brought’ following urgent face-to-face appointments provided by CAMHS led to increased waits and barriers; there is 85% compliance with updated risk assessments across Lambeth CAMHS (with a 97% target).

Delayed discharges: across acute providers, delayed discharge has been an area of increasing challenge. Common themes include children who present with mental health crisis, family relationship breakdown or emotional dysregulation who experience prolonged stays whilst awaiting appropriate assessment and discharge arrangements and housing/homelessness issues impacting on maternity discharge:

- **Activity** – bi-weekly meetings between acute trusts, SEL ICB and CSC have been established to enable appropriate escalation and seek resolution.
- **Impact** – improved collaboration to resolve difficulties.
- **Evidence** – the model is showing some emerging benefits but is not yet replicated in neighbouring boroughs which are also served by acute trusts, limiting impact.



Maternity safeguarding and early identification of risk: maternity services continued to identify and respond to safeguarding concerns at the earliest opportunity:

- **Activity** – enhanced safeguarding referral pathways, safeguarding supervision, pre-birth planning and domestic abuse screening; improved oversight of vulnerable mothers and babies; KCH introduced monthly multi-agency meetings between maternity safeguarding and CSC leads.
- **Impact** – earlier identification of vulnerability; improved safeguarding planning; strengthened multi-agency support before and after birth.
- **Evidence** – GSTT maternity services generated 1,250 safeguarding referrals; key concerns included domestic abuse, maternal mental health difficulties, housing instability and previous CSC involvement; 193 women with Female Genital Mutilation (FGM) were identified and safeguarding monitoring arrangements were put in place for affected families; compliance with routine enquiry on domestic abuse has been variable in GSTT at 87%.

Improving healthcare responses to neglect, medical neglect and child protection: quality assurance activity highlighted the importance of maintaining a focus on neglect, cumulative harm and children's lived experiences:

- **Activity** – revision of GSTT assessment frameworks; implementation of neglect tools; safeguarding training; Think Family approaches; enhanced quality assurance arrangements across acute and community services; KCH delivered training to MASH teams on non-accidental injury, medical neglect and fabricated and induced illness.
- **Impact** – improved identification of neglect; stronger assessments; better consideration of cumulative harm and family vulnerability.
- **Evidence** – across acute healthcare services KCH managed approximately 3,020 safeguarding referrals and GSTT managed 2,273 referrals through hospital services (of which 441 children were resident in Lambeth) and 1,250 via maternity safeguarding; GSTT community health services maintained attendance rates of 99.5% at ICPC and 89% at RCPC; community teams completed 294 CP medicals and 39 Child Sexual Abuse (CSA) examinations; anecdotal evidence of increased neglect toolkit usage.



Children with SEND and complex needs: supporting children with disabilities, neurodevelopmental needs and complex vulnerabilities remained a priority:

- **Activity** – GSTT strengthened transition planning and neurodevelopmental pathways by appointing a dedicated Adolescent Clinical Nurse Specialist; developed specialist CAMHS provision; GSTT delivered training for social workers regarding out-of-hours placements for children with chronic medical needs.
- **Impact** – improved continuity of care; better transition experiences; enhanced multi-agency support for children with complex needs.
- **Evidence** – CAMHS data identified significant cohorts of children with EHCPs, autism and learning disabilities; GSTT supported more than 150 young people with complex neuro-disabilities through transition arrangements.

Primary care: quality assurance activity identified a gap in the information sharing with, and inclusion of, GP providers in multi-agency responses:

- **Activity** – successful appointment of the Named GP for Safeguarding Children; re-establishment of face-to-face safeguarding training for GP Safeguarding Leads; additional learning opportunities focussing on adolescent safeguarding, domestic abuse, exploitation, contextual safeguarding, mental health, court skills and Deprivation of Liberty Safeguards (DoLS); 6-weekly supervision forum for the safeguarding leads for Lambeth's 41 GP Surgeries to provide peer support, case discussion and learning dissemination.
- **Impact** – enhanced GP confidence in recognising, assessing and responding to safeguarding concerns; improvements in quality and consistency of referrals and information sharing.
- **Evidence of impact** – Primary Care safeguarding teams provided over 100 safeguarding consultations to Lambeth practices; GP referrals to MARAC increased from 5% to 9%; improved safeguarding training compliance; ongoing work regarding information sharing gaps to enable timely information sharing with GPs.



Workforce development, learning and safeguarding culture: a significant focus was placed on ensuring staff had the knowledge, confidence and support required to safeguard children effectively:

- **Activity** – revision of training strategy following publication of the revised Safeguarding Children Intercollegiate Document; delivery of safeguarding training and safeguarding supervision; dissemination of learning from reviews; safeguarding bulletins; webinars; 7-minute briefings; workforce development programmes.
- **Impact** – improved safeguarding knowledge, referral quality, professional curiosity and confidence in managing complex safeguarding concerns.
- **Evidence** – training compliance improved significantly across acute services, with GSTT Level 3 safeguarding compliance increasing to approximately 89%, while KCH maintained compliance rates of 90% for Level 3 safeguarding training; CAMHS largely maintained the compliance target of 85% across the year.

Whilst significant progress was made across safeguarding services during the reporting period, several areas remained challenging due to service pressures, workforce constraints and increasing complexity of safeguarding presentations. Delayed discharge is placing significant pressure on acute health settings, with a steady increase in children attending emergency departments in acute mental health crisis, family relationship breakdown and emotional dysregulation due to life stressors. Managing these presentations is time and resource heavy. Alongside this, the number of cases requiring internal and external legal advice has seen an increase in the number of staff required to prepare statements or attend family court as witnesses.

The safeguarding children team in GSTT was affected by high levels of sickness over the year. This demonstrates the complexity of maintaining strong operational safeguarding alongside service improvement activity.

Overall, health partners made a substantial contribution to safeguarding children and young people throughout 2025/26. Despite increasing complexity and significant organisational change across the NHS, health services continued to demonstrate strong partnership working, effective safeguarding leadership and a commitment to placing the welfare, voice and lived experience of children at the centre of practice. Drawing on this, the next steps for health partners include:

- Embed Families First and MACPT reforms.
- Improve multi-agency pathways for discharge planning, housing-related safeguarding concerns and complex adolescent presentations.
- Strengthen responses to children experiencing mental health crisis and emotional distress.
- Improve support for children with SEND, neurodevelopmental needs and complex vulnerabilities.
- Enhance responses to exploitation, contextual safeguarding and risk outside the home.
- Continue strengthening safeguarding supervision, workforce development and training compliance.
- Implement CP-IS Phase 2 and strengthen information sharing across healthcare services.
- Develop a SharePoint-based system to enable the timely sharing of information with GPs.
- Maintain effective safeguarding leadership and assurance arrangements during NHS organisational restructuring and ICB transformation activity.
- Increase compliance with updated risk assessments across Lambeth CAMHS.
- Embed the five-year roadmap for Lambeth CAMHS which was launched in March 2026.



Police

Public Protection teams at the Metropolitan Police's Central South BCU (covering Lambeth & Southwark), continued to play a critical role in safeguarding children and vulnerable families in Lambeth across 2025/26. Activity took place against a backdrop of increasing demand relating to domestic abuse, VAWG, exploitation, missing children and wider vulnerability, whilst the service also prepared for significant system reform including the development of MACPTs.

Public Protection has just over 260 members of staff across ten departments. The bulk are based at Brixton Police Station but several teams are based in Lambeth Council buildings. Departments include the Community Safety Unit, Rape & Serious Sexual Offences (RASSO), Local Missing hub, Risk Management Unit, Child Abuse Investigation Team, Child Exploitation Team, MASH, Police Conference Liaison Officers, Public Protection Referrals Desk and Youth Offending Teams.

Demand was high, with weekly referral volumes to public protection teams regularly exceeding 70 to 80 referrals per week, with the busiest weeks recorded during January, February and March. Domestic abuse and child protection concerns remained the predominant themes, alongside physical abuse, neglect, emotional harm and child sexual abuse allegations. There was a high volume of unborn child referrals, often requiring pre-birth planning, strategy discussions and safeguarding interventions before birth. Repeat families continued to generate demand, with numerous referrals linked to children already known to police and partner agencies, indicating ongoing vulnerability and safeguarding concerns. Children subject to CP Plans account for a significant proportion of referral activity, generating repeat information-sharing requests, ICPC involvement and safeguarding reviews. Exploitation remained a concern, with recurring referrals linked to Child Criminal Exploitation (CCE), Child Sexual Exploitation (CSE), gang association, weapons and missing children. Missing children continued to create demand, particularly involving repeat missing episodes, looked-after children and vulnerable young people at risk of exploitation.

Alongside areas of need, improvement activity was informed through a range of assurance, scrutiny and performance mechanisms, including:

- A Police Protection Audit which identified both strengths (improved understanding of Police Protection powers) and areas for development (inconsistencies in practice and recording reinforced the need for stronger rationale recording and earlier multi agency planning).
- Harmful Practices scrutiny panels.
- V100 oversight activity.
- Joint Operational Improvement Meetings (JOIMs) with the Crown Prosecution Service (CPS) which scrutinised charging outcomes, disclosure performance, timeliness and victim engagement in RASSO.
- Reviews of safeguarding investigations and disclosure performance.
- Analysis of domestic abuse, VAWG, missing persons and safeguarding referral data.
- Learning from Rapid Reviews, practice reviews and partnership audits.
- Feedback from officers, victims and families.



Drawing on this learning, activity focused on several key themes:

Strengthening responses to children affected by domestic abuse: domestic abuse remained a significant source of safeguarding demand and a key area of focus for the MPS:

- **Activity** – significant work was undertaken to implement statutory Op Encompass requirements: CONNECT recording systems were strengthened through enhanced decision-making tools and mandatory recording prompts, requiring officers to capture details of all children linked to domestic abuse incidents and ensure education information was recorded consistently.
- **Impact** – improved identification of children affected by domestic abuse; stronger compliance with safeguarding requirements; enhanced information-sharing with schools and partner agencies; earlier opportunities for intervention and support.
- **Evidence** – domestic abuse offences increased by 11% London-wide, with more than 200 additional offences recorded across Central South BCU, whilst positive outcome rates improved to 14.1%; improved compliance with Op Encompass duties and stronger information-sharing arrangements with education providers were identified.

Developing responses to child protection and safeguarding risk: police continued to strengthen their contribution to local safeguarding arrangements and preparation for national reform.

- **Activity** – active participation in development of the MACPT model; promotion of a consistent approach to significant harm thresholds; continued engagement with Section 47 enquiries, CP conferences and multi-agency safeguarding discussions; support for development of a single child protection pathway; implementation of Robotic Process Automation (RPA) within safeguarding processes; work continued to reduce the use of police stations for children accommodated under Police Protection powers through strengthened partnership working, earlier placement planning and greater awareness of alternative safeguarding arrangements.
- **Impact** – improved consistency in safeguarding decision-making; strengthened partnership responses to risk and enhanced focus on children at risk of significant harm.
- **Evidence** – the Public Protection Referrals Desk managed significant safeguarding demand, with approximately 75-85% of referrals relating to child safeguarding concerns under Section 87A processes. High levels of strategy discussions, child protection activity and repeat involvement with vulnerable families demonstrate the continued importance of safeguarding within police activity.



Responding to exploitation and risk outside the home: exploitation continued to present a significant safeguarding challenge affecting vulnerable adolescent children:

- **Activity** – continued oversight through the Child Exploitation Team (CET), Harmful Practices activity, missing children processes and the Multi-Agency Risk Outside the Home (MAROTH) arrangements, jointly chaired with CSC leadership.
- **Impact** – improved strategic oversight of exploitation and extra-familial harm; strengthened multi-agency responses to vulnerable children exposed to criminal exploitation, sexual exploitation, serious violence and missing episodes.
- **Evidence** – recurring referrals relating to child criminal exploitation (CCE), child sexual exploitation (CSE), gang association, weapons and missing children remained a significant feature of safeguarding demand. MAROTH arrangements were recognised as an area of effective practice during Ofsted inspection activity.

Improving responses to missing children and vulnerable young people: safeguarding arrangements continued to evolve in response to concerns regarding children who go missing:

- **Activity** – introduced and embedded Local Missing Hubs in June 2025; continued multi-agency safeguarding activity relating to repeat missing children; enhanced focus on exploitation risks associated with missing episodes.
- **Impact** – strengthened oversight of missing children; improved coordination between partners; greater focus on vulnerability and exploitation risks.
- **Evidence** – missing person incidents reduced significantly during the reporting period following implementation of the Local Missing Hub model (with 153 reports received in May 2025, reducing to 65 in March 2026), although repeat missing children and vulnerable young people continue to generate substantial safeguarding demand.

Embedding child-centred and trauma-informed practice: improving the experience of children and vulnerable victims remained a priority throughout the year:

- **Activity** – implementation of the Pre-Interview Planning and Preparation Assessment (PIPPA) framework; ongoing delivery of Harmful Practices awareness training; investment in specialist video recorded interview (VRI) facilities designed to create more trauma-informed environments for children and vulnerable victims.
- **Impact** – strengthened victim-centred practice; improved interview planning; enhanced support for children participating in criminal investigations.
- **Evidence** – officers reported positive feedback regarding refurbished VRI suites elsewhere within the MPS, describing improvements in victim engagement and interview environments. Implementation of PIPPA was also identified as contributing to more tailored interview approaches and improved evidence gathering.



