

**WSCP
Annual
Report
2025-26**

**01 April 25 -
31 March 26**

Wakefield
**Safeguarding Children
Partnership**

Annual Report 2025-26

01 April 25 - 31 March 26



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Introduction

This report summarises, reflects on, and presents the work of Wakefield Safeguarding Children Partnership (WSCP) between 01 April 2025 and 31 March 2026. This covers the sixth full financial year of operation by WSCP since it replaced the previous Local Safeguarding Children Board (LSCB) in September 2019. All details about the work the partnership produces is available on the WSCP website at www.wakefieldscp.org.uk.

The partnership is led by an Executive and supported by an Independent Scrutineer. The Executive is led by three statutory partners Wakefield District Metropolitan Council, NHS West Yorkshire Integrated Care Board and West Yorkshire Police, each represented by a Delegated Safeguarding Partner. It is also contributed to by a small number of representatives: lead officers from key services in all three statutory partners, Multi-Academy Trust Chief Executive Officers, heateachers from primary, secondary, and special educational needs schools, the voluntary sector, and Public Health. WSCP is funded by the three statutory partners.

This report focuses largely on the impact the partnership has achieved, analysing the work undertaken by the partnership's Executive and five sub-groups, highlighting areas of strength and areas the partnership needs to focus on developing within the next year.

Lead Safeguarding Partners:



Tony Reeves

Chief Executive
Wakefield Metropolitan District Council



John Robins QPM DL

Chief Constable
West Yorkshire Police



Jonathan Webb

Chief Executive
West Yorkshire Intergated Care Board

Delegated Safeguarding Partners:



Vicky Schofield

Corporate Director
Children and Young People's Services
Wakefield Metropolitan District Council



Stuart Bainbridge

Chief Superintendent
Wakefield District Commander
West Yorkshire Police



Debi Gibson

Deputy Director of Nursing and Quality
NHS West Yorkshire Integrated Care Board

Partnership Structure and Governance

The partnership has an established structure which comprises of an Executive and five sub-groups. The sub-groups are the Child Safeguarding Practice Review Group (CSPRG), Child Death Overview Panel (CDOP), Multi-Agency Child Exploitation (MACE) Group, Learning and Development (L&D) Groups (split into a Strategic and Delivery Group), and the Safeguarding Effectiveness Group (SEG). The function of the Executive is to provide strategic oversight, scrutiny, and assurance of the work the partnership undertakes to ensure multi-agency safeguarding arrangements in Wakefield are effective. Each sub-group has specific responsibilities and identifies, discusses, develops, and delivers a range of multi-agency safeguarding information, resources, assurance, and learning opportunities which are as described within *Figure 1 – Structure of WSCP*.

