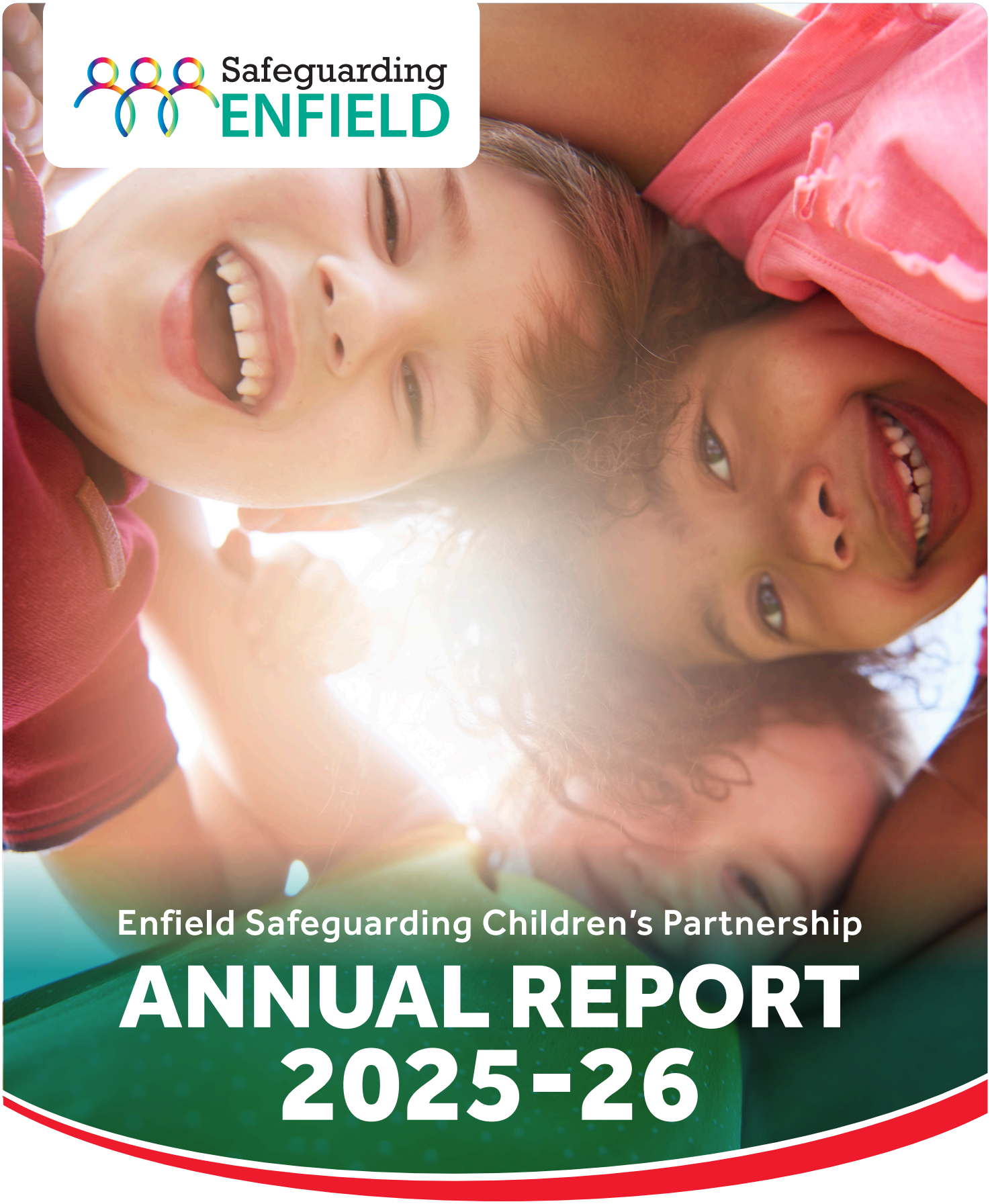
Safeguarding ENFIELD



Enfield Safeguarding Children's Partnership

ANNUAL REPORT 2025-26

www.safeguardingenfield.org

NHS West and North London

METROPOLITAN POLICE

ENFIELD Council

Safeguarding ENFIELD

Here are some of the organisations working to keep children, young people safe in Enfield.

NHS West and North London

ENFIELD Council

METROPOLITAN POLICE

London Ambulance Service NHS Trust

North London Mental Health Partnership

NHS Royal Free London NHS Foundation Trust

North Middlesex University Hospital NHS Trust

healthwatch Enfield

LFB LONDON FIRE BRIGADE

National Probation Service

Department for Work & Pensions

Children & Young Persons' Services

Cafcass Children and Family Court Advisory and Support Service

We all have a role to play to help keep children, young people safe. If you have concerns, please contact us and we can act to stop abuse.

Please talk to us

Safeguarding children and young people is everyone's responsibility. As someone who might live, work or study in Enfield you have a role too. If you are worried about someone or yourself, please talk to us. You can get help in any of these ways.

Children and young people

If you or the person you are concerned about is under 18 (a child or young person):

- Ring the Children Multi-Agency Safeguarding Hub (MASH) Team on **020 8379 5555**, Monday to Friday 9.00am to 5.00pm.
- Call the emergency duty team on **020 8379 1000** at night and weekends and tell them what is happening.
- For people who work with children and young people, please make your referral using the Children Portal: www.enfield.gov.uk/childrensportal
- You can email at: ChildrensMash@enfield.gov.uk
- In an emergency – such as when someone is being hurt or shut out of their home – ring the police on **999**.
- You can also ring **ChildLine** on **0800 1111** or visit the ChildLine website: www.childline.org.uk

If you don't want to talk to someone you don't know, you can ask an adult you trust, like a teacher or youth worker or even a friend, to make phone call for you. When people are working with children they have follow set procedures, but they will explain to you what they will do and should be able to support you through the process.



ChildLine

ChildLine have launched the **'For Me'** app – the first app to provide counselling for young people via smartphone and other mobile devices. For more information and to download the app for free, go to: www.childline.org.uk/toolbox/for-me

We are here to help you.

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Executive Summary

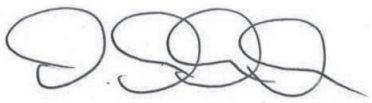
We are pleased to present the annual report for the Enfield Safeguarding Children Partnership (ESCP) covering the period from April 2025 to March 2026. This report reflects the work of our three statutory partners, the North Central BCU of the Metropolitan Police, the West and North London Integrated Care Board (ICB), and Enfield Local Authority, alongside our wider partnership colleagues across the borough.

Over the past year, we have proactively supported the national reform, Families First, agenda and carefully monitored the developing plans through our quarterly Executive meetings. As the system continues to evolve, we have upheld our responsibility to examine proposed changes, assess local implications, and ensure that safeguarding remains central to all decision-making. Our focus on strengthening the role of education partners within the leadership and governance of the ESCP continues to progress, recognising the crucial contribution that schools and learning settings make to the safeguarding landscape.

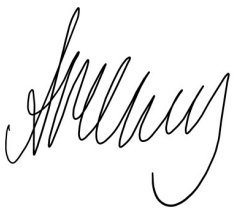
With the government's vision set out in Keeping Children Safe, Helping Families Thrive, the ESCP remains committed to preparing for and shaping the emerging safeguarding and social care model. We will continue to champion an approach that works with the whole family, supported by multi-agency teams, and designed to provide earlier, clearer, and more coordinated plans of support. This includes our commitment to the development of a new multi-agency child protection team, enabling partners to work in a decisive, skilled, and cohesive way to keep children safe. Co production with partners, practitioners, and families will remain central to this work.

We also recognise that the ICB continues to experience significant financial pressures which are expected to result in substantial organisational change across the coming year. Despite these pressures, we remain committed to working closely and constructively with the ICB to ensure that safeguarding duties are maintained and that any changes are managed in a way that protects children's welfare. Our strong collaborative relationships will continue to be essential as we navigate these challenges together.