Workforce development and learning: ongoing professional development was undertaken to support safeguarding practice across Public Protection services:

- **Activity** – delivery of Harmful Practices awareness training; six-monthly professional development events; partnership learning opportunities; training on working with children with SEND; collaboration with social workers and learning dissemination through operational notices, workshops and Public Protection learning platforms.
- **Impact** – increased safeguarding awareness; strengthened professional confidence; improved consistency of safeguarding responses.
- **Evidence** – safeguarding learning was routinely disseminated across Public Protection teams and partner agencies, with learning from reviews, audits and national developments informing practice improvements throughout the year.

Whilst overall progress was positive, some activity experienced delays. The implementation of the RPA tool for Forms 87A and 87B was delayed due to technical issues and bugs within CONNECT. Some VRI refurbishment sites (including Lambeth's) also experienced delays because of additional infrastructure and building works required to achieve the required standard. There have been a large number of staffing challenges in this reporting period; many of these are ongoing. These include the movement of operational officers into fully operational roles and the movement of adjusted duties officers in addition to the civilianisation of some posts.

Overall, the MPS made a significant contribution to safeguarding children throughout 2025/26. Despite increasing demand, workforce challenges and organisational change, there is evidence of stronger information-sharing, improved child-centred safeguarding practice, enhanced partnership working and improved outcomes across several high-harm areas. Building on this progress, key priorities for 2026/27 include:

- Continued MACPT development and piloting activity.
- Completion of VRI suite refurbishment by March 2027.
- Continue Harmful Practices awareness and scrutiny activity.
- Ongoing CPS improvement work through JOIM Meetings.
- Wider implementation of RPA processes.
- Maintaining compliance with Op Encompass requirements.



3.3 Education as a key partner

Across the year, Education services continued to play a central role within Lambeth's safeguarding arrangements, delivering significant improvement activity alongside ongoing operational responsibilities for schools, colleges, alternative provision and early years settings.

Improvement activity was informed through a range of quality assurance mechanisms, including:

- 46 safeguarding audits undertaken across primary and secondary schools
- Learning from CSPRs
- Feedback from schools and designated safeguarding leads (DSLs)
- Pupil surveys
- Complaints and escalation processes
- Safeguarding supervision
- Performance data relating to attendance, exclusions, SEND, inclusion and vulnerability.

This activity highlighted a number of key themes where activity was focussed across the year.

Inclusion, attendance and educational engagement: reductions in exclusions and strengthening inclusive practice remained a key priority throughout the year:

- **Activity** – education services strengthened Inclusion Panels, exclusion prevention arrangements, alternative provision oversight, reintegration planning and destination tracking for vulnerable young people; health and school nursing participation was introduced to the Too Ill to Attend Panel; schools continued to adopt a Think Family approach, working closely with Early Help, Children's Social Care, Health and Housing partners to address underlying factors affecting attendance, behaviour and vulnerability.
- **Impact** – more vulnerable children remained engaged in education, connected to trusted adults and supported through safeguarding systems; earlier intervention and stronger inclusion arrangements reduced vulnerability to exploitation, serious youth violence and social exclusion.
- **Evidence** – permanent exclusions reduced by more than 50% compared to the previous year. Lambeth also maintained very low levels of CME and strengthened pathways for vulnerable learners.



Contextual safeguarding and risk outside the home: schools identified increasing concerns relating to exploitation, serious youth violence, missing episodes, online harms and peer-on-peer abuse:

- **Activity** – education partners continued to contribute to risk outside the home developments via CSSOG, Violence Reduction initiatives, MASH strategic arrangements, DSL forums and multi-agency safeguarding activity; Harmful Sexual Behaviour (HSB) resources were promoted across schools; Operation Encompass arrangements continued to expand.
- **Impact** – improved information sharing and contextual safeguarding approaches supported earlier identification of risk; more effective risk assessment; stronger multi-agency safeguarding responses.
- **Evidence** – schools reported increases in the identification of exploitation, online harms and contextual safeguarding concerns, alongside stronger partnership responses and greater engagement in multi-agency arrangements.

Strengthening safeguarding practice and leadership: quality assurance activity identified the need to continue supporting schools to manage increasingly complex safeguarding concerns:

- **Activity** – the Education Safeguarding Service undertook 46 safeguarding audits across schools; introduced a structured safeguarding supervision programme for DSLs; delivered safeguarding workshops linked to review learning; developed guidance arising from serious incidents; produced a Critical Incident Response brochure and pathway including access to clinical psychologists.
- **Impact** – stronger safeguarding oversight; increased professional confidence; improved threshold decision-making; greater opportunities for reflective practice when managing complex cases.
- **Evidence** – the DSL supervision programme was established to support complex areas including exploitation, domestic abuse, neglect, mental health and serious youth violence, while safeguarding audits identified areas of good practice and opportunities for improvement across the school system.

Education safeguarding portal - a significant safeguarding development during the year was the continued growth of the education safeguarding portal:

- **Activity** – the portal brought together safeguarding procedures, referral pathways, policies, learning from reviews, safeguarding alerts, training materials, toolkits and emerging risk briefings within a single resource.
- **Impact** – improved accessibility of safeguarding information strengthened consistency of practice, professional confidence, information sharing and threshold decision-making across educational settings.
- **Evidence** – as of May 2026, 87 schools had registered on the platform; 173 staff members had booked onto 260 training courses; 24 schools had utilised the portal's automated policy creation function to support safeguarding compliance and policy development.



SEND and vulnerable learners: children and young people with SEND continued to represent a significant safeguarding priority:

- **Activity** – education launched the SEND and Alternative Provision Strategy 2025-2030; strengthened safeguarding oversight within alternative provision; delivered the Difference Matters and Talk Matters projects; worked closely with SEND and Inclusion services to respond to increasing demand.
- **Impact** – vulnerable learners received more timely support and benefited from a highly inclusive education system; SEND-focused initiatives strengthened safeguarding arrangements for children who may experience increased vulnerability due to communication needs, social isolation or barriers to disclosure.
- **Evidence** – Lambeth maintained 3,316 EHCPs and issued 87.2% of new EHCPs within statutory timescales, substantially above the national average of 46.4%; only 37.2% of annual review decisions were completed within the statutory timeframe, below the national average of 44.4%; Lambeth maintained some of the lowest exclusion rates and strongest educational outcomes for children with EHCPs; the annual SEND Family Survey found that 45 families identified a need for improved communication and responsiveness from SEND services.

Embedding the voice of the child: understanding children's experiences remained a central component of education safeguarding activity:

- **Activity** – schools undertook safeguarding pupil surveys and worked with the Youth Council to strengthen young people's influence over safeguarding priorities, including contextual safeguarding and online safety; pupil voice informed reintegration planning and alternative provision decisions.
- **Impact** – children's views increasingly informed both individual safeguarding decisions and wider service development activity; schools strengthened safeguarding communications and made reporting pathways more visible and accessible.
- **Evidence** – 71.4% of pupils reported feeling safe in school; 77.1% reported feeling safe online and in their community; 65.7% knew how to report concerns; 37.1% felt they were able to influence safeguarding arrangements.



Taken together, there is evidence of a strong commitment across the education sector to continuous improvement and the positive impact this is having. Activity demonstrates how education is embedded into operational and strategic safeguarding responses.

During 2026/27, Education will continue to strengthen safeguarding arrangements through:

- Completion of safeguarding audits across all schools and dissemination of emerging learning and best practice.
- Continued development of contextual safeguarding and risk outside the home approaches.
- Expansion and evaluation of DSL safeguarding supervision.
- Further development of the Education Safeguarding Portal as a central safeguarding resource.
- Strengthening pupil participation and the influence of children's voices on safeguarding priorities.
- Improving support for children and young people with SEND, particularly around communication, transitions and preparation for adulthood.
- Working with partners to address attendance challenges, emotionally based school avoidance and increasing safeguarding complexity.
- Supporting schools to respond to emerging risks including exploitation, online harms, harmful sexual behaviour and serious youth violence.
- Continuing to strengthen multi-agency information sharing, safeguarding leadership and professional development across the education sector.





3.4 Activity across the partnership

This section focuses on what was achieved together through the safeguarding arrangements, demonstrating how partners collaborated to improve outcomes for children and families.

A breakdown of how members contributed to our governance framework across the year is as below:

Governance group	# of meetings	# of members ²	Average attendance ³
Executive Board	3	5	100%
Partnership Scrutiny Board	3	30	56.5%
Case Review Subgroup	5	23	57.1%
Performance Challenge Impact Subgroup	3	18	68.7%
Learning & Improvement Subgroup	4	17	62.6%
Education Safeguarding Advisory Committee	3	24	39.9%
Early Help & Family Support	4	23	38.2%
Contextual Safeguarding Strategic Oversight Group	1	17	68.5%
MASH Strategic Oversight Group	2	16	62.7%
Total	28	173	61.6%

² Membership figures exclude input and contributions from the LSCP Business Unit Team

³ Average attendance data should be regarded as indicative rather than definitive as it is subject to a number of limitations, including both changes in membership throughout the year and multiple representatives from one agency often being assigned to the same group.



In addition to the 28 formal governance meetings, several extraordinary focussed and thematic meetings took place across the year.

Alongside the activity across quality assurance & scrutiny, learning from serious incidents and training & learning (which are explored elsewhere in this report), collectively, across this framework we achieved:

Improved joint working arrangements by policy and guidance development:

- **Activity** – the LSCP strengthened our joint working arrangements by introducing our Anti-Racist Charter, an Online Safety Policy and supporting Guidance, Minimum Standards for Safe Commissioning, a Young Carers Policy with supporting Guidance, Access to Education Guidance, a Training Planning Toolkit and a Domestic Abuse Housing Toolkit; targeted engagement and training support offers were rolled out to complement these developments.
- **Impact** – we established clearer expectations regarding anti-racist and inclusive practice; developed a tool to assess risks related to online harms and inform appropriate responses; set baseline standards to ensure commissioned services are safeguarding compliant and contribute to information sharing; clarified the support pathways for Young Carers, children not in full time education and families impacted by domestic abuse with housing needs.
- **Evidence** – whilst there is evidence of reduced waiting lists for Young Carers, evidence is less established elsewhere. Section 2 of this report highlights that disproportionality continues to impact Lambeth's Black children and families and we see across reviews and scrutiny that children who are not in full time education are disproportionately represented. Our anti-racist, online safety and education safeguarding training are routinely undersubscribed and underattended.

Strengthened channels for communication and engagement:

- **Activity** – the LSCP updated and re-launched our website; re-established monthly newsletters; undertook several workforce surveys and consultations; organised an annual conference event in November 2025 which focussed on risk outside the home; internal guidance was issued in September 2025 to strengthen understanding of Lambeth's Statutory Partners by providing a breakdown of roles, responsibilities and organisational hierarchies to support collaborative working.
- **Impact** – partnership information is more accessible and dynamic; we have expanded ways to reach and engage with our workforce and provided support to understand the contributions of our statutory partners.
- **Evidence** – around 90 people attended the LSCP in-person annual conference; 573 people subscribe to the LSCP newsletter with 50% actively engaged, meaning we reach 289 staff and volunteers every month with safeguarding news and updates; this hasn't yet translated into engagement with surveys, which had limited reach and impact (fewer than 10 respondents per survey); learning from reviews indicates there continue to be assumptions and misunderstanding of 'health' as a single entity which stresses the need to strengthen the reach of our guidance to our workforce. there continue to be assumptions and misunderstanding of 'health' as a single entity which stresses the need to strengthen the reach of our guidance to our workforce.



Introduced risk registers:

- **Activity** – in June 2025, the LSCP introduced quarterly operational risk register returns to help identify the risks which were compromising our partners' ability to deliver day-to-day support and protection to children and families; returns feed into our strategic risk register for consideration of where strategic intervention is required.
- **Impact** – improved visibility of operational pressures and emerging risks across partner agencies; enabling the LSCP to identify common themes and escalate concerns through appropriate governance routes; providing opportunities to target strategic support.
- **Evidence** – further work is needed in this area, with agency compliance with returns varying from 100% to 0%, with an average return rate of 43.3%.

The activity represents the continued growth of LSCP governance arrangements and our growing ability to work collectively to address strategic safeguarding priorities. Our activity has strengthened the foundations that support effective multi-agency safeguarding practice with evidence of genuine progress. However, challenges remain regarding capacity to engage and participate with the LSCP and there is a need to develop how we evidence the impact LSCP work is having on children and families. Building on this, during 2026/27, the partnership will focus on:

- Strengthening attendance and representation across governance groups, with particular attention to areas where engagement has been inconsistent or below expected levels.
- Improving compliance with operational risk register returns to ensure partnership risks are identified, escalated and addressed in a timely and consistent way.
- Increasing practitioner awareness and uptake of partnership policies, guidance and training, particularly in relation to anti-racist practice, online safety and education safeguarding.
- Expanding the reach and impact of communication and engagement activities, including improving participation in consultations, surveys and learning events.
- Developing stronger measures of impact to better understand how partnership activity is influencing practice, decision-making and outcomes for children and families.
- Continuing to challenge and address disproportionality, ensuring partnership activity translates into tangible improvements for children and families who experience unequal outcomes.