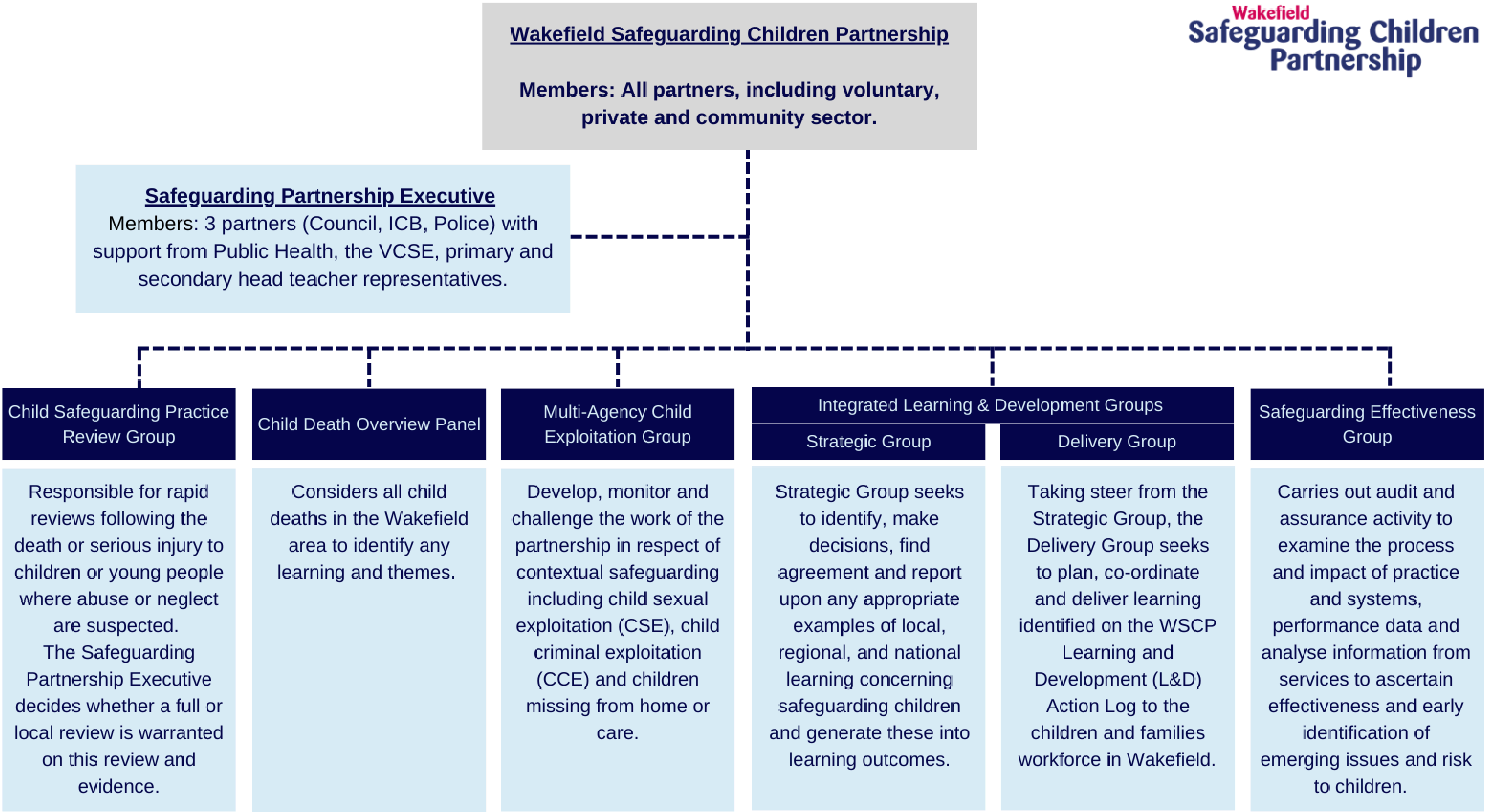


Figure 1 – Structure of WSCP

WSCP is aligned to the wider system in the district and continues to contribute to the strategies and priorities from other strategic partnership and boards such as:

- Wakefield District Safeguarding Adult Board
- Wakefield District Community Safety Partnership
- Health and Well-being Board
- Children and Young People's Partnership Board

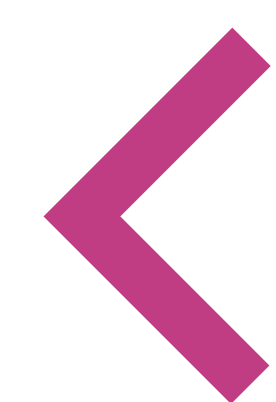
WSCP's Delivery Plan is aligned to the district wide Children and Young People's Plan, 2025-28. The delivery plan contains five overarching priorities which the partnership has continued to focus on this year whilst accommodating any emerging areas of development. The five priorities are as follows:

1. Educational neglect is identified and responded to effectively
2. Children who are victims of domestic abuse receive effective support
3. Risks posed outside of the home are well understood, identified and responded to effectively, with particular focus on child exploitation and online harm
4. Strong arrangements are in place to identify, recognise, respond, protect and support children who are victims of intra familial child sexual abuse
5. Children on the cusp of adulthood who require continued support in relation to their risk and vulnerability, experience good transition to services who support adults

The key areas of focus identified in the [partnership's previous Annual Report](#) was to complete the work detailed within the WSCP 2022-25 delivery plan and review the impact made across the 3-year cycle, this is detailed below. Throughout the report further detail is provided on the overall work the partnership has undertaken during 2025-26.