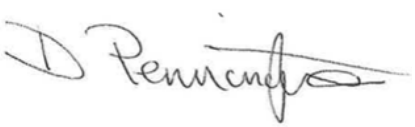
Finally, we extend our thanks to ESCP staff for their dedication in supporting the coordination and visibility of the Partnership. We also thank our stakeholders and all frontline practitioners and managers for their resilience, professionalism, and unwavering commitment to keeping children and young people safer in Enfield.



Tony Theodoulou
Executive Director – People
Enfield Council



Anna McCartney
Chief Superintendent – MPS
North Area BCU



David Pennington
Director of Safeguarding
Director of Safeguarding and
Looked After Children,
NHS WNL ICB

Overview

This report outlines the key activities, achievements and learning undertaken by the ESCP from April 2025 to March 2026. This year's work has focused on strengthening multi agency responses to Child Sexual Abuse (CSA), improving visibility of children who are vulnerable or out of sight, and embedding learning from local and national reviews.

Major achievements include:

- Completion of a mock Joint Targeted Area Inspection (JTAI) on CSA within the family environment, producing a robust set of recommendations for improvement and highlighting areas of good practice.
- Published materials on Child M highlighting essential learning about medical neglect, visibility, parental influence, professional curiosity, and Elective Home Education (EHE).
- Publication of a suite of new learning materials, including:
    - CSA 7 Minute Briefing and Podcast
    - CSA Pathway Guidance
    - EHE Safeguarding 7 Minute Briefing and Podcast
    - Updated ESCP Escalation & Resolution Protocol
- Delivery of a safeguarding event for voluntary and community settings which was a successful way to engage settings within the community and build stronger links.

These items form part of the year's achievements and appear again in the detailed body of the report.

1. Introduction and Purpose

This report reflects the collective commitment and achievements of partner agencies working together to safeguard and promote the welfare of children across Enfield.

It provides a transparent and accountable overview of activity over the past year, demonstrating our shared responsibility for protecting children and evaluating the effectiveness of our safeguarding arrangements. The report highlights areas of strength, alongside those requiring further development, ensuring that our practice continues to evolve in response to the needs of children and families.

It also showcases the strength of multi-agency partnership working and the impact of training and workforce development in supporting high-quality practice and improving outcomes for children. Importantly, this report informs our future priorities, supporting a culture of continuous improvement and reinforcing our commitment to ensuring the safety and wellbeing of all children in Enfield.



2. Governance and Accountability

The Partnership operates through a robust governance structure including:

- Executive Group – strategic leadership, oversight, and decision making.
- Activity Groups – Practice Improvement and Quality Assurance.
- Independent Scrutineer – providing independent challenge, deeper learning analysis, and assurance.

Roles and Responsibilities: Key stakeholders within the partnership have clearly defined roles and responsibilities to ensure effective safeguarding practices:

Lead Safeguarding Partners (LSPs): Senior representatives from the three key agencies (Enfield Council, NHS WNL ICB, and MPS) who are publicly named and meet regularly to fulfil their responsibilities. They speak with authority for their agencies, make decisions on policy, resourcing, and practice matters, and hold their agencies accountable for participating in and implementing local arrangements.

- Chief Executive of Enfield Council
- Chief Executive Officer for NHS WNL ICB
- Assistant Commissioner for MPS

- Delegated Safeguarding Partners (DSPs): Appointed by each LSP to oversee operational delivery and chair the Multi-Agency Safeguarding arrangements. They are senior enough to make decisions on behalf of their agencies and ensure their sectors are held accountable.
  - Tony Theodoulou: Executive Director, People Department, Enfield Council
  - David Pennington: Director of Safeguarding and Looked After Children, NHS WNL ICB
  - Anna McCartney: Chief Superintendent, MPS North Area BCU
- Independent Scrutineer: Provides objective oversight and constructive challenge across both strategic and operational activity, ensuring statutory responsibilities are fulfilled, appropriate quality assurance systems are in place, and that findings from local and national child safeguarding practice reviews are thoroughly examined and acted upon. The Independent Scrutineer chairs our Practice Improvement Group and undertakes in depth audit work. This year she contributed to the mock JTAI on intrafamilial child sexual abuse and commenced a deep dive on our MASH service.
- Activity Group Chairs: Lead the specific workstreams within their groups, ensuring that meetings are efficient, child-focused, and that actions are followed through.

This governance structure and the defined roles and responsibilities ensure that the ESCP operates effectively, with clear accountability and a strong focus on continuous improvement in safeguarding practices.

3. Overview of Key Safeguarding Activities (2025–2026)

Mock JTAI on Child Sexual Abuse (CSA)

The mock JTAI involved numerous multi agency partners and examined seven CSA related cases. Findings included:

- Individual partner interviews were positive demonstrating good partnership relationships and a strategic understanding of intra- familial CSA.
- Within the case audit, findings highlighted a need for multi- agency practice improvement on this subject area from frontline practitioners.
- Areas for development included strengthening the child's voice within practice, encouraging more consistent use of escalation where appropriate, and enhancing multi-agency alignment.

Local recommendations now being enacted include:

- Monthly monitored CSA Action Plan which is completed by a task and finish group.
- Strengthening training, use of escalation, and a child sexual abuse pathway.
- Improving quality of data collection and analysis.

Summary of the Local Child Safeguarding Practice Review (LCSPR) – Child M

Purpose of the Review

The Enfield Safeguarding Children Partnership (ESCP) commissioned this LCSPR following a Rapid Review in February 2024. Child M was admitted to hospital with severe malnutrition, with no medical cause identified. Both parents were later arrested in relation to concerns of child cruelty and neglect. The LCSPR aimed to identify system learning, rather than assign blame.

Child M – Background

- Child M is an autistic child who lived with their family and was educated at home.
- The family made use of a combination of statutory, private and alternative services.
- There was a history of missed appointments, inconsistent engagement with health services and concerns regarding meeting the child's health and developmental needs.
- Child M experienced limited visibility to professionals, with no single agency having a complete understanding of their circumstances.

Key Issues Identified

1. Safeguarding children – the need for children to be seen and heard

Key concerns

- Child M was effectively invisible to services due to home education, fragmented healthcare and limited professional contact.
- Child M required tailored approaches to communication, which were largely absent.
- COVID-19 did not significantly impact access to healthcare, though the effect on private services is unknown.

Learning

- Lack of continuity meant no professional truly "knew" Child M.
- Hospital staff, once Child M was admitted, demonstrated good practice in adapting communication to meet their needs.

2. A holistic view of children's needs

Key concerns

- No professional had an integrated view of Child M's history because of fragmented care and poor information sharing.
- There were indicators of possible Fabricated or Induced Illness (FII), including inconsistent parental accounts, an implausible medical history, missed appointments and reliance on unproven therapies.
- Child M's educational progress was not effectively monitored, and systems did not identify them as being educated at home.
- Attempts by the GP to raise safeguarding concerns were not progressed.

Learning

- There were missed opportunities to explore:
  - Parents' beliefs and motivations
  - Cultural influences
  - Reasons for rejecting conventional healthcare
- National challenges in monitoring children educated at home contributed to Child M becoming "out of sight".

3. The role of families

Key concerns

- One parent appeared to dominate decision-making, while the role of other family members was not fully understood.
- Wider family members contributed to care, but their influence was not well understood.

- Financial resources allowed the family to access a range of services, reducing professional oversight and at times creating a false sense of reassurance.
- Fragmented healthcare arrangements contributed to fragmented information.

Learning

- Families with greater financial resources can present unique safeguarding challenges, including:
  - Reduced visibility
  - Uncoordinated use of private services
  - Professionals assuming lower levels of risk
- Understanding the roles, stresses and needs of all caregivers is essential.

Key Practice Episodes

Prior to the safeguarding incident

- Professionals had longstanding concerns regarding engagement with services, missed appointments, fragmented healthcare arrangements and limited oversight of Child M's wellbeing.
- Opportunities to build a comprehensive understanding of Child M's needs were hindered by fragmented information and limited professional contact.

Safeguarding incident and response

- Concerns escalated following Child M's presentation to hospital with significant unmet health needs.
- The admission prompted safeguarding enquiries and a multi-agency response.
- Children's Services undertook statutory child protection processes and coordinated interventions to safeguard the children in the family.