3.5 Quality assurance and scrutiny

Our framework for quality assurance and scrutiny

Quality assurance and scrutiny are essential to the LSCP because these mechanisms provide independent challenge, assurance and evidence about whether safeguarding arrangements are effective in protecting children and improving outcomes. LSCP arrangements include:

Independent scrutiny arrangements: in line with Working Together our ISCYPC plays a vital role in independent advocacy, scrutiny, assessment of systems and processes, resolving disagreements, promoting a culture of scrutiny, evaluating performance, reviewing arrangements and ensuring effective challenge. They do this by:

- Chairing our Executive Board and Partnership Scrutiny Board
- Chairing our CRSG, MASHSOG and CSSOG
- Chairing Rapid Review and Case for Consideration Panels
- Quarterly one-to-ones with our DSPs
- Requesting and reviewing additional information and assurance as needed

LSCP quality assurance (QA) framework: the LSCP QA framework combines various data and intelligence sources to understand the quality and effectiveness of safeguarding arrangements including:

- **Quarterly datasets:** datasets are presented to and considered by various subgroups to identify overall performance, demand and emerging trends and areas of need.
- **Quarterly reporting:** partners are required to submit quarterly reports outlining progress, evidence of impact, operational risks and responses to a themed assurance question focused on a specific area of partnership delivery.
- **Multi-agency thematic audits:** provide an opportunity to consider the involvement of different agencies, quality of practice and lessons to be learnt in relation to multi-agency and multi-disciplinary practice against a specific theme.
- **Safeguarding self-assessment audits (S11/S175):** provide an opportunity for agencies to self-assess their safeguarding leadership, policy, practice and performance and inform overall levels of assurance across Lambeth.
- **Learning from serious child safeguarding incidents:** provide an opportunity to establish key learning, areas of strength and areas for development following situations where children have died or suffered serious harm where abuse or neglect was known or suspected.

Child's voice

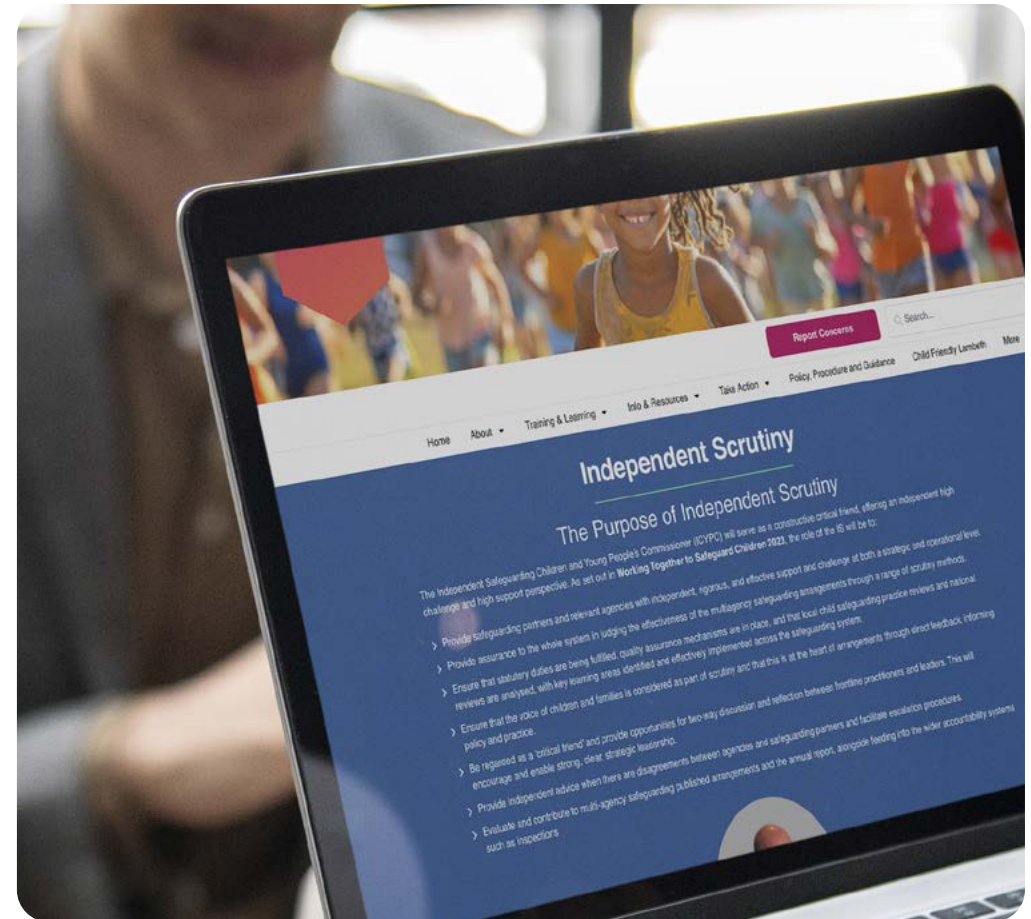
Our partners are required to provide evidence of how the voice of the child is captured across service delivery and design within quarterly reporting and audit activity.



Targeted scrutiny activity

Alongside activity across quarterly datasets, learning from serious child safeguarding incidents and child's voice (which are covered elsewhere in this report), targeted scrutiny activity during 2025/26 included:

- A multi-agency thematic audit into the partnership response to physical abuse was finalised in June 2025.
- A multi-agency thematic audit into the partnership response to risk outside the home was mobilised in September 2025 and was nearing completion by the end of the reporting year.
- A targeted multi-agency Section 11/Section 175 assurance exercise, issuing self-assessment audit tools simultaneously across partner agencies and education providers to inform thematic analysis of the findings.
- Thematic scrutiny of key themes like stop & search disproportionality and transitional safeguarding arrangements at our Partnership Scrutiny Board.





Key findings from scrutiny

Our response to physical abuse:

- **Areas of strength** – timely referrals; appropriate application of child protection thresholds; effective and prompt strategy discussions between CSC and Police; timely Section 47 enquiries; good capture of children's voices; comprehensive CP medical reports; examples of effective multi-agency working that reduced risk and improved outcomes for children.
- **Areas for improvement** – inconsistency in understanding and applying procedures across agencies, particularly around physical abuse referrals, parental consent, CP medicals and information sharing; concern about an over-reliance on medical findings to substantiate abuse, with questions raised about whether children's disclosures were always afforded sufficient weight; inconsistent use of review strategy meetings; weaknesses in sharing outcomes with partner agencies (especially primary care); the emotional impact on children when allegations did not result in further action; the need for stronger challenge of parental narratives where abuse was denied.

Our safeguarding self-assessment assurance exercise:

- **Areas of strength** – evidence of strong leadership commitment to safeguarding; effective governance arrangements; good inter-agency working; robust safeguarding policies; comprehensive workforce training across most organisations.
- **Areas for improvement** – some adult-facing services did not fully recognise their responsibilities towards safeguarding children, creating potential risks around 'think family' practice; safeguarding responsibilities were not always clearly reflected in job descriptions; nearly a quarter of respondents reported insufficient safeguarding supervision for DSLs and DDSs; training was often driven by mandatory requirements rather than local safeguarding priorities and risks; there were notable weaknesses around peer-on-peer abuse, social media guidance, VAWG, escalation procedures, accessibility of safeguarding information and use of interpreters.

Stop and search disproportionality

Partnership scrutiny identified significant disproportionality in stop and search activity, with higher rates for Black children compared with other ethnic groups. Scrutiny discussions emphasised the need to better understand context, demographics, repeat encounters and outcomes in order to improve trust and confidence and strengthen strategic oversight.

Transitional safeguarding

Partnership scrutiny identified transitional safeguarding as an area requiring further examination. The board requested a dedicated update and deeper scrutiny of transitional safeguarding arrangements, reflecting a partnership recognition that this remained an important strategic issue requiring further development and assurance.



What we did and continue to do

Key decisions and actions taken as a result included:

Completed	In Progress
• To strengthen culturally competent assessments and improve professional challenge of harmful parenting practice, targeted social work training was rolled out across Lambeth's Social Care Academy • To ensure that adult vulnerabilities, behaviours or responses to support don't lead to a loss of focus on the child, a new multi-agency training offer was mobilised regarding working with adults • To promote information sharing and engagement with the LSCP, Minimum Standards for Safe Commissioning were launched and embedded. • To develop more locally based training offers across agencies, a training planning toolkit was published. • To increase access to supervision in the education sector, ESAC led on introducing a supervision pilot for school DSLs and the LSCP launched training for safeguarding supervisors. • To promote awareness of the LSCP escalation policy, a campaign was mobilised via newsletters, forum engagement and targeted activity culminating with a decision at the end of the year to review and update the policy.	• The LSCP will develop a clear local protocol and pathway to ensure consistent responses to physical abuse concerns, with a complementary training offer; a task and finish group was mobilised and was nearing completion of the protocol at the end of the reporting period. • ESAC will develop guidance to help schools who are managing the emotional needs of children who have disclosed physical abuse where assessment has ended with no further action. • The LSCP will continue to seek assurance around adult services and their engagement with child safeguarding responsibilities.

We are yet to see the evidence of impact from this activity, which will be overseen through our governance framework moving forward. Taken as a whole, collective scrutiny activity identified both strengths and areas for improvement across safeguarding arrangements and resulted in a series of partnership action plans, new policy and training workstreams, enhanced scrutiny arrangements, and widespread dissemination of learning across the LSCP.



3.6 Data and information sharing

Alongside the qualitative data obtained via our quality assurance framework and learning from serious incidents, the LSCP uses quantitative data to try and identify key trends, emerging issues, disproportionality and areas meriting further attention.

Data driven activity was established as a strategic priority in 2024/25, and we have achieved some key milestones towards our goal of utilising multi-agency data to measure the effectiveness of safeguarding responses and inform the work of the LSCP:

- A multi-agency data set was adopted and mobilised by PCI.
- Key performance indicators and a data-set to evaluate training and learning impact were adopted and mobilised by LI.
- Data presentations are built into the terms of reference of our EHFS and MASH Subgroups.

Whilst these mark important developments, the use of data as an intelligence source is not fully established, with some notable limitations:

- Health and police partners have not provided data towards the multi-agency data set since it was mobilised, creating a position where data is heavily focussed upon CSC data.
- CSC data draws heavily on raw data regarding the number of children receiving support at a given time, without comparative information or cross-cutting analysis of vulnerability and complexity factors.
- EHFS received limited data intelligence, with the only notable data presented being specific to Young Carers.

This is against the context of a number of broader contributing factors and challenges:

- It is not always clear who holds what data, which can make building a complete picture challenging. Inconsistent data-sharing arrangements across the partnership exacerbate this and can lead to datasets becoming siloed within agencies that produce them.
- While some agencies can readily extract detailed performance information and thematic reports, other systems were not designed with sophisticated data interrogation in mind and information is reliant on time-consuming manual case identification and record trawls.
- There is a lack of analytical capacity across the LSCP to provide analytical narrative around the information.



At an operational level, there has been significant enhancement in the quality of information sharing. Partners continued to share intelligence, risk information and learning through a range of established and emerging mechanisms, including IRH, MASH, MARAC, CP Conferences, Missing Panels and Health and Social Care Forums. Bi-weekly escalation meetings between acute trusts, SEL ICB and CSC were mobilised, alongside monthly joint meetings with maternity safeguarding and CSC. Significant developments included implementation planning for CP-IS Phase 2 and an Information Sharing Agreement between SLAM and CSC. Partners reported that improved information sharing contributed to earlier identification of risk, stronger safeguarding decision-making, higher quality referrals, more coordinated support for vulnerable children and families, and improved multi-agency responses to complex safeguarding concerns.

Notwithstanding, notable gaps in operational information sharing included:

- A lack of formal Information Sharing Agreements across the partnership
- A lack of information sharing with primary care, which was a consistent theme across audit and review activity.





Strategic information-sharing arrangements remain less mature than operational arrangements. Across the year, our partners did not routinely respond to LSCP information sharing requests in a timely manner:

Example	Impact
Quarterly reporting returns to our Partnership Scrutiny Board were inconsistent, with only 2 of 12 agencies consistently returning.	Reduced the LSCP's ability to maintain a comprehensive understanding of safeguarding performance, identify emerging risks and provide robust multi-agency challenge and assurance.
Multi-agency audit programmes were delayed by late case nominations and audit returns, pushing the Risk Outside the Home thematic audit outside of timescales and incomplete at the end of the reporting period.	Delayed the LSCP's ability to identify and respond to learning, limiting opportunities to strengthen practice and implement improvements in a timely manner.
A CSPP initiated in June 2025 was delayed due to late return of agency reports, and remained ongoing at the end of the reporting period.	Slowed the identification and dissemination of learning from a serious safeguarding incident, reducing the LSCP's ability to promptly implement changes to policy, practice and service delivery.
A Rapid Review Panel scheduled in March 2026 was delayed due to late return of agency reports.	Delayed collective understanding of the circumstances surrounding the incident and reduced the timeliness of decisions relating to learning, review activity and safeguarding improvements.
Analysis of training mapping across agencies was delayed and remained incomplete at the end of the reporting period, due to incomplete agency returns.	Limited the LSCP's ability to identify workforce development gaps, assess consistency of safeguarding training provision and plan a coordinated multi-agency training offer.
Quarterly reporting returns to LI were inconsistent, with only 2 out of 13 agencies consistently returning and 6 agencies failing to return at all.	Restricted the LSCP's oversight of learning activity, reducing assurance regarding how learning from reviews, audits and safeguarding incidents was being embedded across partner agencies.