Key Areas of Development identified in 2024-25

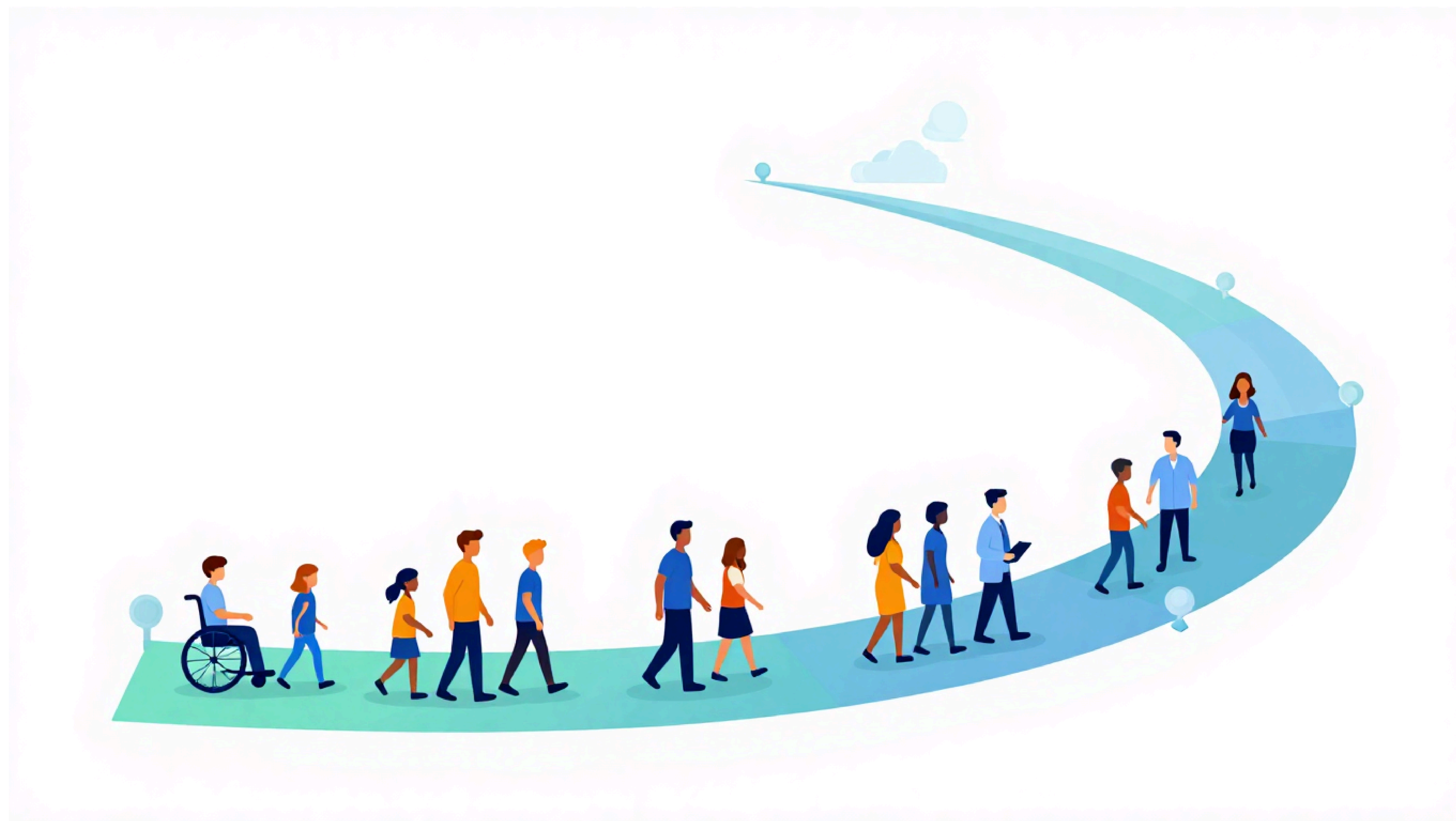


Progress made in 2025-26



Complete the work detailed within the
WSCP 2022-25 Delivery Plan, measure its
impact to inform a 2025-28 plan

- The partnership carried out review and development sessions as an Executive and Sub-Group Chairs, along with running a partnership wide survey to assess the impact made as part of the 2022-25 Delivery Plan
- Highlights of the work achieved across the 13 priority areas, which included safer sleep, neglect, child exploitation, harmful sexual behaviour, safeguarding thresholds, non-accidental injury, and trauma informed practice can be viewed here - [WSCP Delivery Plan 2022-25 Review](#)
- This review, along with findings from audit activity, safeguarding reviews and data helped to inform the priority areas for the new 2025-28 Delivery Plan which the partnership is now taking forward



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Independent Scrutineer Yearly Summary

I had the pleasure of taking up the role of Independent Scrutineer for WSCP in July 2025 following the departure of the previous long established postholder, Stuart Smith. I joined a supportive and collaborative partnership, with well-established working relationships and robust governance processes.

Building on the baseline assessment completed by Stuart, I have continued to evaluate the partnership using [the six steps to effective scrutiny framework](#) and plan to undertake a refreshed assessment using the latest The Association of Safeguarding Partners (TASP) tool. The Lead and Delegated Safeguarding Partners remain open to challenge, learning and continuous improvement, demonstrating a shared commitment to delivering the best outcomes for children, young people and families across the district.

The [new 2025-28 WSCP Delivery Plan](#) provides clear focus through five key priorities, with strong progress already evident. I have attended the majority of partnership and subgroup meetings, all of which are well attended, supported by effective governance, high-quality documentation and robust action tracking arrangements that provide assurance of continued progress and accountability.

I have attended the majority of the WSCP Meetings, including subgroups:

- Statutory Lead Officer Group
- Safeguarding Partnership Executive (SPE)
- Safeguarding Executive Group – providing Chair role for this group (SEG)
- Multi Agency Child Exploitation (MACE)
- Child Safeguarding Practice Review Group (CSPRG)
- Learning and Development (L&D)

Performance, Practice Oversight and Learning

Performance, practice improvement and learning remain key strengths across the partnership. The Safeguarding Effectiveness Group provides effective oversight of audit activity and has strengthened its multi-agency audit approach, ensuring future activity is intelligence-led and informed by partnership data. I have been assured by the quality and transparency of data, intelligence and management information shared across the partnership. This supports effective challenge and promotes continuous improvement. Examples include significant improvements in Return Home Interview completion rates and timeliness following partnership scrutiny, together with ongoing work to further embed the Neglect Toolkit through targeted training and practitioner support.