Overall Findings

- Child M was largely hidden from the safeguarding system due to home education, fragmented healthcare arrangements, missed appointments and parental control over information.
- Professionals lacked:
  - Persistent safeguarding curiosity
  - Coordinated multi-agency communication
  - Effective systems for identifying children educated at home
- There were alerting signs of FII, though fragmented care prevented a full assessment.
- Financial resources appeared to reduce professional scrutiny and challenge.
- Significant health, communication and educational needs were not adequately met.

Good Practice Identified

- Hospital staff made substantial efforts to understand Child M's communication needs once admitted.
- The GP raised concerns and attempted to initiate safeguarding contact.
- Enfield Health is developing new resources to support families seeking autism-related interventions.

Recommendations

1. Strengthen parental awareness of approaches

Promote evidence-based approaches to autism interventions and highlight the risks of unregulated complementary therapies.

2. Establish a multi-agency pathway for children educated at home

Ensure children are identifiable, have coordinated oversight and do not become lost to systems.

3. ESCP assurance

Review the effectiveness of local arrangements for safeguarding children educated at home using Child Safeguarding Practice Review Panel (2024) guidance.

Closing Note

The review highlights the critical importance of visibility, coordinated oversight and professional curiosity, particularly for disabled children and those educated outside mainstream settings. While identifying shortcomings, it also recognises professional reflection and a commitment to improvement across agencies.

Publication of Learning Materials

To support the embedding of Child M learning, ESCP has published:

- EHE Safeguarding Briefing – summarising safeguarding expectations when children are educated at home, including deregistration processes and visibility risks.
- Updated Escalation Protocol – reinforcing constructive challenge, clear escalation routes and expectations for multi-agency resolution.

These materials have been disseminated widely and form a key part of the partnership's learning and improvement framework.



4. Safeguarding Event for Voluntary and Community Settings

Through Enfield Children and Young People's Services (ECYPS), the SafeGUARD Youth Organisations Networking Event brought together 42 youth organisations from across Enfield, providing a key platform to strengthen safeguarding awareness and promote effective partnership working.



Hosted at Millfield Theatre in collaboration with Platinum Arts and the Enfield Safeguarding Team, the event combined expert-led presentations, interactive learning, and youth-led contributions to strengthen frontline understanding of safeguarding responsibilities.

A wide range of safeguarding themes were addressed, including child exploitation/ extra-familial harm, online safety, knife crime, mental health, and violence against women and girls. Attendees were provided with comprehensive resources and guidance, alongside updates on children's social care reforms and referral pathways.



Young people's voices were central to the event, with spoken word performances and films by young people shown, reinforcing the importance of practice that places the voice and experience of the children and young people at the centre of decision-making.

The event also facilitated meaningful networking opportunities, enabling organisations to build relationships, share good practice, and identify areas for ongoing collaboration.

The event strengthened safeguarding knowledge, improved access to practical resources, and enhanced collaboration across the voluntary and community sector building links with statutory services. Positive feedback from attendees and the identification of new partnership opportunities demonstrate the ongoing value of this type of event in supporting both immediate safeguarding needs and longer-term network building to improve outcomes for children and young people.

5. Quality Assurance Activity

The Partnership continued a strong programme of multi agency audits this year, including the mock JTAI CSA case audit and commencing the EHE audit.

Outcomes have informed the CSA Action Plan, updated procedures, and training requirements.

A 7 min briefing and accompanying podcast video on CSA and EHE were created and shared.

Independent Scrutiny

I have been the Independent Scrutineer since June 1st 2025, covering 9 months of this reporting cycle. This report details activity from April 2025 to March 2026.

Three Rapid Reviews have been held, leading to one Local Safeguarding Practice Reviews now in progress. A second is being completed by colleagues in Leicester, as the child concerned was a Leicester child placed in Enfield. All three Rapid Review Reports received detailed feedback from the National Panel, which the Executive Group discussed in full and since then various changes have been made locally. There is now much more focus during each Rapid Review meeting on the Key Lines of Enquiry, which has sharpened the focus and led to a better 'learning vehicle' for the partnership. The ESCP is a strong and committed partnership, keen to learn together and make changes when required.

As well as overseeing the various practice reviews, I have undertaken an audit of the Multi Agency Partnership Hub (MASH). This has been discussed at the Executive Group, and this will continue into 2026/27. Maximising the team's assessment skills and focusing on those contacts that require more attention is critical and an in-depth analysis continues.

The Partnership completed a 'mock inspection' in the Autumn on the area of Sexual Abuse within the family. The National Panel Report (November 2024) 'I Wanted Them All To Notice' was used as the basis for testing out how this important practice area was being managed across all partners. I was involved in meeting various partners and was part of the file reading team, incorporating external colleagues, from Health, Education and the Police. The Executive Group responded well to the findings and regular updates are provided. Also, a strengthened training programme was implemented.

I can provide assurance that the Enfield Multi Agency Safeguarding Arrangements are compliant with Working Together 2023. The year ahead will involve considerable change across the Partnership with the Social Work Reforms and the refresh in Working Together 2026. The ICB and Metropolitan Police are also subject to organisational churn and budget pressures.

The Partnership is one year into a 2-year Business Plan and this Annual Report discusses that in more detail.

Geraldine Gavin

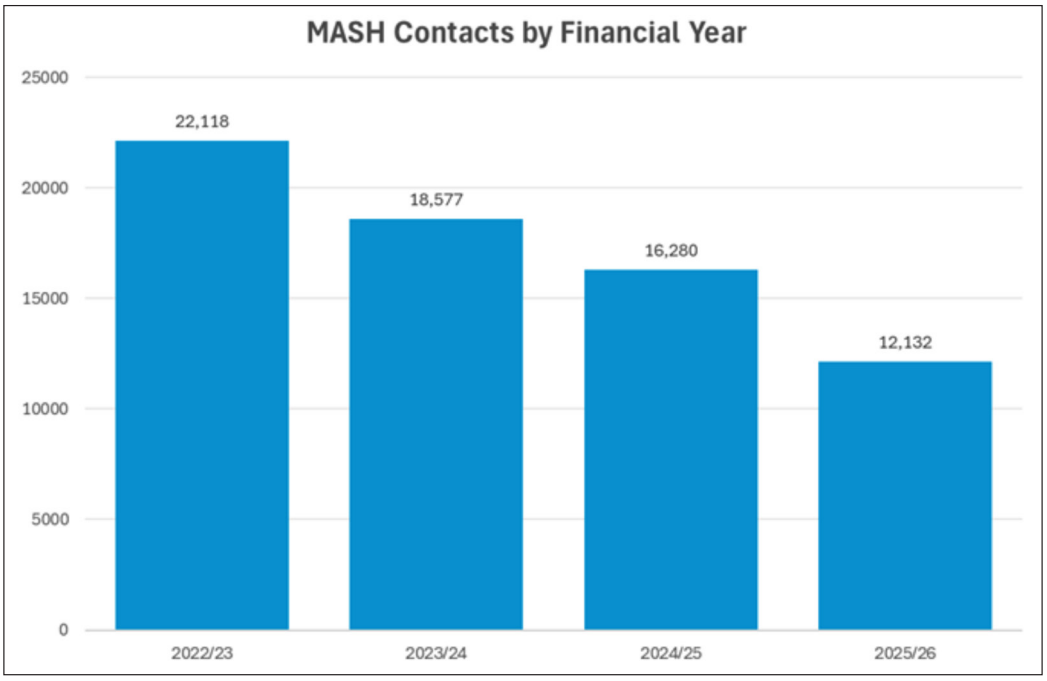
6. Performance and Impact

This section outlines key data trends and performance insights in Enfield in 2025/26.