These examples highlight a stark reality: the LSCP is approaching a point where capacity is becoming a material risk to effective partnership functioning. Whilst safeguarding practice at the frontline remains a priority and partners have continued to demonstrate commitment to children and families, the increasing demands of operational delivery, reform implementation and governance responsibilities against a background of budget, staffing and resourcing cuts are placing sustained pressure on leadership and LSCP infrastructure. The cumulative effect is being seen through delays to critical functions of the LSCP.

Despite these challenges, the LSCP remains clear that the effective use of data, intelligence, information and insight is critical to understanding the experiences of children and families, identifying emerging risks, challenging ourselves about the difference we are making, and ensuring resources are directed towards the areas of greatest need.

Looking ahead, the LSCP will review and refresh its Multi-Agency Safeguarding Arrangements to align with the Children's Wellbeing and Schools Act. This will include a renewed focus on strengthening strategic information-sharing arrangements, improving the quality and breadth of multi-agency data, clarifying expectations regarding partner contributions, and developing a more mature intelligence-led approach to understanding safeguarding effectiveness.

Importantly, the challenges described within this report are not unique to Lambeth. Safeguarding partnerships across the country are reporting similar difficulties in relation to data quality, information sharing, analytical capacity, workforce pressures and competing demands. The progress achieved during the year represents an important platform on which to build; however, further progress will require continued collective commitment from all safeguarding partners to ensure that data and intelligence are not viewed as an administrative requirement, but as a vital component of understanding need, driving improvement and ultimately improving outcomes for children and young people.





3.7 Learning from serious incidents

A core function of all Safeguarding Children Partnerships is to assess serious child safeguarding incidents to identify key learning for the safeguarding system and ensure this, and any key recommendations, are effectively implemented.

By law, where a local authority knows or suspects that a child has been abused or neglected, they must notify the Child Safeguarding Practice Review Panel if:

- The child dies or is seriously harmed in the local authority's area
- Whilst normally resident in the local authority's area, the child dies or is seriously harmed

Notifications are made using the Department for Education (DfE) online child safeguarding notification system, which then requires the LSCP to undertake a Rapid Review and submit this to the Panel within 15 working days. The purpose of the rapid review is to:

- Gather the facts about the case, as far as they can be readily established
- Discuss whether any immediate action is needed to ensure children's safety and share any learning appropriately
- Consider the potential for identifying improvements to safeguard and promote the welfare of children
- Decide what steps they should take next, including whether to undertake a local CSPR.

Additionally, under Working Together, any other person or organisation with duties relating to children should also notify the LSCP of any incident they think should be considered for a child safeguarding practice review. The LSCP manages these notifications under our 'case for consideration framework', which requires involved agencies to share information and reflections about their involvement. Returns are collected and collated to inform a panel discussion and decision by Case Review Subgroup Members.

Over the course of 2025-26, the LSCP:

- Completed
1 Rapid Review
- Completed
4 Cases for Consideration

The children involved were disproportionately of Black and Global Majority ethnic backgrounds:

- Black
2
- Asian
1
- Latin American
1
- Mixed Black Caribbean and White British heritage
1

The primary form of abuse or harm most closely associated with the incident was

- Neglect
4
- Physical abuse
1



The themes below describe the vulnerability and contextual or contributing factors which emerged from these combined processes:

- Children with disabilities, autism and complex health needs
- Hidden, unseen or socially isolated children
- Parental mental health
- Parental disability or chronic health condition
- Parental substance use
- Poor school attendance and elective home education
- Poverty and parental stress
- Young, vulnerable and care experienced parents
- Cross-boundary issues
- Unmet health and developmental needs
- Non-resident fathers and unexplored wider family networks
- Domestic abuse history
- History of care proceedings
- Poor home conditions
- Multiple overlapping vulnerabilities

In responding to these complexities, identified areas of good practice include:

- Strong early maternity and safeguarding intervention
- Individualised, patient-centred responses to a child who was not brought
- Well attended multi-agency meetings, with multi-agency input into assessment





The learning below summarises the headline insights gained into how responses to these children could have been strengthened:

- **Acting on indicators of neglect:** across several reviews, indicators of neglect were visible but not always recognised, named, assessed or responded to as a safeguarding concern. Concerns often accumulated over time, particularly where children had disabilities, parents were engaging with services or wider vulnerabilities were present.
- **Professional curiosity:** reviews repeatedly identified missed opportunities to ask additional questions, explore historical information, understand family circumstances more deeply and test parental explanations. This included understanding the lived experiences of children, considering fathers' roles, exploring unexplained injuries, understanding educational absence, and responding to indicators of vulnerability.
- **Voice of the child:** children's experiences and daily lived reality were not always sufficiently explored, particularly where children were non-verbal, neurodivergent, medically complex, electively home educated, or socially isolated.
- **Think family practice:** several reviews identified a need for greater consideration of wider family circumstances, including parental health, parental mental health, domestic abuse, fathers, siblings and extended family networks. Better understanding of how adult vulnerabilities affect children's experiences was a recurring area for development.
- **Multi-agency management of co-sleeping:** there was a lack of coordination around safe sleeping arrangements, with limited evidence of risk assessment or tailored intervention.
- **Improving oversight of step-down, transfer and closure:** step-down from CIN to Early Help, CIN to Short Breaks, CLA to CIN, supervised placements to semi-independent accommodation and school to EHE all created points where professional oversight reduced. In several cases, the reduction in oversight did not appear to be matched by evidence that risks had reduced or that protective factors were sufficiently embedded.
- **Escalation and professional challenge:** professionals did not always escalate concerns when progress was limited, information was unavailable, or risks were increasing.
- **Educational safeguarding:** a recurring theme was recognising educational attendance, participation and engagement as safeguarding issues. This included elective home education, children not in full-time education, attendance concerns, school disengagement and reduced professional oversight.
- **Multi-agency communication and information sharing:** information was not always shared effectively between agencies, particularly across organisational boundaries and local authority areas. Reviews highlighted assumptions that another professional would share information, gaps in notifications, and limited mechanisms for ensuring critical information informed safeguarding decision-making.
- **Anti-racist and inclusive practice:** several reviews emphasised the importance of understanding race, ethnicity, culture, adultification, family identity and lived experience. Reviews identified opportunities to strengthen culturally responsive practice and ensure assumptions do not contribute to reduced professional curiosity or altered threshold decisions.



As the learning identified from these incidents was already well understood locally and clear improvement activity could be progressed through existing governance arrangements, it was determined that a CSPR was not required in relation to any of the notifications received and considered this year. Recommendations and actions developed from these learning processes included:

Completed	In Progress
• CSC undertook a thematic audit into the experiences of children under Supervision Orders • The cases of all children open to CSC and listed as EHE or Educated Otherwise than at School (EOTAS) were reviewed to ensure any safeguarding concerns were identified and responded to • Study Bugs data is now used within MASH to ensure school attendance is considered within decision making • LSCP Access to Education Guidance and complementary training offer was launched • CSC launched and embedded regular training around working with fathers, male carers and family networks • SEND implemented new processes for children subject to an EHCP where parents choose elective home education • GSTT introduced clinical supervision to ensure cases were reviewed before being stepped down to universal services • LSCP continued and targeted delivery of neglect toolkit training	• Cross-jurisdictional working guidance is in development and close to completion at the end of the reporting period • CSC and GSTT recording systems will be updated to ensure safe sleep advice is provided and recorded, including when quality assuring placement providers • A rapid audit of out-of-borough notifications across the partnership will be undertaken • A rapid audit of safe sleep practice across the partnership will be undertaken • LSCP Neglect Strategy and Toolkit will be reviewed • Multi-agency thematic audit into children who are EHE to be completed 2026/27

Additionally, during 2025/26 the LSCP published 3 CSPRs concluded during previous financial years and initiated 1 CSPR (agreed at the end of the last reporting period) which remained in progress at the end of the reporting period.

The key learning and areas for development were disseminated across the workforce via seven-minute briefings and through LSCP attendance at forums and service meetings throughout the reporting period, as set out in Section 4. This reached audiences including Head Teachers, SENCOs, DSLs, GPs, CAMHS, VCS Providers, Youth Justice Services and a wide range of children's social care services.



3.8 Child & family feedback

The LSCP does not currently have direct mechanisms for engaging with children and families. Child and family voice was therefore captured across the year through our governance framework and reporting requirements. Headlines include:

Partner area	You said	Our partners did
Education	Through consultation activity, the SEND Young Inspectors Programme, engagement with families and wider participation opportunities, children, young people and families identified a number of priorities including inclusion, independence, preparation for adulthood, community belonging, support from trusted relationships and, importantly, having their voices heard in decisions that affect them.	'Amplifying the Voice of Children, Young People and Families' was established as one of the seven core priorities of Lambeth's SEND and Alternative Provision strategy 2025-2030, ensuring that lived experience sits at the heart of local SEND planning and delivery. £7 million has been invested in 257 additional SEND places.
Education	The safeguarding pupil survey found that: • 71.4% of pupils feel safe in school • 7.1% of pupils feel safe online and in their communities • 65.7% of pupils know how to report concerns • 37.1% of pupils feel they influence safeguarding arrangements	Schools have improved safeguarding communications and reporting pathways. Safeguarding information has become more visible and accessible. Pupil voice has informed reintegration planning and alternative provision decisions. Education is working with the Youth Council to support young people's influence on safeguarding priorities, including contextual safeguarding and online safety.
VAWG	Service user feedback from Lambeth's commissioned violence against women and girls provider, the Gaia Centre, established that 100% of young people felt safer on exit from the service, less frightened and more confident to access support.	Funding was secured for a specialist advocate providing 1-to-1 independent advocacy and support tailored to identified needs.
Care Leavers	Engagement through the Children in Care Council (Visions of Success) and the Bright spots survey, alongside direct consultation and participation with care leavers, established that the things that mattered most were: having stable and trusting relationships with professionals, being listened to and involved in decisions about their lives, access to emotional wellbeing support, support with housing, education, employment and independence and having clear information about services and their rights.	Pathway Plans were re-designed to make them more meaningful and focussed on young people's priorities and the Life Skills Hub; the local care leavers offer was enhanced with greater emphasis on accommodation, employment, education, emotional wellbeing and independent living support; the 'Leaving Care Pledge' was co-produced with young people to reflect these priorities.



Partner area	You said	Our partners did
Children's Centres	Via parent satisfaction surveys, parents said that accessible early help, practical family support, parenting programmes and opportunities to build confidence and resilience were making a positive difference to family life. 98% of parents reported satisfaction with Children's Centre services.	Feedback was used to reinforce investment in Children's Centres and Family Hub development, with services continuing to provide early intervention, parenting support, employment advice and targeted family support.
CP Conferences	Through post-conference feedback, parents reported that they wanted to be listened to, treated with respect and involved in planning for their children. Feedback was obtained from 94 parents and 121 professionals during the year.	Conference processes were reviewed and refined, with follow-up undertaken where concerns were raised. Learning informed improvements to communication, parental participation and safeguarding planning.
FGCs	Through child and family feedback, families said they wanted to be empowered to find solutions within their own family networks and felt most positive when they were involved in decision-making.	Positive feedback contributed to continued expansion of the Family Group Conferencing offer, with referrals increasing by 41% over the previous year and greater use of family network solutions.
CAMHS	Children and families told CAMHS that timely support, clear communication, feeling heard and receiving practical support for emotional wellbeing made a positive difference. Families also highlighted concerns about waiting times. Parents and carers provided feedback through dedicated engagement events about what was working well and where there were gaps in provision in mental health support in schools.	CAMHS increased transparency around waiting times, expanded ADHD assessment capacity, introduced additional prescribing capacity, strengthened first-care-contact arrangements and developed waiting-list initiatives to improve access to support. Median wait times reduced whilst caseloads increased. Feedback is being used to inform future service planning and development of the Mental Health in Schools offer.
Maternity services	Neurodiverse parents reported that greater awareness and understanding of their needs throughout maternity care would improve their experience of services.	GSTT introduced alerts to clinical records to identify how individuals could best be supported, helping staff tailor care and communication approaches
GSTT Children's Services	Children highlighted the importance of understanding what information is being shared about them, who it is being shared with and why.	Health needs assessments, child protection medicals and safeguarding processes were adapted to ensure children were informed of escalation decisions and involved in discussions where appropriate.