Independent Scrutineer Challenge

Through my biannual reports to the Safeguarding Partnership Executive, I have highlighted areas for consideration and monitored progress against identified actions. Whilst these were not areas of significant concern, they were issues that I felt SPE and the Statutory Lead Officers should be made aware of. Some examples were:

- No named GP Safeguarding Lead and ICB officers representing GPs at safeguarding reviews
- Resources available to ensure timely completion of Initial Health Assessments for Children In Care was in place
- Increased missing from home episodes, including those that are excluded, not in education or electively home educated
- Reduction in Makesafe Operations

Children missing from home and care

Data highlighted that return home interviews (RHI) were identified as low, as was timescales for completion when they were being completed. Following challenge and discussions at various WSCP meetings, it was agreed that targeted work was needed to ensure children missing were safeguarded and supported. This has led to significant improvement in the number of RHI being undertaken, as well as the timescales for these being completed.

Children experiencing neglect

Single agency audit highlighted that the Neglect Toolkit that was developed last year could still be better embedded into practice, with usage not being as consistent as it could be. To improve knowledge of the toolkit and thus increase confidence in utilising it more, bitesize training is being used and encouraged. It is positive that all matters raised have either been resolved or continue to progress appropriately, providing assurance that the partnership responds effectively to challenge and maintains focus on improvement.

Independent Scrutineer Assurance Work

Children Vulnerable to Exploitation

At the request of the Statutory Lead Officers, I undertook an assurance review of arrangements to safeguard children vulnerable to exploitation. The review identified many areas of effective practice, providing assurance that children assessed as being at risk receive timely support and intervention. Staff across agencies demonstrated strong knowledge of the children and families they work with, alongside a clear understanding of local communities and contextual safeguarding.

The review found that children assessed as medium or high-risk, benefit from dedicated social work and exploitation support, alongside effective oversight through established risk management processes. Opportunities were identified to strengthen support for children with emerging vulnerabilities, and encouragingly, the recently established Risk Outside the Home (ROTH) Group has already begun developing solutions to improve awareness and access to available services. The openness, honesty and engagement shown by staff throughout the review was particularly reassuring.

Multi-Agency Child Protection Teams

My involvement as an observer member of the Multi-Agency Child Protection Group has provided insight into the development of new arrangements under the Family First Programme. The collaborative approach, openness to challenge and considered pace of implementation demonstrate a strong commitment from statutory partners to achieving sustainable and effective system reform. Plans remain on track for implementation in November 2026.

Future Approach

As the partnership continues to mature, I have proposed a more thematic approach to scrutiny during my second year in role. This will enable greater focus on specific areas identified through data, intelligence and audit activity, while increasing direct engagement with practitioners across the partnership. This approach will strengthen assurance arrangements, enhance visibility of the Independent Scrutineer role and support continued learning and improvement across WSCP.

Suzy Joyner
WSCP Independent Scrutineer



Suzy Joyner

Independent Scrutineer

Executive

Function of the Executive

Has strategic oversight for all the work WSCP undertakes, having responsibility for driving the business and the development of the partnership forward through a delivery plan, ensuring compliance in having effective multi-agency safeguarding arrangements in place.

Key Areas of Development

What impact has this made?



1

Development of a new 2025-28 Delivery Plan



1.1

In November 2025, WSCP published its new **3-year Delivery Plan**. Along with responding to any emerging areas, the partnership has committed to focusing on the following five priorities:

- Educational neglect is identified and responded to effectively
- Children who are victims of domestic abuse receive effective support
- Risk posed outside of the home are well understood, identified and responded to effectively, with particular focus on child exploitation and online harm
- Strong arrangements are in place to identify, recognise, respond, protect and support children who are victims of intra familial child sexual abuse
- Children on the cusp of adulthood who require continued support in relation to their risk and vulnerability, experience good transition to services who support adults

1.2

Given the plan is in its infancy, progress has been positive. Between November 2025 through to March 2026 work undertaken has included:

- Strengthening the identification and response to educational neglect through a multi-agency strategy, improved guidance, workforce training and planned quality assurance activity
- Establishment of the Integrated Domestic Abuse Response Team (IDART), in January 2026 to provide coordinated support for children as victims of domestic abuse in their own right
- Significant activity is taking place to strengthen responses to child exploitation, online harm and other contextual safeguarding risks. This includes enhanced multi-agency working, disruption of perpetrators, workforce development, improved intelligence sharing, and greater support for children and families at the earliest stage of risk
- Improving awareness, identification and responses to intra-familial child sexual abuse through multi-agency audits, specialist training and strengthened safeguarding processes. A key focus is building practitioner confidence, supporting early identification, and ensuring children receive effective, trauma-informed support
- A new multi-agency strategic group is being established to strengthen safeguarding transition arrangements, promoting preparation for adulthood, and improve outcomes for vulnerable young people as they enter adulthood

2

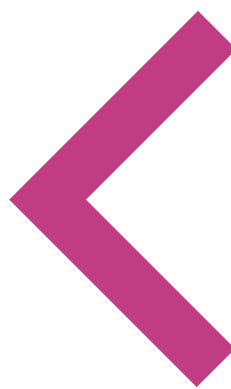
Oversee the implementation of the Families First Partnership (FFP) Programme

2.1

WSCP has overseen the progress of the FFP programme, which is on track for implementation by the end of 2026. The reforms have focussed on three core elements, along with system developments to enable the new ways of working:

- Create a new Multi-Agency Child Protection Team (MACPT)
- Introduce a new model of Family Help
- Establish Family Group Networks

Key Areas of Development



What impact has this made?