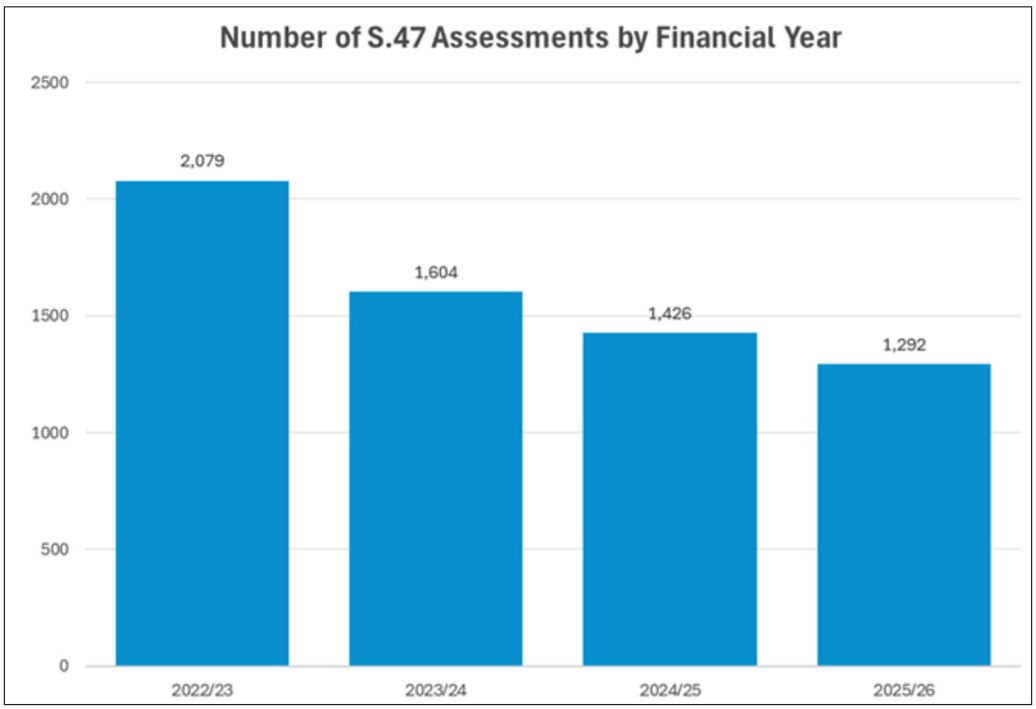
Performance, Learning and Impact

Across the reporting period, safeguarding demand indicators continue to show a sustained downward trend, alongside strong performance against statutory expectations. This reflects the collective impact of a more stable workforce, improved management oversight, and a maturing early intervention offer across the partnership.

MASH contacts have continued to reduce year on year, falling to 12,132 in 2025/26, from a high of over 23,000 in 2022/23, representing a significant reduction over the four-year period. This is likely linked to a combination of improved front-door decision-making, clearer thresholds, and greater partner understanding of appropriate pathways.



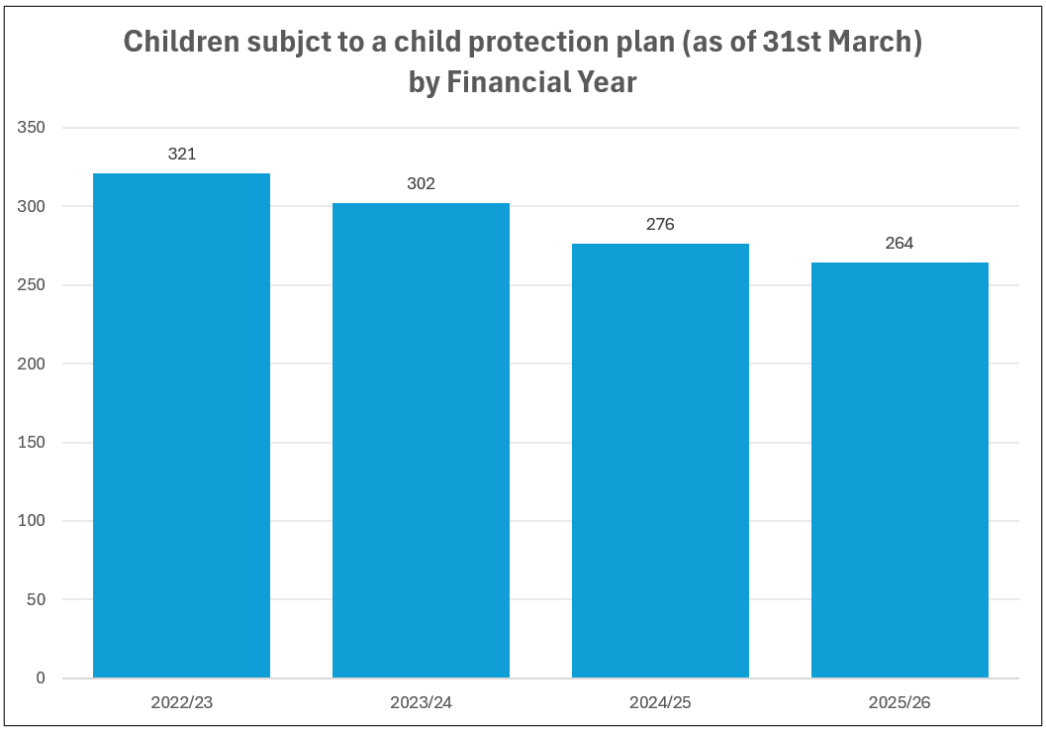
In parallel, the number of Section 47 enquiries has continued to decline, with 1,292 recorded in 2025/26. This sustained reduction suggests that risks are increasingly being identified and addressed earlier, reducing the need for high-threshold statutory intervention.