Collectively, these examples provide strong evidence that partners across Lambeth are increasingly listening to children, young people and families and, importantly, translating what they hear into tangible service improvements. Across education, health, early help, care leaving services, safeguarding and specialist provision, lived experience has directly influenced strategic priorities, service design, investment decisions, communication approaches and support offers. This demonstrates a growing commitment to participation as a mechanism for improving outcomes, rather than simply a consultation exercise.

However, the LSCP also recognises that this work is not yet consistently embedded across all areas of safeguarding activity nor at a partnership level. We want to build on these examples of excellent practice and strengthen partnership with the LSCP as an assurance and strategic body. Ultimately, we want children and families not only to be heard, but to be able to see how their views have influenced the decisions, services and support available to them. To achieve this, direct partnership-wide engagement will be strengthened through the introduction of Young Scrutineers during 2026/27.



3.9 The role of independent scrutiny

Independent scrutiny is a critical component of local accountability. Its purpose is to provide authoritative, evidence-based challenge, enable early identification of system weakness and support continuous improvement. It is distinct from inspection and functions as an independent, learning-focused mechanism within the wider accountability framework.

In Lambeth, this function is provided by Jim Gamble QPM, the Independent Safeguarding Children and Young People Commissioner (ISCYPC). Across the year, scrutiny activity has included:

- Chairing 14 LSCP Board & Subgroup meetings.
- Chairing 1 Rapid Review Panel and 4 Case for Consideration meetings.
- Quarterly meetings with the DSPs and Lambeth Council's Chief Executive.
- Engagement with community providers during and following the LSCP Annual Conference.
- Visit to a local secondary school.
- Ad hoc meetings and communications with individual agencies and senior leaders.
- Initiation of an independent review into contextual safeguarding in Lambeth, including surveys and one-to-one interviews.

The key areas of challenge and assurance have centred around:

- The impact of police 'tough choices' and ICB cuts, including police civilianisation and reduced MASH capacity.
- Delays, performance issues and effectiveness within MASH and referral pathways.
- Partnership engagement with LSCP governance and information sharing requests.
- Serious Incident Notification (SIN) thresholds and processes.
- Priority areas such as online safety, local responses to contextual safeguarding in Lambeth, stop and search activity and transitions support.



Outcomes and improvement achieved include:

- Improved mechanisms for strategic risk management.
- Strengthened expectations around evidencing impact and accountability.
- Launch of an explanatory video for serious incident notifications and an internal procedure for managing these.
- LSCP Online Safety Policy & complementary Guidance launched.
- Audit into the timeliness of referrals and strategy meeting requests was allocated to CSC.
- Audit into the outcomes of NSPCC referrals was allocated to CSC.

Overall, through a programme of governance oversight, case review activity, stakeholder engagement and independent inquiry, scrutiny has influenced improvements in risk management, serious incident processes, online safety arrangements, and the commissioning of targeted audits to address identified system concerns. Independent scrutiny directly influenced the commissioning of audits, development of policy, strengthening of risk management arrangements and increased focus on evidencing impact.





3.10 Funding, resources and value for money

The partnership operates a jointly funded safeguarding arrangement, with statutory safeguarding partners contributing resources to support the effective delivery of local safeguarding arrangements. During 2025/26, the LSCP operated with a total budget of £293,257 across the year, funded through contributions from safeguarding partners as below:

Partner Agency	2025/26 Contribution	% of 25/26 total budget	2024/25 Contribution	% of 24/25 total budget
Lambeth Council	£243,257	82.9%	£211,797	82.5%
SEL ICB	£40,000	13.6%	£40,000	15.6%
Metropolitan Police Service	£5,000	1.7%	£5,000	1.9%
Total contribution / income	£293,257		£256,797	





SEL ICB and Police contributions remained equivalent to 2024/25, with the local authority contribution increasing by 14.9% this reporting period. Funding was directed towards activities that support statutory safeguarding responsibilities, with expenditure broken down as follows:

Area of expenditure	Spend	% of total	Purpose	Activity	Impact
Partnership staffing and business support	£243,257	68%	The LSCP Business Unit provides the infrastructure, coordination and professional expertise required to deliver the partnership's statutory functions and annual work programme.	• Providing secretariat support, professional advice and coordination of LSCP governance infrastructure • Coordinating and managing the learning from serious incidents and cases for consideration • Delivering and evaluating the multi-agency safeguarding training programme • Producing 7-minute-briefings and learning resources • Drafting policy, procedure and guidance • Managing and overseeing audit programmes • Monitoring progress against recommendations arising from reviews, audits and agreed action plans • Coordinating partnership communications	• 28+ meetings successfully delivered • Rapid Review activity completed within timescales • 2,488 staff and volunteers trained • 13 x 7-minute-briefings produced • 8 x factsheets published • 3 x guidance produced • 2 x multi-agency audit programmes successfully delivered • Newsletter re-launched in January 2026
Training & workforce development	£22,335	6.2%	This expenditure is used to supplement the programme of learning and development delivered directly by the LSCP Business Unit and partner agencies. Funding is targeted towards specialist areas where external expertise is needed.	• Adultification, anti-racist and inclusive practice training x 5 • Child sexual abuse x 5 • Harmful sexual behaviour x 2 • Online safety x 2 • Risk outside the home x 8 • Trauma informed practice x 7 • Safeguarding supervision x 1 • LSCP Annual Conference completed	• Specialist training was available for 716 people, although only 470 bookings were achieved and only 274 people actually completed • Around 90 people attended the LSCP Annual Conference



Area of expenditure	Spend	% of total	Purpose	Activity	Impact
Independent scrutiny	£53,449	14.9%	This expenditure enables authoritative, evidence-based challenge, early identification of system weakness and supports continuous improvement.	• Chaired 14 LSCP Boards/Subgroups • Chaired 1 Rapid Review • Chaired 4 Case for Considerations • Quarterly meetings with the DSPs and Lambeth Council's Chief Executive	• Improved strategic risk management. • Improved evidence of outcomes. • SIN video published. • Audits allocated.
Communications, website & systems	£33,303	9.3%	This expenditure supports learning dissemination, workforce engagement, translation and participation in the partnership.	• Re-designed and re-launched the LSCP website • Introduced a new learning management system for Level 3 Training • Continued to offer e-learning modules • Introduced the Education Safeguarding Portal • Introduced the Private Fostering App	• LSCP news, policy, procedure, pathways and information more visible and easy to navigate • Training non-attendance fell from 24% in 2024/25 to 11% in 2025/26 • 1,402 e-learning completions
Policy & procedure development	£5,500	1.5%	This expenditure enables external expertise to support development of local policy and procedure.	• External specialist drafted policy and guidance	• LSCP Online Safety Policy, Guidance and Risk Assessment template launched.

Total Spend £357,844

Whilst expenditure exceeded total income for the year by £64,587, the LSCP has a ring-fenced reserve fund which enabled this.

The value of LSCP arrangements extends beyond direct expenditure. Partners contributed substantial in-kind resources through attendance at governance meetings, participation in audits, delivery of improvement activity, review panel

membership and practitioner engagement. These contributions significantly increased the overall capacity of the safeguarding system and would not have been achievable through partnership funding alone. The LSCP recognises that increasing financial pressures across all agencies present a potential risk to future sustainability. However, continued joint investment remains essential in maintaining effective safeguarding arrangements and driving system-wide improvement.

The LSCP considers that the funding received during 2025/26 delivered good value for money. Resources were targeted towards statutory safeguarding functions and priority improvement activity. Through a relatively small central budget, the partnership was able to convene and coordinate significant multi-agency activity.



Training and Learning Activity

How did we support our workforce to embed best practice?



4. Training and learning activity

How did we support our workforce to embed best practice?

The training opportunities offered by the LSCP are designed to meet the diverse needs of staff and volunteers at different levels within the wide range of organisations that work with children and families living in, or looked after by, Lambeth. The training programme consists of the following elements:

- Online e-learning courses
- Live training in-person or online (half or full-day courses)
- Shorter in-person and online briefings
- Self-guided learning resources

A total of 2,488 people received training during the reporting year (a 28% increase from 1,938 last year).

The LSCP employs a Training & Development Manager to oversee the training programme with strategic direction provided by the LI subgroup. LI receives quarterly reports and 6-monthly training needs analysis to oversee the design, delivery and evaluation of the training programme.



E-learning (Level 1 & 2)

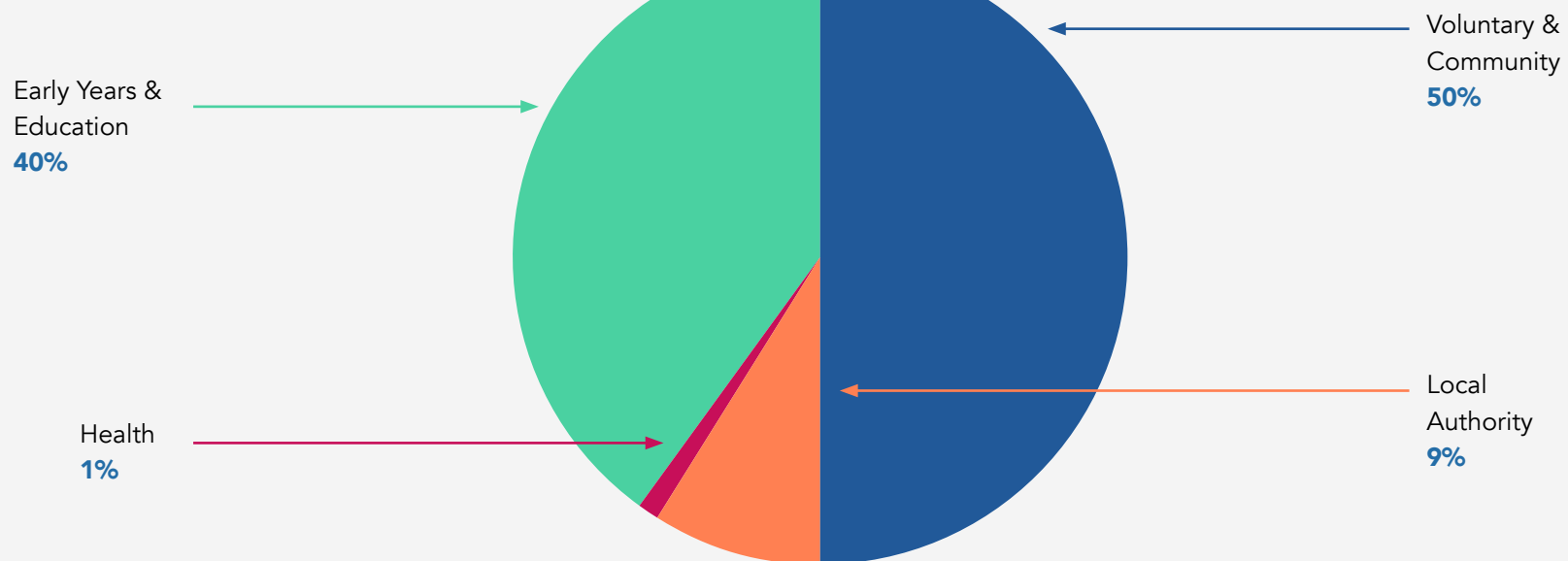
5 e-learning modules were available across the year, covering 4 safeguarding topics:

1. Level 1 safeguarding (parts 1 and 2)
2. Level 2 safeguarding
3. Unconscious bias
4. Healthy relationships toolkit

A total of 1,402 people completed e-learning (an increase from 1,277 last year) broken down as follows:

- **Level 1 (Basic awareness):** including 'Safeguarding Level 1: Part 1', 'Safeguarding Level 1: Part 2' and 'Unconscious Bias' = 1,042 completions
- **Level 2 (Intermediate):** including Safeguarding Level 2 and Healthy Relationships Toolkit = 360 completions (an increase from 347 last year).