3

Continued to produce a multi-agency safeguarding data set which provides an overview of the vital signs of the child safeguarding system, generating analysis, and informing action for system and practice development

3.1

To help enable the Executive to determine if the safeguarding system is working well and to identify any issues at an early stage, the Partnership receives a performance report with a range of key performance indicators (KPIs) some of which have targets linked to them. An analysis from each report is presented highlighting where targets have been achieved evidencing good performance, where there has been a change in data compared with previous months and any targets that have not been achieved against KPIs. Following discussion of performance, the Safeguarding Effectiveness Group is tasked to consider further action. Below is a summary of performance seen in 2025-2026.

A high level of performance was sustained or improved across a range of KPIs with targets consistently achieved throughout the year:

- Percentage of contacts not meeting the threshold for Children’s Social Care remained below the maximum target
- The monthly volume of referrals to Children’s Social Care remained below the maximum target
- Timeliness of referral decision making within the Integrated Front Door met the required standard

For the following KPIs, improved performance was evidenced during the year compared with the previous year:

- Initial Child Protection Conferences held in timescale

For the following KPIs there was generally good performance although the target was not achieved every month and for some performance fluctuated:

- Engagement of children and young people in return home interviews
- Re-referrals to Children’s Social Care
- Completion of Section 47 Investigations within timescale

For some indicators where targets have not been set, trend information is reviewed to identify areas for improvement and detail, a summary is found below:

- The number of children waiting for core Child and Adolescent Mental Health Services (CAMHS) assessment and core group support has remained low throughout the year with very few children waiting over 12 weeks. There have been higher numbers of children waiting for CAMHS core individual support
- The number of children identified at medium and high risk of Child Exploitation for periods exceeding 3 and 5 months has increased during the year

As part of the scrutiny of performance, partners were able to describe the reasons for improvements and areas to further strengthen in performance, and what action was being taken to address this to provide reassurance to the Executive.

KEY STEPS for 2026-27

- Oversee the completion of the FFP Programme locally, assessing its impact through the year prior to it needing to be statutorily in place by the end of March 2027
- Implement the new Statutory Information Sharing Duty
- Locally manage the raft of national legislative and statutory guidance changes affecting child safeguarding systems and practice
- Engage as requested with the national inquiry into Group-Based Child Sexual Exploitation, whilst simultaneously overseeing the implementation of the findings from local review and audit work on child exploitation

Function of the CSPRG

Considers serious safeguarding incidents concerning children where abuse and/or neglect has been suspected to have caused or contributed to the incident, with a view to undertaking reviews to identify multi-agency learning to develop safeguarding systems and practice.

Key Areas of Development

What impact has this made?



1

Undertaken four safeguarding reviews (two learning circles and two rapid reviews) concerning respective children, to identify learning for multi-agency systems and practice

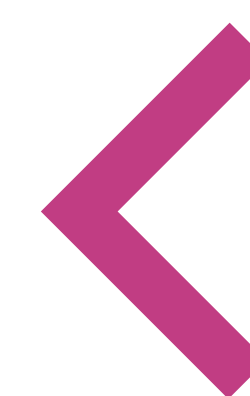
1.1

The findings from the reviews identified specific learning for services along with wider action the partnership needs to take which is being implemented by WSSCP through its sub-grupos. Some of the actions remain in progress, with some being implemented. In summary these include:

- Services to ensure they engage with GPs so information can be provided in respect of ongoing support, information for ongoing assessment, planning and intervention(ongoing)
- South West Yorkshire Partnership Foundation Trust(SWYFPT) to report to WSSCP on the progress made in respect of suicide prevention work being undertaken by the Trust (ongoing)
- Review guidance in respect of red marks and infliction concerning babies(ongoing)
- Explore documentation of marks and buruses within Emergency Departments(ongoing)
- Use the findings of a review to highlight what strong professional curiosity and challenge looks like when managing complex safeguarding need/implemented)
- Use the findings of a review to help inform ongoing modelling of Family Help (implemented)
- Developing cross-border guidance on best practice in working with children whose parents and carers take them to visit areas out of area (ongoing)
- Assessments and safety planning, where applicable, reflect long distance environments a child may be in an outside of their home (ongoing)
- Where domestic abuse and/or physical violence is a known risk factor, ensure any physical injury a child has is viewed through a safeguarding lens (ongoing)
- Strengthen discharge information between maternity and the 0-19 service to share safeguarding concerns (ongoing)
- Ensure within records is clear as to who has parental and caring responsibility for a child (ongoing)
- Where no further police action is taken, consider where additional problem-solving occurrences could be applied from the early help hub and welfare visits (implemented)
- Where child is not present when a domestic incident is attended to, is recorded as not present rather than there are no children (implemented)
- The where the submission of evidence is required from a victim who is a child, consideration of the child's age and vulnerability to be taken into account for the primary contact to be their parent rather than themselves (ongoing)
- When a child attends the emergency department due to a suspected attempt to take their own life, follow up is undertaken with Children's Social Care / CAMHS (ongoing)



Key Areas of Development



What impact has this made?