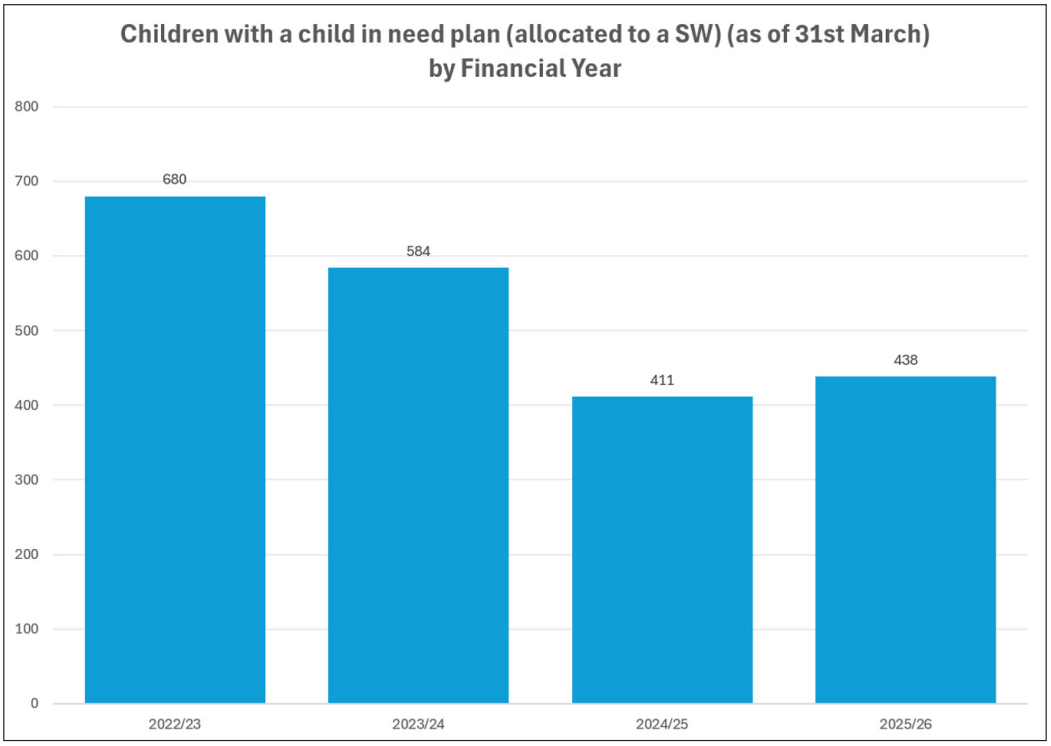


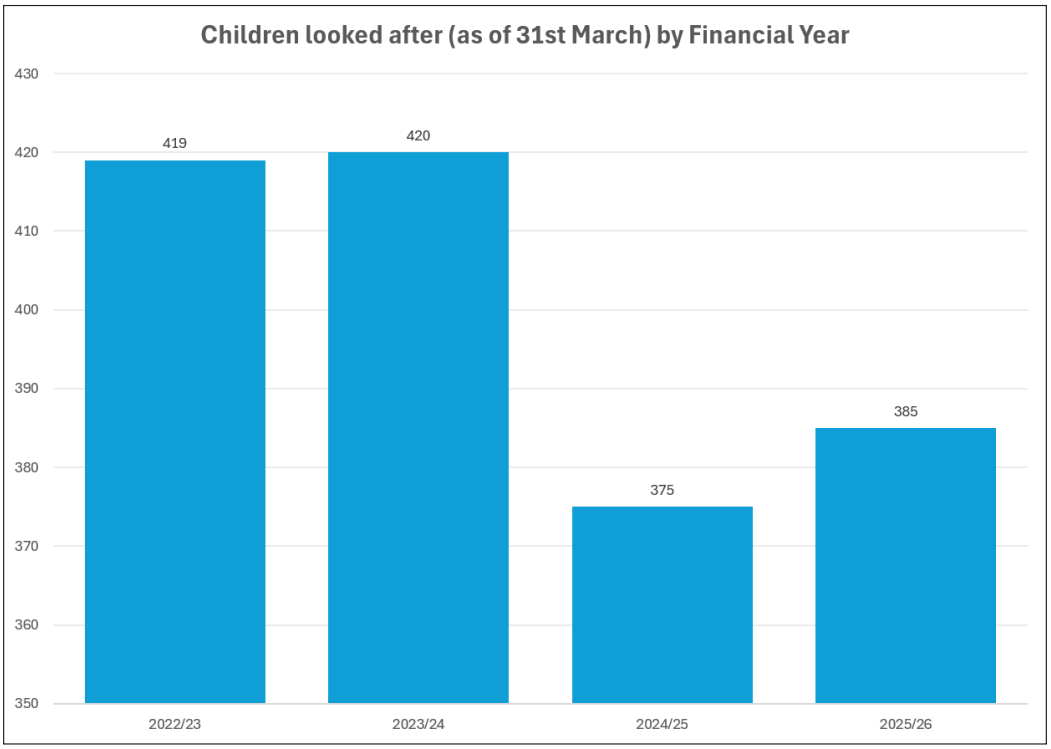
Statutory Intervention and Care Trajectories

The number of children subject to statutory plans has continued to decrease overall:

- Children subject to a Child Protection Plan reduced to 264 as of 31 March 2026. This is part of a year-on-year reduction over the last 4 years.
- Children with a Child in Need plan decreased significantly over the last 4 years, with a small increase in 2025/26 (to 438).
- Children Looked After numbers remain broadly stable (385), following a sustained reduction in earlier years.







Crucially, these reductions of children with plans have not resulted in increased care entry. This indicates risk is being managed effectively and safely within families, supported by purposeful intervention and improved planning.

Quality and Timeliness of Practice

Performance in completing Child and Family assessments within 45 working days remains strong, at 86.7% in 2025/26, following a peak of 92.5% the previous year. While this represents a slight decrease,

performance remains above statutory expectations and reflects continued focus on quality and oversight rather than pace alone. The partnership recognises the need to balance timeliness with depth of analysis, particularly in more complex cases, and this will remain an area of focus.

Allegations Management (LADO)

The number of new allegations meeting the LADO threshold has fluctuated across the period, with 43 cases in 2025/26. The spike seen in 2024/25 has not been sustained and the current level is understood to reflect clearer threshold application, and improved confidence in holding case consultations rather than a change in underlying risk.

Partnership analysis of data and qualitative learning

During the year, the Partnership undertook a deeper analysis of multi-agency data, triangulating safeguarding indicators with qualitative learning from audits, reviews, and practitioner feedback. This analysis informed a refreshed set of partnership priorities, ensuring that activity is targeted where it can achieve the greatest impact for children and families.

This has included closer examination of:

- Demand patterns at the front door
- Care pathways and lengths of intervention
- The relationship between early help, statutory thresholds, and outcomes

The Partnership has moved beyond monitoring performance in isolation, using data to ask better questions about impact, effectiveness, and equity.

In preparing for Working Together to Safeguard Children 2026, the Partnership recognises the increased emphasis on:

- The purposeful use of data
- Measuring impact, not just activity
- Understanding and addressing disproportionality

Over the next year, the Partnership will further strengthen its data-driven approach by:

- Continuing to develop and deepen analysis of disproportionality, including by ethnicity, disability, age, and geography
- Embedding data review more consistently into Partnership executive decision-making and independent scrutiny
- Further enhancing the ability to link safeguarding activity to outcomes for children, alongside existing process measures

This work will support the Partnership in understanding who is most affected by safeguarding systems, why, and what needs to change, ensuring that interventions are both effective and equitable.

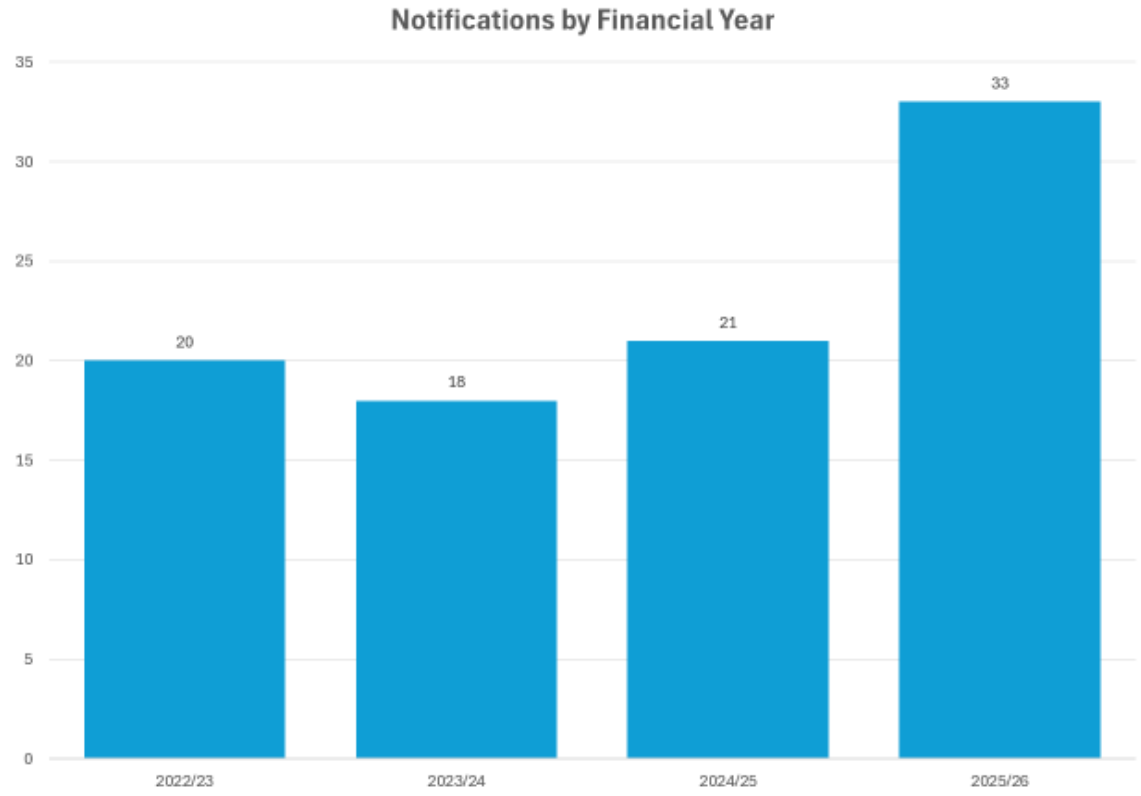
Overall, the data demonstrates a safeguarding system that is stable, improving, and increasingly reflective. Reductions in demand for statutory intervention, alongside sustained performance and improved data maturity, provide a strong foundation for the improvements. The Partnership recognises that continued improvement will depend in part on how effectively data is used to understand impact, effectiveness, and disproportionality.