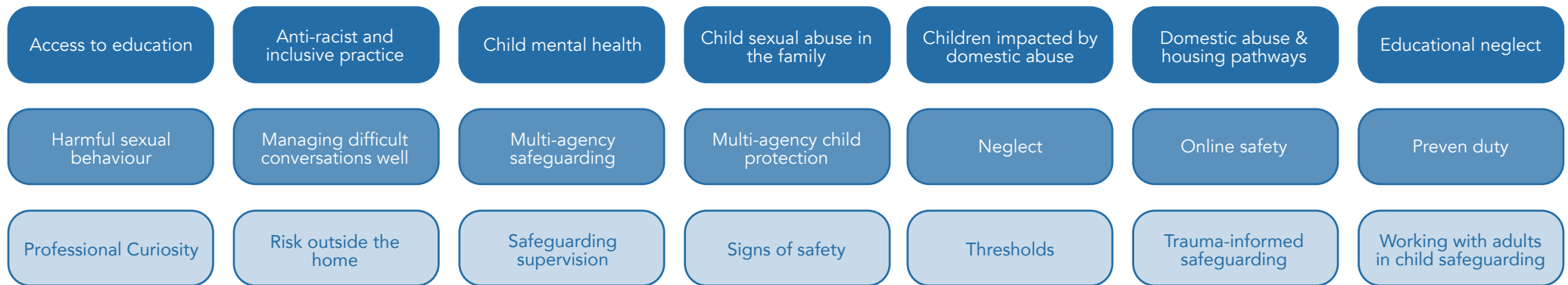
Completion by Sector





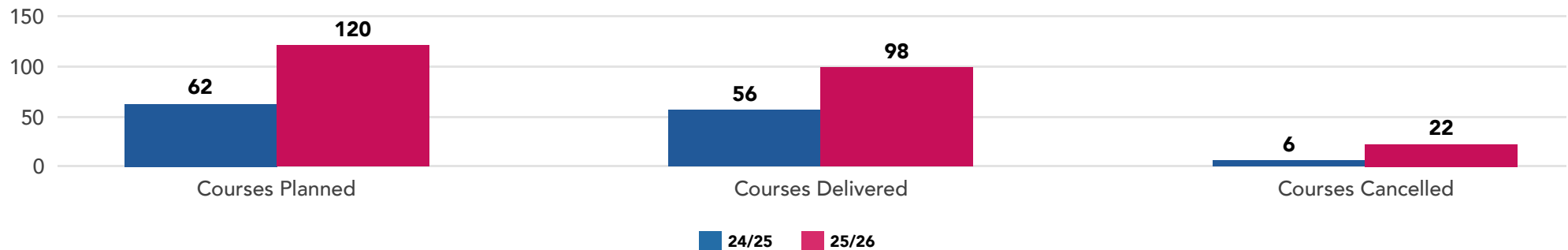
Live Training (Level 3)

Level 3 training is aimed at safeguarding leads and practitioners with direct involvement in multi-agency working to safeguard children. 120 half or full-day training courses were available across the year, covering 21 safeguarding topics.



This is an almost 94% increase on the number of training courses available last year (62), with an almost 24% increase on the number of safeguarding topics covered last year (17). However, the number of courses cancelled due to low bookings increased from 6 in 24/25 to 22 in this reporting period.

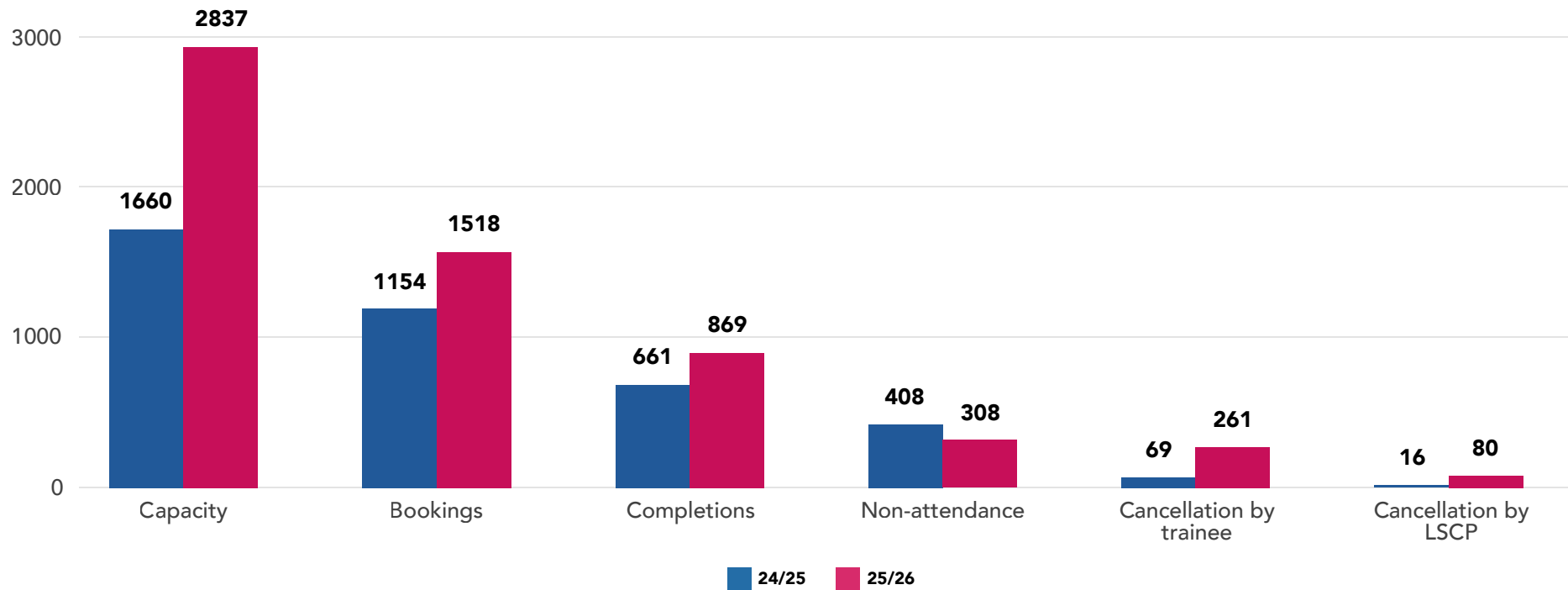
Course availability & delivery





Annual comparisons of capacity & completions

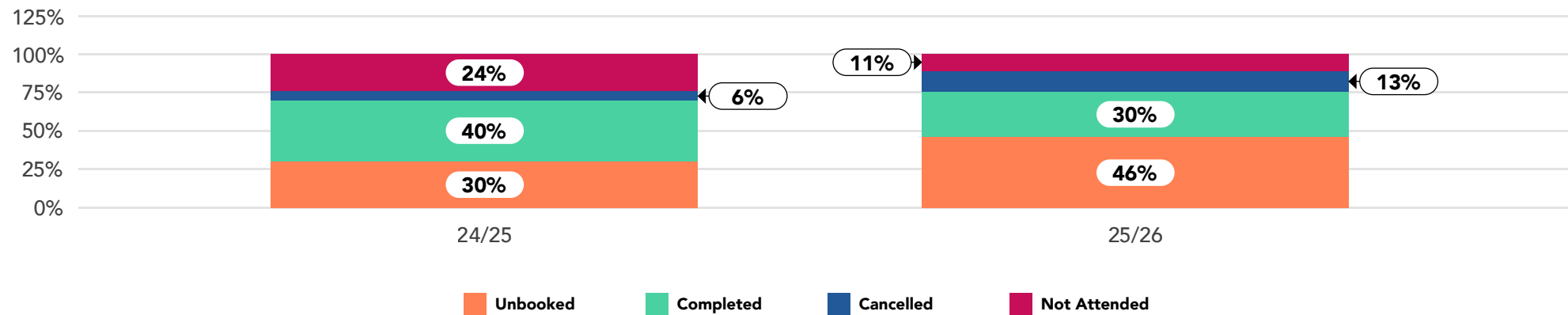
There was a 71% increase in training capacity this year, with 2,837 places available. A total of 869 people completed training (an almost 32% increase from last year).





Capacity Utilisation: Annual Comparison

Whilst training capacity was increased, this is not reflective of the overall appetite to learn with only 54% of places being booked (a decrease from 70% bookings last year).

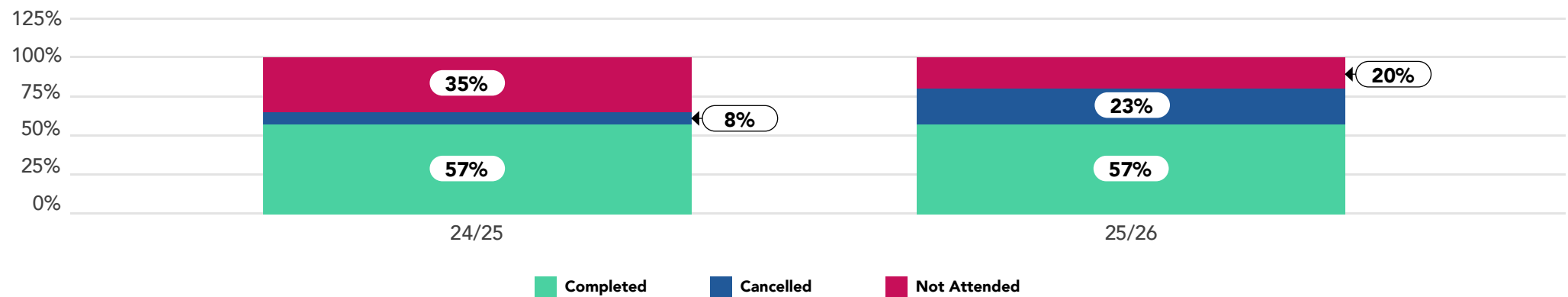




Booking Outcomes: Annual Comparison

The decline in delegates booking to attend training coincides with the introduction of a new learning management system which changed how delegates access training. This was adopted by the LSCP in June 2025 and quarterly reports demonstrate that booking fell from an average of 69% to 48% following implementation. There was a recovery in bookings towards the end of this reporting year, and it is hoped that the reintroduction of LSCP monthly newsletters in January 2026 will translate into increased bookings during 2026/27.

The ratio of booking to completion has remained static at 57%. The reasons why delegates do not progress to completion after booking have, however, changed: delegates are now more likely to cancel their place in advance as opposed to non-attendance on the day. Whilst the reduction in non-attendance rates is a welcome trend which helps to ensure that vacated places can be reallocated for courses that operate waiting lists, the increasing prevalence of cancellations most commonly linked to 'work commitments' is an unwelcome impact of wider demand and workforce pressures.





Appetite to learn remains a key area of focus for the LI Subgroup as only 30% of total training capacity was utilised this year (a decrease from 40% last year).

This year has seen an increase in the number of delegates attending from the health and education & early years sectors, which aligns with a decline in the proportion of Voluntary & Community Sector (VCS) delegates accessing the training (albeit this sector continues to account for the highest levels of training completion).

	2025/2026		2024/2025	
Early Years & Education	19.3%		15%	
Health Economy	28.3%		23%	
Local Authority	10.9%		13%	
Police	0.3%		0%	
VCS	41.2%		49%	



Briefings (Level 4)

The LSCP also provides bespoke training and briefings covering local and national learning. These are delivered both via bespoke targeted training and online multi-agency briefings.

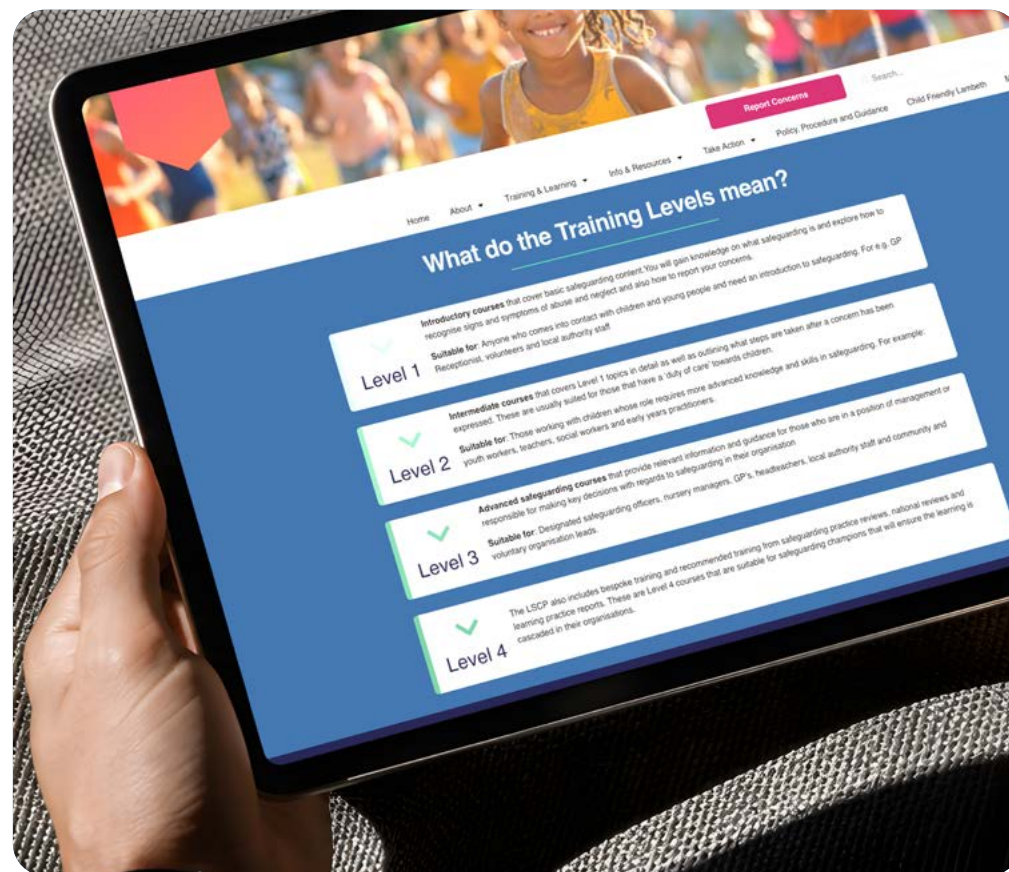
Throughout this year, the LSCP delivered bespoke targeted training to:

- 17 colleagues from registered housing providers
- 18 colleagues who contribute to MASH
- 14 Lambeth Councillors
- 11 St Thomas' Hospital Midwives
- 73 GP Safeguarding Leads and Social Prescribers.
- 35 Lambeth Children's Social Care staff.