2

Completed the implementation of the recommendations from 2 action plans generated from previous safeguarding reviews

2.1

In addition to the learning implemented from the review undertaken as listed above, further system and practice development has been achieved as a result of the completion of actions from previous safeguarding reviews which took place prior to this year, this includes:

- Ensure workforces are aware of the [professional disagreement guidance and procedure](#) as a means to challenge decisions where there is disagreement
- Remind workforces to include Vico Homes in any multi-agency assessment, planning and intervention, given they can be well placed to support services in gaining engagement with a family
- Where domestic abuse between parents is present within a household, the lived experience of the children is understood effectively, and parent(s) who are perpetrating the abuse are appropriately engaged
- When offers of non-statutory support is not consented to or consent is withdrawn by parents, ensure any risks posed to the children are reassessed
- SWYPFT to provide an update in 6-months to WSCP on the progress made in respect of further embedding a think family approach
- The role of Forensic CAMHS is promoted with staff across the partnership, along with multi-agency resources on understanding sexual behaviour
- [Professional curiosity and challenge resources on the WSCP website](#) are promoted with staff across the partnership



KEY STEPS for 2026-27

- Maintain the oversight of learning identified from safeguarding practice reviews and ensure recommendations are implemented across safeguarding systems and practices
- Continue to respond accordingly to national safeguarding reviews and identify where local action is best placed to be undertaken from within
- Embed locally the recent published Child Safeguarding Practice Review Panel's (National Panel) website and resource repository as part of WSCP workforce development

Function of CDOP		
Considers all child deaths in the district, reviewing information to analyse the circumstances, confirm cause of death, determine any contributing factors and identify learning arising which may prevent future child deaths.		
Key Areas of Development		What impact has this made?
1 Maintained a well-established CDOP	1.1	12 deaths of children (deaths occurred between 2021 to 2023) within the district were reviewed, with all 12 reviews being completed across four respective CDOP meetings. Of the 12 reviews which were closed (deaths occurred between 2021 to 2023), eight (67%) had one or more modifiable factors identified (deaths can have multiple modifiable factors). These included: • Parental Drug Use (3) • Parental Smoking (4) • Parent alcohol misuse (2) • Non-recent domestic abuse (2) • Concealed, unmonitored pregnancy, baby delivered outside of hospital setting, non-engagement with maternity services (1) • Unsafe sleeping practices (1) • Domestic Abuse (not historical) (2) • Neglect of children (1) • Maternal high BMI (obesity) (2) • Preventable fall from height due to equipment failure (industrial accident) (1) • Damp and mould at family home (1)
	1.2	Of the 12 reviews completed, 6 were unexpected (Sudden Unexpected Death in Childhood) and all the categories were: • Perinatal / neonatal event (5) • Chromosomal, genetic, and congenital anomalies (2) • Sudden unexpected, unexplained death (2) • Chronic Medical Condition (1) • Malignancy (1) • Trauma and other external factors including medical / surgery (1)
	1.3	Identifying modifiable factors from a breadth of cases has enabled developments to be undertaken which is informed by need. Throughout the reporting year, CDOP undertook specific developments, which included recurring water safety and safer sleep campaigns respectively.
	1.4	The median number of days between a child’s death and CDOP review is currently 955, although this is a significant numerical increase from 551 in 2024/25, 565 in 2023/24, and 555 in 2022/23, this was anticipated given there were a number of deaths which occurred in 2021 and 2022 which required Health & Safety Executive and police investigations respectively. When discounting those reviews, the median average is in line with previous years and in 2026-27 the average figure to revert to this. The national average, which has increased slightly to 435 days (from 411 in 2024/25). Wakefield CDOP continues to review five cases per meeting, prioritised by date order where possible. However, some cases—such as one dating back to 2022—remain open longer as they cannot proceed to review until all investigations are complete. As a result, factors beyond local control can delay reviews.