7. Child Death Reviews

North Central London Child Death Review Partners have completed their fourth annual report of the Child Death Overview Panel (CDOP). The panel reviews every death of a child and young person aged up to 18 years of age, resident in Barnet, Camden, Enfield, Haringey, and Islington boroughs.

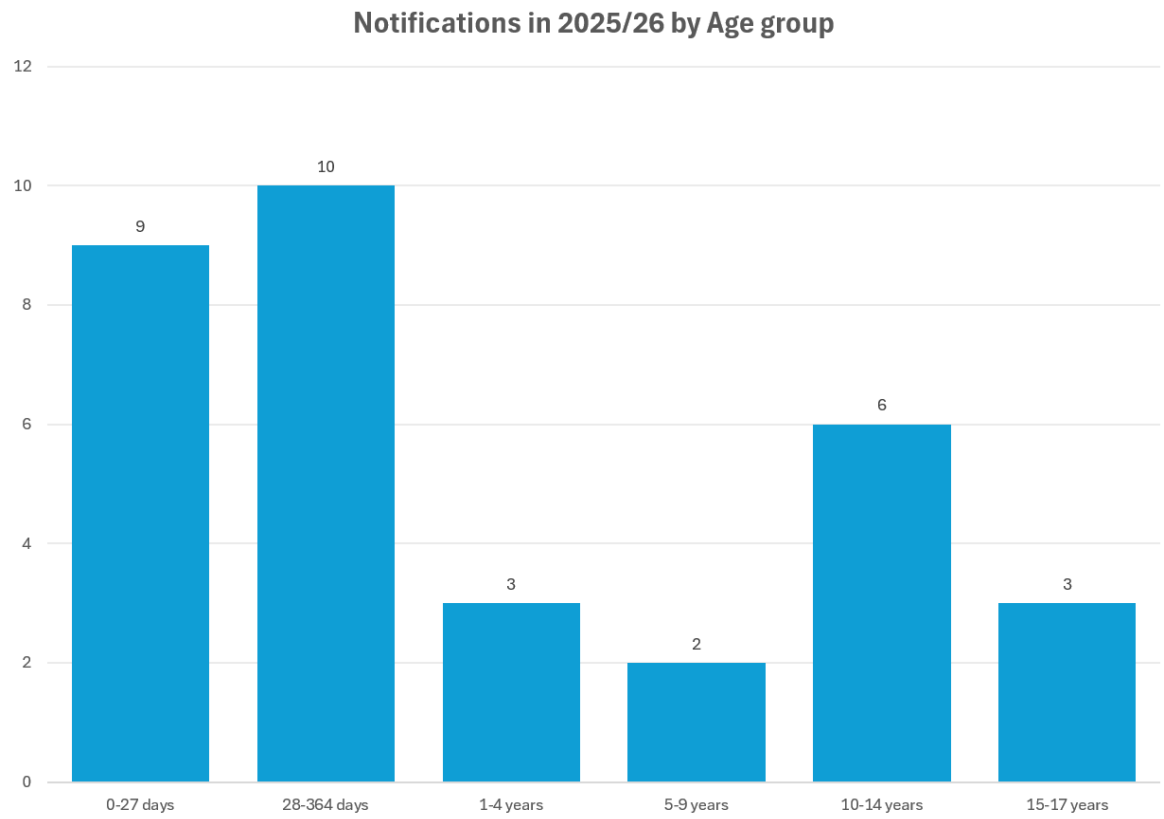
The partners recognise every death of a child is a tragedy that deeply affects their families, friends, and the communities in which they lived. The loss of a child is difficult to accept, particularly for bereaved families and friends. North Central London Child Death Overview Panel (NCL CDOP) recognises this and works hard to identify opportunities to recommend changes and improvements that might prevent a child death and assist children and families in the future who may be facing the death of a child. All child deaths, regardless of how they died, are subject to review, and the CDOP engages in the final stage of this review process.

In 2025-26, NCL CDOP received 96 notifications of child deaths. Of these cases, 33 were for Enfield children. This is an increase on previous years, further analysis will be undertaken in the child death annual report.



Statutory guidance defines an unexpected death as the death of a child that was not anticipated as a significant possibility 24 hours before the death. When this happens a Joint Agency Response (JAR) meeting takes place. There were 10 JAR meetings in Enfield in 2025-26.

Immediate safeguarding steps were taken where appropriate in relation to siblings and family support. The JAR meeting also identifies a key worker for each family to provide support and guide them through the child death review process.



Thematic panels

In July 2025, a Serious Youth Violence Panel took place and found that each case had modifiable contributory factors relating to all National Child Mortality Database Domains - Factors intrinsic to the child, factors related to the family, factors related to the environment and factors related to service provision. All cases were recorded as modifiable.

The various themes identified included:

- Domestic abuse in childhood by male perpetrators
- Impact of deprivation
- Bereavement/witnessing death or trauma
- Importance of belonging and identity
- Parental needs including poor mental health
- Social media – music videos
- Adverse school experiences

A 7 min briefing was developed and shared with Partnerships.

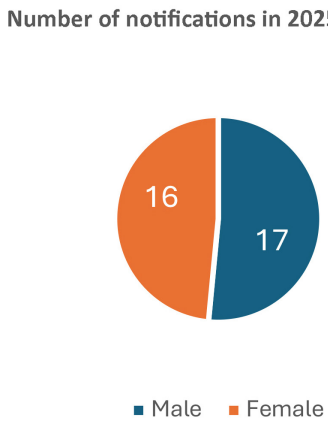
In January 2026, a panel focusing on child deaths by Suicide was undertaken. The learning themes included:

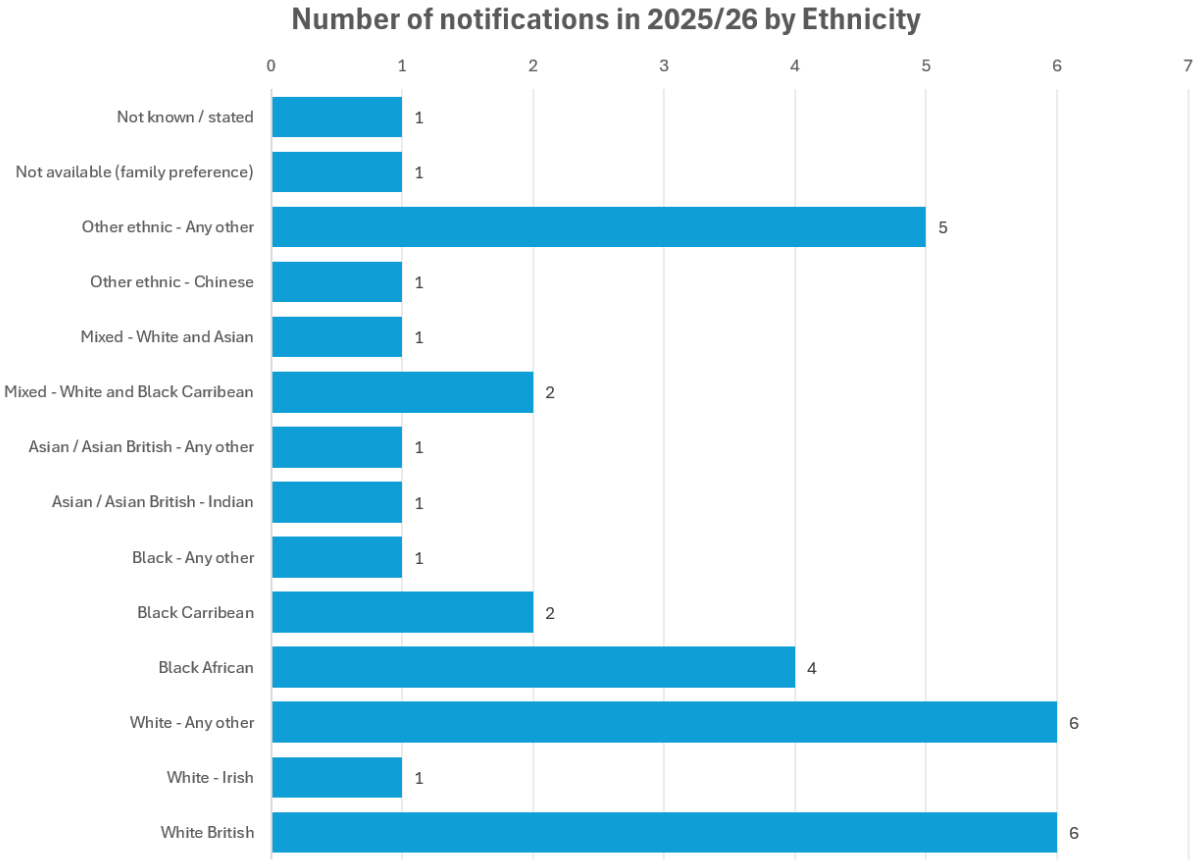
- Child and parental mental health issues
- Language barriers to accessing services
- Information sharing issues between different providers (including private sector)