49 multi-agency partners also attended online LSCP briefings which covered the following themes:

- Information sharing & consent
- DBS duties
- Child sexual abuse in the family (key learning from the National Review: I wanted them all to notice)
- Race and racism in safeguarding (key learning from the National Review: It's silent)
- A local child safeguarding practice review featuring themes of child sexual abuse in the family, neglect, physical abuse and domestic abuse

The LSCP maintained a presence and presented key learning themes at 31 forums and service meetings throughout the reporting period. This reached a wide range of audiences from Head Teachers, SENCOs, DSLs, GPs, CAMHS, VCS Providers, Youth Justice Services and a wide range of children's social care services.





Self-guided learning resources

Recognising the diverse needs of our multi-agency workforce, throughout 2025/26 the LSCP has produced and promoted a range of self-guided learning resources to support staff and volunteers who prefer to access learning in an unstructured and self-guided way. **These include:**

- Factsheets - providing information about complex or challenging safeguarding themes and what can be done to provide effective safeguarding responses.
- 7-minute-briefings: designed to concisely share key learning and encourage reflective practice.
- Guidance: advice regarding how to apply policy, procedure and protocol in practice.
- Videos: accessible visual guides to key safeguarding topics.

New learning resources were published on our website covering 17 safeguarding topics:

Responding to serious child safeguarding cases

Multi-agency escalation pathway

Overview of local learning themes 2022-2025

Responding to physical abuse

Parental substance use

Safeguarding children with chronic medical needs

Understanding police bail conditions

Private fostering arrangements

Parental learning disability

Lambeth MARAC

Lambeth DAPP

Deprivation of liberty safeguards

Access to education

Allegations against staff and volunteer meetings

Young Carers

Online safety

Training planning toolkit



Measuring the impact

Historically, the impact of learning was primarily measured through training attendance figures and post-course evaluations. While this provided useful insight into participant experience and self-reported confidence, it offered a limited and largely subjective view of whether learning was translating into meaningful outcomes in practice.

To strengthen our approach, this year we moved beyond evaluations alone and introduced a clearer impact framework. This is structured around 3 core goals:

1. The workforce can recognise and respond to safeguarding concerns by making high-quality referrals to Lambeth CSC.

2. The workforce can complete high-quality risk & needs assessments and deliver interventions that make a difference to children and families.

3. The workforce will have the right knowledge, skills and attitudes to perform at their level of competency.

We expanded the measures which we used to evaluate impact beyond post-course evaluation, capturing these directly from delegates at the 3-month and 6-month stage as well as requesting feedback from line managers at the 3-month stage. Four operational measures support evaluating progress against these goals, with data collected to assess whether learning is contributing to the intended outcomes (an additional five measures will be mobilised during 2026/27). Impact is summarised as:

Measure	2025/2026	2024/2025
Excluding 'automatic contacts', there will be a reduction in 'no further action' outcomes for referrals made to Lambeth CSC.	Total NFA: 50% - No further action: 16% - Signposting: 34%	Total NFA: 47% - No further action: 9% - Signposting: 38%
Training delegates will state they feel more confident to identify, report, assess and respond to safeguarding concerns once they have completed post-course stage 1 evaluation.	209 Level 3 evaluations - Learning gain: 2.47 out of 10.00 - Confidence: 95%	574 Level 3 evaluations - Learning gain: 2.27 out of 10.00 - Confidence: 97%
Training delegates and their line managers will provide examples of how they have used the learning to improve the quality of children's social care referrals in post-course stage 2 and 3 and line manager evaluations.	0 Evaluations	104 Evaluations 54 examples provided 84% delegates report continued confidence improvement
There will be an increase in the number of interventions graded 'good' or 'outstanding' in the LSCP Multiagency Audit Cycle.	11%	40%

All four success measures have been achieved, demonstrating that the programme is meeting its intended outcomes. The primary area for development in 2026/27 is expanding its reach so that more people can benefit from this effective approach.

Analysis, Challenges and Areas for Development

What does all of this activity tell us about the effectiveness of our partnership?



Analysis, challenges and areas for development

This section provides an overall assessment of partnership effectiveness, scrutinises progress against our three strategic priorities, and identifies the areas where further development is required.

It draws on all the decisions and activity outlined in sections 3 and 4, which are summarised as:

- Undertook visits to Families First pathfinder areas and engaged with national reform programmes
- Introduced strategic and operational risk registers
- Adopted a multi-agency dataset
- Initiated an independent review of contextual safeguarding arrangements
- Launched the LSCP Anti-Racist Charter, with complementary training offer
- Launched the LSCP Online Safety Policy and practice guidance, with complementary training offer
- Launched the LSCP Access to Education Guidance, with complementary training offer
- Launched the LSCP Young Carers Policy and Guidance, with forum engagement
- Launched the LSCP Minimum Standards for Safe Commissioning
- Produced internal guidance outlining the roles and responsibilities of LSCP statutory partners
- Launched the new LSCP website and re-introduction of the LSCP monthly newsletter
- Completed a thematic multi-agency audit into local responses to physical abuse
- Mobilised development of a local physical abuse protocol and pathway
- Mobilised development of LSCP Cross-Jurisdictional working guidance
- Mobilised a review of the LSCP Escalation Policy
- Agreed a review of the LSCP Neglect Strategy and Toolkit
- Completed the safeguarding self-assessment audit across the partnership
- Mobilised a thematic multi-agency audit into local responses to risk outside the home
- Mobilised targeted audit activity following independent scrutiny
- Launched the Education Safeguarding Portal
- Launched DSL supervision pilot
- Produced critical incident response guidance and pathways
- Completed an annual conference on risk outside the home
- Launched a new learning management system for level 3 training
- Expansion of the multi-agency training programme and introduction of 24 new self-guided learning resources



Progress against our strategic priorities

Throughout the year, the LSCP focussed on three strategic priorities:

Priority 1: Back to Basics

The Back to Basics priority recognised that strong safeguarding outcomes depend on strong fundamentals, including timely information sharing, effective escalation, clear thresholds, professional curiosity, robust challenge and consistent multi-agency practice. Across the year, there is clear evidence that this priority has driven activity across governance, policy, practice and learning.

What have we achieved? The partnership strengthened a number of core safeguarding arrangements during the year. This included improved operational information sharing through MASH, MARAC, Missing Panels, Child Protection Conferences, health and social care forums, bi-weekly escalation meetings between acute trusts, SEL ICB and CSC, and monthly joint meetings between maternity safeguarding and CSC. New and updated guidance was also developed across several areas, including online safety, access to education, young carers, domestic abuse and housing, and minimum standards for safe commissioning. Quality assurance activity also supported this priority. The LSCP completed a multi-agency physical abuse audit, mobilised a Risk Outside the Home thematic audit, undertook a targeted Section 11/Section 175 safeguarding self-assessment exercise, and used scrutiny activity to explore themes including stop and search disproportionality and transitional safeguarding.

What difference has this made? There is evidence that operational safeguarding practice has strengthened. Partners reported improved referral quality, stronger professional curiosity, better information sharing and more coordinated safeguarding responses. For example, MASH activity increased significantly across the year, and the proportion of contacts resulting in No Further Action without intervention reduced from 12% in Q1 to 5% in Q4. The LSCP has also developed clearer tools and expectations to support practitioners. This includes stronger safeguarding guidance, targeted training, learning briefings and refreshed escalation activity. Together, these developments have strengthened the foundations for consistent safeguarding practice.

Where are we still challenged? The Back to Basics priority has been strongest at an operational level. Strategic arrangements remain less mature. Attendance at some governance groups was variable, partner returns were inconsistent, and delays to audits and review processes affected the timeliness of learning and assurance. This means that while operational safeguarding practice has strengthened, the LSCP still needs to improve the consistency with which agencies contribute to strategic oversight, challenge and assurance.

Overall assessment: good progress has been made, particularly in strengthening operational safeguarding practice, but further work is required to ensure the fundamentals are consistently embedded across strategic partnership arrangements.



Priority 2: Active Anti-Racism

The Active Anti-Racism priority reflects the LSCP's commitment to addressing inequity, challenging racism and ensuring safeguarding services respond effectively to the diverse experiences of Lambeth's children and families. This priority is particularly important in Lambeth, where 63% of children are from Global Majority backgrounds and where local data shows persistent disproportionality across several safeguarding pathways.

What have we achieved? During the year, the partnership launched its Anti-Racist Charter, delivered anti-racist and inclusive safeguarding training, and incorporated learning from the national review It's Silent. Race, culture, identity, adultification and disproportionality were increasingly considered within audit, review and scrutiny activity.

What difference has this made? The LSCP has developed a stronger shared language and understanding of anti-racist safeguarding practice. There is evidence that race, culture and identity are more routinely considered within scrutiny activity, local learning and training. This is an important foundation for improving culturally responsive safeguarding practice and challenging assumptions that may influence thresholds, assessments or professional responses.

Where are we still challenged? Despite this progress, the partnership cannot yet demonstrate that this work has reduced disproportionality in children's experiences or outcomes. Black children remain overrepresented in several statutory safeguarding pathways, including contacts, CIN, CP, CLA and care proceedings. In contrast, available data suggests that Black children may be less visible in some early help and wellbeing pathways, including CAMHS referrals, raising important questions about access, trust, cultural responsiveness and whether support is reaching children and families early enough. Anti-racist training has been under-subscribed and under-attended, limiting the reach and impact of the LSCP training offer. The priority has therefore helped establish important foundations, but further work is required to translate awareness, training and scrutiny into measurable change for children and families.

Overall assessment: Foundations have been established and the LSCP has strengthened its focus on anti-racist practice, but impact is limited and further work is required to demonstrate measurable improvement in outcomes and experiences.



Priority 3: Data-Driven Activity

The Data-Driven Activity priority recognised that the LSCP needed to make better use of data and intelligence to understand need, identify emerging risks, evaluate impact and inform strategic decision-making. This priority aligns closely with national expectations that safeguarding partnerships provide stronger evidence of impact and use data more effectively to understand the effectiveness of local arrangements.

What have we achieved? A multi-agency dataset was adopted and mobilised through PCI. A training and learning impact dataset was adopted through LI. Data presentations were built into the terms of reference for EHFS and MASHSOG.

What difference has this made? The LSCP has a stronger understanding of safeguarding demand and vulnerability across Lambeth. Data is beginning to help identify key patterns, including disproportionality in stop and search. The introduction of training impact measures is also a positive development. The LSCP is now better able to assess learning gain, delegate confidence, examples of practice change and the quality of interventions identified through multi-agency audit activity. This represents a stronger approach to measuring whether learning is translating into improved practice.

Where are we still challenged? This is the priority where progress has been most limited. The multi-agency dataset is not yet fully established, with health and police partners not consistently contributing data since mobilisation. As a result, partnership data remains heavily weighted towards CSC information. There are also limitations in analytical capacity, inconsistent data-sharing arrangements, and a lack of cross-cutting analysis of vulnerability, complexity and outcomes. The LSCP is not yet able to describe itself as fully intelligence-led. Much of the available data remains descriptive rather than analytical, and the LSCP does not yet have sufficient capacity to consistently translate data into strategic intelligence, thematic insight and evidence of impact.

Overall assessment: Important foundations have been established, but this remains a significant area for development. The LSCP needs to strengthen data quality, partner contributions, analytical capacity and the use of intelligence to inform decision-making.



5.2 Areas of strong progress

Across the year, several areas stand out as evidence of strong progress and partnership maturity.

Strengthened operational safeguarding collaboration

Operational partnership working remains one of Lambeth's clearest strengths. Partners continue to work together through established safeguarding mechanisms, including MASH, MARAC, Missing Panels, Child Protection Conferences, safeguarding strategy meetings, health and social care forums, and specialist multi-agency arrangements. These mechanisms support timely information sharing, coordinated risk assessment and multi-agency planning for children and families.

Improved inspection outcomes and external assurance

Inspection activity during the year provided significant assurance that key services are improving. CSC received a Good judgement from Ofsted, Care Leaver services were judged Outstanding, Youth Justice Services were judged Good, and GSTT Urgent and Emergency Care Services were judged Outstanding by CQC. These findings demonstrate progress across important parts of the local safeguarding system.

Improved inspection outcomes and external assurance

The partnership has strengthened its approach to learning and quality assurance through thematic audits, safeguarding self-assessment activity, review learning, training evaluation and scrutiny of priority areas. Learning has resulted in new guidance, updated policies, targeted training, task and finish groups, and strengthened governance oversight.

Increased focus on child and family voice

There are several examples where children, young people and families have influenced service design and delivery. These include the SEND and Alternative Provision Strategy, safeguarding pupil surveys, care leaver participation, Children's Centre feedback, CP Conference feedback, Family Group Conference feedback, CAMHS engagement, maternity feedback from neurodiverse parents and children's involvement in health safeguarding processes.

Preparation for national reform

Partners have taken steps to prepare for Families First, MACPT arrangements, CP-IS Phase 2, SEND reform, Best Start for Life, Integrated Neighbourhood Working and wider national changes. Much of this work remains in the design or mobilisation phase, but the partnership has laid important foundations for implementation in 2026/27.