Key Areas of Development	What impact has this made?
2 Using findings from CDOP to inform future development, key campaigns and awareness	2.1 The focus on water safety has continued throughout the reporting year, with regular promotion of safety information and awareness raising on the dangers of children entering open water. Given the pattern the district was experiencing in deaths occurring of children each year between 2019 – 2022, it is pleasing to report there have been no further open water related deaths of children since the launch of the Be Water Wise campaign and supporting resources available on the WSCP Water Safety Page. Given the prevalence of deaths sadly in other parts of West Yorkshire, the resources have been made available for neighbouring areas to use. 2.2 During the reporting year the CDOP reviewed a number of deaths, which resulted in direct action being taken outside of the meeting to improve outcomes for future children and families who may experience similar circumstances. This included: • Reviewing the death of a child resulting from an industrial incident, which took place outside of the district, linked to equipment failure. A full investigation was undertaken by HSE, which led to a national safety alert being issued. Following discussion at CDOP, the alert was shared with Wakefield Council's Health and Safety team for local dissemination. It was subsequently confirmed that the equipment involved is not used within the Wakefield district • Reviewing the death of a child whose family had recently moved to the UK, had no recourse to public funds, and were living in poverty. Their circumstances were compounded by NHS medical charges. CDOP heard that the Child Death Lead Nurse and Health Visitor worked closely with colleagues to advocate on the family's behalf and successfully secured the removal of these charges. Their dedication had a significant positive impact, and CDOP acknowledged the high standard of care provided to the family during a time of considerable need • A child tragically died following a collision while riding a moped. Although this case has not yet been reviewed by The Panel, it highlighted the urgent need to share safety advice across the partnership to help prevent similar incidents. In response, WSCP launched a targeted children's road safety campaign to raise awareness among parents and carers of the risks and legal responsibilities associated with mopeds and e-scooters • Receiving confirmation from the National Child Mortality Database (NCMD) that the Office for Product Safety and Standards (OPSS) had issued a product safety alert regarding baby sleep pillows. Thanks, were formally expressed to all those who reported relevant cases to NCMD, as this information was shared with OPSS through regular meetings and directly contributed to this action. In Wakefield's 2023/24 reviews, sleeping equipment, including pillows, had been identified as a risk factor in previous child deaths 2.3 This year's CDOP Development Day, hosted by Wakefield, took place in September 2025 and was attended by colleagues from Calderdale, Kirklees, and Wakefield. The session included: • Review of Pan-CDOP successes against the 2024/25 priority areas • Review of the 2024/25 CDOP Annual Report, collated and produced by Wakefield • Input from the West Yorkshire Eastern Coroner's Service on their roles and responsibilities, the role of Medical Examiners, processes following a SUDIC, the purpose of inquests, and prevention of future deaths • Input from the NCMD on defining modifiable factors and ensuring consistency in determining modifiability

Wakefield Safeguarding Children Partnership Introduction Partnership Structure & Governance Progress made in 2025-26 Independent Scrutineer Yearly Summary Executive Child Safeguarding Practice Review Group (CSPRG) Child Death Overview Panel (CDOP) Multi-Agency Child Exploitation (MACE) Group Strategic and Delivery Learning & Development (L&D) Groups Safeguarding Effectiveness Group (SEG) Safeguarding Advisor for Education Communication and Engagement Key Areas of Focus for 2026-27	3.3 Positive partnership working was evident, particularly between Police, Children’s Social Care and the Youth Justice Service, demonstrating a commitment to safeguarding children at risk of exploitation. 3.4 Areas for development included strengthening multi-agency ownership of disruption activity, improving recording and evaluation of impact, increasing involvement from health, education, housing and GP services, and enhancing workforce understanding of disruption approaches. 3.5 The audit also highlighted the need to address victim-blaming language, strengthen trauma-informed and perpetrator-focused practice, and improve oversight of disproportionality and outcomes for children. 3.6 Overall, the audit concluded that while strong foundations are in place, a more consistent, partnership-wide approach to disruption would further enhance the arrangements. 4 Delivered a series of bite sized multi-agency Learning Exchange offers in respect of different types and areas associated with exploitation 4.1 This is the second year of a series of Learning Exchange events which have formed part of the multi-agency child exploitation offer. All recorded learning exchanges can be accessed through the Speak Up! Stand Up! Stop Exploitation section of the WSCP Knowledge Hub. 4.2 Collectively the sessions saw over 210 practitioners access the learning, and evaluation from the sessions showed: - Disrupting Child Exploitation was given an overall average score of 92% for the session, 98% said it met expectations with positive feedback for the case studies and lived experience sections as well as the array of excellent speakers in the session - Drug Awareness received very positive feedback from practitioners across education, health, police, youth justice and children's services, with participants reporting a significant increase in knowledge, rising from an average of 5.5/10 before the session to 8.8/10 afterwards. The event strengthened practitioner confidence in identifying signs of drug use and exploitation, promoted greater awareness of local drug trends, and supported professionals to improve safeguarding practice, information sharing and early intervention with children, young people and families - Tackling Child Exploitation was highly rated by practitioners from across education, health, police, social care, housing, probation, youth services and the voluntary sector, with participants praising the quality of speakers, practical learning, and opportunities for multi-agency networking and collaboration. The event increased awareness of exploitation risks, referral pathways and intelligence-sharing processes, with attendees reporting greater confidence in identifying concerns, sharing information and supporting vulnerable children and young people. Participants identified a number of positive actions arising from the event, including cascading learning within their organisations, increased use of intelligence-sharing systems, strengthened safeguarding practice and improved partnership working to prevent, identify and disrupt child exploitation KEY STEPS for 2026-27 - Embed the recently published MACE and Contextual Safeguarding Strategy, adopting a reviewed performance framework with focused data set, and refreshed approach in how the MACE meetings operate - Implement findings of the Independent Scrutineer review and disruption audit respectively - Introduce a revised child exploitation quality assurance programme - Participate and support services in any requested involvement in the Gang-Based Child Exploitation National Inquiry - Continue with the schedule of bite-sized multi-agency Learning Exchange offers in respect of the different types and areas associated with child exploitation For individual evaluations for the sessions please see the breakdowns here.
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Function of the Strategic & Delivery L&D Group

Responsible for responding to the multi-agency safeguarding learning and development of needs of the children and families workforce by developing, coordinating and delivering learning opportunities such as multi-agency training, conferences, masterclasses and safeguarding resources.