- Risk assessments
- Telephone assessments
- Lack of empathy from agencies
- Lack of continuity of key workers
- Challenges navigating the coronial service.

National Learning. The national database system used by all CDOPs (eCDOP) has allowed for analysis of all child deaths by the National Child Mortality Database (NCMD) team. The NCMD, commissioned by NHS England, published several thematic reports in 2025/26. NCL CDOP shared the learning and recommendations from these publications through the Safeguarding Partnership Managers.

Enfield data analysis summary 2025-26:





8. Workforce Development and Training

During 2025/26, the Safeguarding Partnership delivered a comprehensive, multi agency training programme aligned to statutory responsibilities, emerging safeguarding risks, and partnership priorities. This section will reflect the year's training figures, themes, impact, and practitioner feedback.

The programme covered a wide range of topics, including Multi Agency Safeguarding Practice, Prevent, Child Sexual Abuse, Extra Familial Harm (introductory and advanced), Managing Allegations (LADO), Substance Misuse, Mental Capacity Act and Deprivation of Liberty, National Referral Mechanism, Anti Racism, and Language: Why It Matters.

Training Reach and Engagement 2025–26	Total
Number of training events delivered	29
Total bookings	455
Number of attendees	277
Attendance rate (%)	61%
Number of DNAs	140
Number of cancellations	38

Attendance by Professional Sector	Cancelled	Did not attend	Attended	Grand Total
Care Home & Supported Tenancies	0	12	13	**25**
Children and Young People Service	8	17	49	**74**
Early Years	0	4	2	**6**
Education	15	22	63	**100**
Health	9	36	57	**102**
Housing	0	1		**1**
LBE Other	1	13	15	**29**
other	4	30	71	**105**
Probation	1	2	3	**6**
VCS	0	3	4	**7**
Grand Total	**38**	**140**	**277**	455

29 training events were delivered, with 455 bookings across the programme. 61% of booked places resulted in attendance. This level of attendance is consistent with other large, multi agency training programmes, particularly those delivered online and involving partners with frontline operational pressures. That said the Partnership will work at increasing the attendance rate in 2026/27. Training reached professionals across children's services, education, health, probation, housing, the voluntary sector, and independent care providers, supporting a shared, multi agency safeguarding approach.

Some courses demonstrated particularly high demand, including:

- Managing Allegations Against Staff and Volunteers
- Substance Misuse and Hidden Harm
- Child Sexual Abuse
- Missing Training
- Multi Agency Safeguarding Awareness

These courses also show repeat delivery and high booking numbers, indicating ongoing workforce need. Training data supports the Partnership in prioritising its training offer appropriately, aligning delivery with areas of highest workforce demand and risk.

Training Impact

Training participants are directed to complete an evaluation form at the end of each course. Feedback across all training was consistently positive, with participants reporting that sessions were relevant to their roles, well delivered, and directly applicable to practice. The quality of facilitation was a particular strength, with trainers frequently described as knowledgeable, confident, and able to create a safe and supportive learning environment. Participants also reported high levels of engagement, appropriate pacing, and opportunities to ask questions and reflect on practice, even when addressing complex or emotionally challenging subject matter.

A key theme across all courses was the positive impact on professional confidence. Participants consistently reported feeling more confident in recognising safeguarding concerns, understanding their role and responsibilities, and responding appropriately. Training strengthened practitioners' readiness to have difficult conversations, apply professional judgement, and take timely safeguarding action. This was particularly evident in feedback from courses addressing child sexual abuse, extra familial harm, preventing extremism, and managing allegations, where increased confidence and clarity were repeatedly highlighted.

The Language: Why It Matters training further enhanced practitioner confidence by supporting professionals to reflect on how language influences understanding, decision making, and safeguarding outcomes. Participants reported greater awareness of how language can either support or hinder effective practice and expressed confidence in applying this learning in written and verbal communication.

Across the programme, participants indicated a strong intention to apply learning directly to practice, with many describing immediate relevance to current cases. Feedback highlights improved understanding of safeguarding thresholds, referral pathways, risk assessment, and information sharing, particularly following Multi Agency Safeguarding Practice training. Practitioners valued gaining practical tools, frameworks, and guidance that could be embedded into everyday work, supervision, and team discussions. Training also supported improved quality of referrals and recording, clearer professional reasoning, and more confident engagement with children, young people, families, and partner agencies. Participants frequently reported sharing learning with colleagues, extending the reach and impact of the training beyond those who attended.

Several courses, including Anti Racism and Language focused training, prompted significant reflection

on professional assumptions, culture, and values. Participants described becoming more reflective practitioners, with increased awareness of how bias, language, and systemic factors intersect with safeguarding. This reflective impact supports the Partnership's commitment to inclusive, trauma informed, and child centred practice.

Multi agency learning was a notable strength of the training offer. Courses brought together professionals from health, education, social care, probation, housing, and the voluntary sector, supporting a shared understanding of safeguarding responsibilities and promoting effective collaboration. Participants valued hearing perspectives from different agencies and developing a common safeguarding language, contributing to more joined up practice across the partnership.

Participants across all courses reported being likely or very likely to recommend the training to colleagues, they also reported strong confidence in both the content and delivery. Feedback also provided constructive suggestions for further development, including requests for additional time on complex subjects, more case studies, and greater interactivity. These insights are being used to inform ongoing improvements and future training design.

Overall participant feedback demonstrates that the Partnership's training programme is effective in strengthening skills, confidence, and professional judgement across the safeguarding workforce. The programme supports individual's practice, enhances multi agency understanding, and contributes to a more confident, competent, and reflective safeguarding system. Collectively, this training plays a key role in improving safeguarding practice and supporting better outcomes for children, young people, and families in Enfield.



Financial Overview

The Local Partners who contribute to the work of the Safeguarding arrangements are, The Local Authority, ICB, MPS, National Probation, North Middlesex University Hospital, Barnet Enfield and Haringey Mental Health Trust (BEHMHT) and the Royal Free Hospital. The board made a commitment to operate within the available budget, and any excess must be agreed by all partners.

Our annual spend

	Amount
Salaries	£104,245.78
Independent Scrutineer	£8,523.36
Other	£1,426.00
Training	£700.00
Reviews and audits	£5,000.00
Total costs	**£119,895.14**

Our contributions from partner agencies

Contributions	Amount
LA	£50,600
ICB	£50,600
North Middlesex	£3,000
BEHMHT	£3,000
Royal Free	£3,000.00
Probation	£3,190.00
Police	£5,000.00
Total	**£118,390.00**

9. Partner update

Police

Op Encompass

Significant work has been undertaken across the Metropolitan Police Service to strengthen compliance with statutory Op Encompass responsibilities, supporting safeguarding arrangements for children in the London Borough of Enfield. Enhancements to the CONNECT Domestic Abuse decision tree, alongside reinforced guidance to officers and a mandatory acknowledgement prompt, ensure that all children under 18 associated with a domestic abuse incident are accurately recorded, including their education setting details and relevant associations, regardless of whether they were present or witnessed the incident. This improved recording process promotes greater consistency, accountability, and safeguarding practice, reducing the risk of missed or incomplete information. As a result, children affected by domestic abuse in Enfield are more likely to be identified at the earliest opportunity, enabling timely information sharing with schools, education providers, and safeguarding partners, supporting earlier intervention, improved educational outcomes, and a more coordinated response to reduce safeguarding risks for vulnerable children and young people.