5.3 Areas where progress has been limited

Alongside the strengths described above, there are several areas where progress has been slower than intended.

Partnership engagement and attendance

Attendance and participation across governance arrangements remain inconsistent. Average attendance across the governance structure was 61.6%, with some groups experiencing significantly lower attendance. Inconsistent engagement risks limiting the breadth of challenge, assurance and shared ownership across the partnership or inadvertently enabling single agency perspectives to dominate arrangements.

Compliance with partnership returns

Partner returns to quarterly reporting, audits, review processes, training mapping and risk registers were inconsistent. This affected the timeliness of audit activity, serious incident review processes, training analysis and strategic oversight. These delays reduced the partnership's ability to identify learning, disseminate findings and implement improvements at the pace intended.

Strategic information sharing

Operational information sharing has strengthened, but strategic information-sharing arrangements remain less developed. There is a lack of formal Information Sharing Agreements across the partnership, and information sharing with primary care providers has been identified as a recurring theme in audit and review activity.

Data and analytical maturity

The LSCP has made progress in developing datasets, but it does not yet have a fully mature multi-agency intelligence function. Data contributions are inconsistent, analytical capacity is limited, and there is insufficient cross-cutting analysis of vulnerability, complexity and outcomes.

Evidence of impact

The LSCP has made significant progress in describing activity, impact and evidence. However, in several areas, evidence of impact remains emerging. Some initiatives are new, others are still being embedded, and some areas do not yet have robust measures to demonstrate whether activity has improved outcomes for children and families.

LSCP-level child and family voice

While individual agencies have strong examples of participation and co-production, the LSCP does not yet have a direct, systematic partnership-wide mechanism for hearing from children and families. The LSCP remains reliant on feedback gathered by partner agencies rather than a coordinated LSCP approach to participation, assurance and strategic influence.



5.4 Risks and challenges moving forward

The LSCP is operating in an increasingly complex environment. Partners are balancing rising safeguarding demand, increasing complexity of need, major reform programmes, workforce pressures, financial constraint and organisational restructuring. The breadth and pace of reform is significant, including Families First, SEND reform, NHS restructuring, local government budget pressures and policing reform.

These pressures are beginning to have a visible impact on partnership capacity. Delays to audit activity, review processes, reporting returns and data submissions show that capacity is becoming a material risk to the effective functioning of the LSCP. While frontline safeguarding remains a priority for all agencies, the capacity to contribute consistently to strategic safeguarding activity is increasingly stretched.

Importantly, this should not be interpreted as a lack of commitment, capability or engagement from the workforce. Across the partnership, practitioners, managers and leaders continue to demonstrate considerable dedication to safeguarding children and supporting families, often working beyond contracted hours and managing increasingly complex caseloads within constrained resources. The reality is that agencies are operating in an environment of rising demand and reduced resources. Staff are frequently required to balance multiple competing priorities, making difficult decisions about where limited time and capacity can have the greatest impact. This is translating into increased sickness rates across the workforce, compounding and exacerbating these challenges. The challenges identified are therefore best understood as symptoms of system-wide pressure rather than a reflection of the commitment or professionalism of the workforce.





5.5 Overall Effectiveness

LSCP arrangements are effective, strengthening and increasingly reflective. There is clear evidence of operational collaboration, improved safeguarding practice, positive inspection outcomes, greater focus on learning and quality assurance, and developing approaches to child and family voice. The LSCP has also made important progress against its strategic priorities, particularly in strengthening safeguarding fundamentals and establishing the foundations for anti-racist and data-driven activity. Inspection activity also provided significant assurance.

However, the LSCP is not yet where it wants to be. Strategic engagement remains inconsistent, data systems are not yet mature, evidence of impact requires further development, and child and family voice needs to be more systematically embedded at partnership level. The LSCP must also address the growing risk that capacity pressures across agencies will affect the ability to deliver strategic safeguarding functions alongside operational practice and reform implementation.



Future Planning

What will we do next?





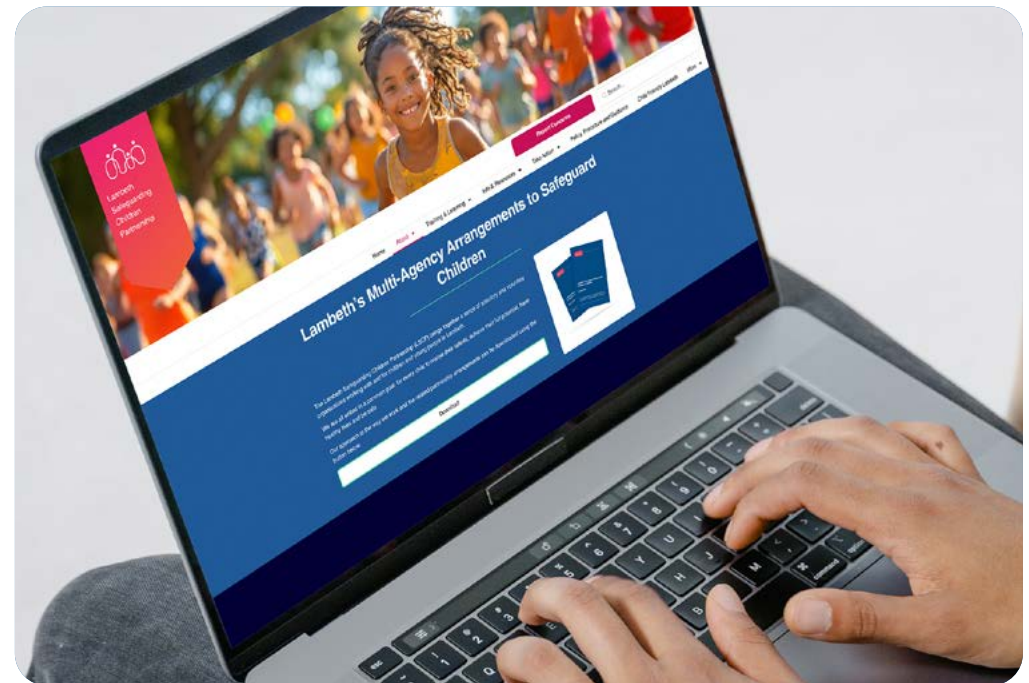
Future planning

Our priorities for 2026/27 are to continue to strengthen our arrangements by ensuring the structures, policies, dataset, learning mechanisms and participation approaches developed this year are consistently used, evaluated and owned across the LSCP, whilst simultaneously strengthening our arrangements to align with the Children's Wellbeing and Schools Act 2026 and the wider reform agenda.

Some core workstreams already identified or mobilised include:

- **Strengthening partnership effectiveness and workforce engagement:** reviewing and updating our arrangements, improving information-sharing arrangements, strengthening escalation oversight, strengthening workforce consultation mechanisms, exploring the safe use of AI, and increasing engagement with schools, the voluntary sector and faith communities.
- **Embedding the voice of children and tackling disproportionality:** establishing Young Scrutineers, improving the partnership's ability to evidence how children's voices influence decision-making, developing partnership-wide disproportionality measures, strengthening oversight of children not in full-time education, and improving workforce confidence in engaging children.
- **Improving safeguarding practice and quality assurance:** reviewing and strengthening approaches to neglect, risk outside the home, safe sleep, pre-birth safeguarding, Think Family practice and measuring impact on frontline practice via the LSCP Quality Assurance Framework.
- **Developing a stronger learning culture:** expanding learning opportunities beyond traditional training, reviewing safeguarding training expectations across agencies, consulting with the workforce on learning needs, and making better use of national learning resources and safeguarding review findings.
- **Strengthening support during transition and adolescence:** developing pathways for children transitioning into adulthood, aligning learning across statutory review processes, and improving responses to children at risk of moving from exploitation victimisation into exploitative behaviours themselves.

Collectively, these priorities reflect a continued commitment to strengthening both the effectiveness and sustainability of Lambeth's safeguarding arrangements. By maintaining a clear focus on partnership working, learning, participation and practice improvement, the LSCP aims to ensure that local safeguarding arrangements remain responsive to emerging needs, evidence-informed, and well positioned to deliver lasting improvements for children and families.





Conclusion

Putting it all together





Conclusion

2025/26 has been a year of both progress and challenge for the LSCP. Partners have continued to strengthen safeguarding arrangements, respond to learning, prepare for significant national reform and improve how we work together to protect children and support families.

Inspection outcomes, strengthened quality assurance arrangements and examples of improved multi-agency practice provide positive assurance that the partnership is making a difference. There has been significant improvement activity across all statutory partners, with clear evidence of the difference this has made.

At the same time, this report has highlighted areas where further development is needed, particularly around partnership engagement, data and intelligence, evidencing impact, and ensuring the voices of children and families consistently influence strategic decision-making. These challenges sit within a wider context of rising demand, increasing complexity and significant pressure on public services.



Increasingly, the effectiveness of LSCP arrangements is being affected not by a lack of commitment or capability, but by the cumulative impact of sustained system pressures. Across safeguarding agencies, leaders, managers and practitioners are managing rising workloads, increasing complexity and competing priorities whilst simultaneously supporting major reform programmes. The resilience, professionalism and commitment of the workforce remain clear strengths of the local system; however, maintaining effective LSCP infrastructure and improvement activity alongside operational delivery is becoming more challenging.

Looking ahead, the LSCP will embed and build upon progress made this year by strengthening collective accountability, improving the quality and use of multi-agency intelligence, embedding anti-racist practice, enhancing information sharing, increasing the influence of children and families on partnership decision-making and preparing for the implementation of social care reforms. Success will require shared ownership, meaningful engagement from all partners and a continued willingness to learn, challenge and adapt.

Ultimately, the evidence contained within this report demonstrates a partnership that is effective, reflective and ambitious. Whilst there remains more to do, partners have shown a genuine commitment to continuous improvement and to working together in the interests of children and families. The foundations established during 2025/26 provide a strong platform for the next phase of development, giving confidence that the partnership is well placed to respond to future challenges whilst continuing to improve outcomes for Lambeth's children and families.



Appendix





Appendix A – Table of acronyms

A&E	Accident and Emergency Department	FFPP	Families First Partnership Programme
AD	Assistant Director	FGC	Family Group Conference
ADHD	Attention Deficit Hyperactivity Disorder	FGDM	Family Group Decision Making
CAMHS	Child and Adolescent Mental Health Service	FGM	Female Genital Mutilation
CCE	Child Criminal Exploitation	GP	General Practitioner
CET	Child Exploitation Team	GSTT	Guy's and St Thomas' NHS Foundation Trust
CIN	Child in Need	HAF	Holiday Activities and Food Programme
CLA	Children Looked After	HMIP	His Majesty's Inspectorate of Probation
CME	Children Missing Education	HSB	Harmful Sexual Behaviour
CP	Child Protection	ICPC	Initial Child Protection Conference
CP-IS	Child Protection Information System	ILACS	Inspection of Local Authority Children's Services
CPS	Crown Prosecution Service	IRH	Integrated Referral Hub
CQC	Care Quality Commission	ISCYPC	Independent Safeguarding Children and Young People Commissioner
CRSG	Case Review Subgroup	JOIM	Joint Operational Improvement Meeting
CSA	Child Sexual Abuse	KCH	Kings College Hospital NHS Foundation Trust
CSC	Children's Social Care	LADO	Local Authority Designated Officer
CSE	Child Sexual Exploitation	LI	Learning and Improvement Subgroup
CSPR	Child Safeguarding Practice Review	LSCP	Lambeth Safeguarding Children Partnership
CSSOG	Contextual Safeguarding Oversight Group	MACPT	Multi-Agency Child Protection Team
DAPP	Domestic Abuse Perpetrator Panel	MARAC	Multi-Agency Risk Assessment Conference
DfE	Department for Education	MAROTH	Multi-Agency Risk Outside the Home Strategic Panel
DoLS	Deprivation of Liberty Safeguards	MASA	Multi-Agency Safeguarding Arrangements
DSCO	Designated Social Care Officer	MASH	Multi-agency Safeguarding Hub
DSL	Designated Safeguarding Lead	MASHSOG	Multi-agency Safeguarding Hub Strategic Oversight Group
EHCP	Education Health and Care Plan	NFA	No Further Action
EHE	Elective Home Education	NODG	Neighbourhood Operational Delivery Group
EHFS	Early Help and Family Support Subgroup	NSPCC	National Society for the Prevention of Cruelty to Children
EOTAS	Educated Otherwise Than At School	NVR	Non-Violent Resistance
ESAC	Education Safeguarding Advisory Committee	PCI	Performance Challenge Impact Subgroup



PIPPA	Pre-Interview Planning and Preparation Assessment
RASSO	Rape and Serious Sexual Offences
RCPC	Review Child Protection Conference
RHI	Return Home Interview
SEL ICB	Southeast London Integrated Care Board
SENCO	Special Educational Needs Coordinator
SEND	Special Educational Needs and Disabilities
SIN	Serious Incident Notification
SLAM	South London and Maudsley NHS Mental Health Trust
UASC	Unaccompanied Asylum Seeking Children
VAWG	Violence Against Women & Girls
VCS	Voluntary & Community Sector
VRI	Video Recorded Interview

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