VRI suite refurbishment

The Metropolitan Police Service is delivering a phased refurbishment programme of Video Recorded Interview (VRI) suites to improve the investigation of child sexual abuse and other serious offences, with benefits for victims and investigators across London, including the London Borough of Enfield. The programme is creating modern, trauma-informed environments designed to help children and other vulnerable victims feel safe, supported, and able to provide their best evidence. Improvements include enhanced privacy, more suitable waiting areas, and better facilities for families and carers, reducing stress and anxiety during the investigative process. Early feedback from officers has been highly positive, with refurbished suites contributing to improved victim engagement and higher-quality video-recorded interviews that support Achieving Best Evidence (ABE) principles. The programme is expected to strengthen investigations through more reliable evidence, increase confidence in the criminal justice process for victims and their families, and support more effective partnership working with agencies such as the Crown Prosecution Service. Ultimately, these improvements enhance the experience of vulnerable victims from Enfield and across London while supporting stronger safeguarding outcomes and more effective prosecutions.

Health

On 12 March 2025, all Integrated Care Boards (ICBs) were advised of the requirement to reduce operational budgets by 50%, with further direction issued by Sir James Mackey, Chief Executive of NHS England, on 1 April 2025. This was followed by publication of the Model ICB Blueprint which set out the first stage of a national programme to reshape the focus, role and functions of ICBs in preparation for delivery of the 10 Year Health Plan.

In July 2025, the Boards of both NHS North West London Integrated Care Board (NWL ICB) and NHS North Central London Integrated Care Board (NCL ICB) made the decision to merge their organisations as a significant part of the response to the national Model.

As strategic commissioners, ICBs will continue to play a key role in improving population health, reducing inequalities and ensuring more equitable access to consistently high-quality care. Ensuring that the merger establishes an effective and sustainable organisation, capable of delivering these priorities, is therefore a critical success factor.

The amalgamation of North West London (NWL) and North Central London (NCL) ICBs represents a significant organisational change, creating a single ICB serving 13 boroughs. Alongside the required budget reductions, this will likely result in a reduction in Designated ICB safeguarding roles across the new footprint.

As local delivery models and partnership arrangements evolve, there will be a need to carefully manage the impact on safeguarding capacity, leadership and partnership engagement to ensure statutory responsibilities continue to be met effectively. The safeguarding partnerships have benefited from stable health representation and well-established, trusted relationships, and maintaining strong collaborative working across the new organisation will be essential to support effective safeguarding arrangements and system-wide assurance.

West & North London ICB, as one of the three Statutory Safeguarding Partners of Enfield Safeguarding Children Partnership (ESCP), holds equal and joint responsibility for the multi-agency safeguarding arrangements in Enfield. The West & North London ICB Chief Executive Officer (CEO) is accountable for safeguarding children and young people, including children looked after, and acts as the Lead Safeguarding Partner (LSP).

Within Enfield health representation is delegated to the West & North London ICB Director of Safeguarding and Looked After Children, who leads safeguarding across the safeguarding children partnerships within the West & North London footprint. The Director of Safeguarding and Looked After Children acts as the Delegated Safeguarding Partner (DSP), supporting the Chief Nursing Officer (CNO) in ensuring statutory safeguarding responsibilities are met and escalating safeguarding matters to the ICB CEO where appropriate.

Safeguarding expertise is provided through borough-based Designated Safeguarding Children Professionals, Designated Children Looked After/Care Experienced Professionals and Named GPs for safeguarding children.

The Designated safeguarding team has contributed to system leadership across acute, community and mental health providers thus strengthening multi-agency safeguarding arrangements through providing expert advice, scrutiny, and challenge across safeguarding practice. This work has supported a coordinated and consistent safeguarding response across the local health economy.

Children's Social Care

During 2025/26, Enfield Children's Services strengthened its focus on prevention and early intervention. Family Hubs became a focus of local support, bringing together services for children and families in their communities, while youth services expanded their reach and developed a more inclusive offer for young people, including those with SEND and young carers. The borough also continued to invest in programmes that help young people stay safe, build resilience and access support before problems escalate.

A significant change during the year was the continued implementation of the Families First Partnership reforms. Enfield completed the first phase of the programme, introducing Family Help teams, expanding Family Decision Making and developing a more joined-up approach to supporting families. This strengthened the role of family networks in decision-making and increased opportunities for children to remain safely within their wider family and community wherever possible.

Two new local children's homes opened, increasing local placement options for children in care and helping more children remain close to their families, schools and support networks.

The year also saw continued investment in the children's workforce and the conditions that support good practice. Workforce stability improved, reliance on agency staff reduced, learning and development opportunities expanded, and early career pathways were strengthened. Leadership remained focused on service improvement, safeguarding, quality assurance and listening to the experiences of children, families, carers, staff and partners.

10. Future Priorities for the Partnership in 2026-2027

Neglect

The Partnership will prioritise the review, refresh, agreement and relaunch of its Neglect Strategy and accompanying guidance to ensure it reflects current learning, statutory guidance and local need. This work will focus on strengthening a shared multi-agency understanding of neglect, supporting earlier identification, and promoting consistent, strengths-based practice across the partnership.

Harm Outside the Home

Harm outside the home remains a key priority for the Partnership. Building on existing work, the Partnership will strengthen awareness, understanding and professional curiosity in relation to extra-familial risks. This will include delivering a programme of awareness sessions within schools for parents and carers of children in Years 6 / 7 on missing episodes and associated risks.

In response to emerging themes, the Partnership will also develop and deliver training on incel and manosphere ideologies, supporting practitioners to understand how these can lead to risks including harmful sexual behaviour and links to extremist worldviews. A 7-minute briefing and podcast video will be produced and shared to support understanding of this phenomenon across agencies.

The existing missing training offer will be enhanced to include workshop-based sessions, providing practitioners with dedicated time to apply learning to real-world scenarios, strengthen professional judgement, and share practice. In addition, the Partnership will work with the local Police Child Exploitation Team to facilitate police-led training on Child Sexual Exploitation, further strengthening multi-agency knowledge and response.

Protecting All Vulnerable Babies Better / Pre-Birth Protocol

The Partnership will support the joint development of the pre-birth protocol, ensuring alignment with the recommendations set out in Protecting All Vulnerable Babies Better (2026). This will include a focus on considering how best to identify and respond to concealed pregnancies, reflecting on approaches to engaging parents, exploring opportunities to strengthen multi-agency working between partners, and recognising domestic abuse as a significant risk factor in pre-birth planning.

To support effective implementation, the Partnership will facilitate additional workforce development opportunities, including training in Motivational Interviewing and Police led Domestic Abuse training and Community Safety led Domestic Homicide Review training. This approach will support practitioners to build stronger relationships with families and improve understanding of risk for babies and how to safeguard them.

Anti-Racism and Disproportionality

The Partnership will take forward a clear commitment to addressing disproportionality and promoting anti-racist practice across all safeguarding activity. This will include the development of an Enfield Children's Safeguarding Partnership Anti-Racist Practice Statement, which will set out shared principles, expectations and standards for partners.

This statement will underpin a refreshed multi-agency training offer on anti-racist practice, ensuring that practitioners are equipped to recognise and challenge bias, understand the impact of structural inequalities, and deliver equitable services to children and families. Through this work, the Partnership aims to strengthen culturally competent practice and ensure that safeguarding responses are fair, inclusive and responsive to Enfield's diverse community.

Acknowledgements

We thank all ESCP partners, frontline practitioners, and safeguarding ambassadors for their commitment to improving the lives and safety of children in Enfield.



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Enfield Safeguarding Children Partnership

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ENFIELD Council