Key Areas of Development

What impact has this made?



1

Delivered a wide range of multi-agency learning and development for the workforce across the partnership

1.1

Across the year, nearly 800 practitioners from the workforce across the partnership accessed a range of learning which included:

- Working Together to Safeguarding Children – A Shared Responsibility training
- Managing Allegations Against Those Who Work or Volunteer with Children training
- Multi-Agency Neglect training
- UK Safer Internet Centre Online Safety Live 2026
- Young Gamers and Gamblers Education Trust (YGAM) – Gaming and Gambling Harms training
- National Centre for Domestic Abuse (NCDV) – Civil Orders training
- Every Sleep is a Safer Sleep training
- Reducing Parental Conflict training
- Safeguarding Week Masterclass – Creating an Inclusive Environment
- Impact of Parental Illness on Children
- Supporting and Safeguarding Children who are LGBTQIA+
- Engaging with Men
- Child Exploitation Learning Exchanges on Disruption, Drug Awareness and Tackling Child Exploitation respectively

1.2

Evaluation feedback drew parallels with the previous year in reporting most attendees highly rated the quality and relevance of learning with over 90% of saying their skills and knowledge had improved because of the training they received.

Some of the more specific evaluation reports can be found on the links below:

- [Multi-Agency Neglect training 2025 evaluation](#)
- [Drug Awareness](#)
- [Tackling Child Exploitation](#)



Wakefield Safeguarding Children Partnership Introduction Partnership Structure & Governance Progress made in 2025-26 Independent Scrutineer Yearly Summary Executive Child Safeguarding Practice Review Group (CSPRG) Child Death Overview Panel (CDOP) Multi-Agency Child Exploitation (MACE) Group Strategic and Delivery Learning & Development (L&D) Groups Safeguarding Effectiveness Group (SEG) Safeguarding Advisor for Education Communication and Engagement Key Areas of Focus for 2026-27	Key Areas of Development What impact has this made?
2 Progressed the development of new multi-agency learning and development offers	2.1 Given the work undertaken in previous years in establishing and embedding multi-agency learning offers in respect of neglect, professional curiosity, child exploitation and safer sleep, during this reporting period focus was applied to broadening the wider offer. Learning offers developed this year, some of which continue to be in progress include: - Best Practice in Building Trusting Relationships within Children & Families: Following on from a workshop delivered by Research in Practise, a task and finish group was set up to disseminate the learning across multi agencies. WSCP developed a comprehensive resource which explores the basics of safeguarding relational practise, signposting to services, motivational interviewing and links to professional curiosity to support the work of the wider partnership - Engaging with Men: Following on from a multi-agency workshop delivered by Research in Practice, a task a finish group was set up to determine how to best disseminate the learning from the session. This task and finish group amalgamated with an existing group run by public health and has since developed bespoke face to face training which has been delivered throughout 2025/26 and a toolkit which is due to be launched Summer 2026 - Special Educational Needs and Disabilities (SEND) Toolkit: WSCP developed a single point of access on the website to include a suite of one-minute guides, resources, and a dedicated training offer ‘add on’ PowerPoint slides for single agencies to include in their own training. With the intention that safeguarding children with SEND is a golden thread throughout all training, the resource has been very well received and accessed over 400 times since launching in October 2025 - Practitioner Essentials: This mini-induction into the WSCP has been adapted from the previous years ‘New Starter Toolkit’ which WSCP recognised practitioners were not accessing enough. The resource was reviewed and rebranded and the partnership is in the process of making this a mandatory training offer for all services
3 Continued to publish a range of safeguarding resources including One-Minute Guides, 7-Point Briefings, videos providing easy to access information across a variety of safeguarding topics	3.1 Across the year, activity regarding the partnership’s learning resources has continued to progress strongly, in seeking to make safeguarding inclusive and accessible for all. 3.2 One Minutes Guides in 25/26 have been published on Complex Care Needs Team, Education, Health & Care Plans, Elective Home Education, Personal Budgets and Direct Payments, SENART, SENDIASS, Short Breaks, Wakefield Local Offer, WISENDSS. 3.3 7-Point Briefings have provided key headlines on three safeguarding reviews concerning a baby, an infant and a teenage child respectively. The key information detailed within the briefings enables findings in relation to learning to be disseminated to frontline practitioners in a more concise and proportionate manner as opposed to lengthy reports
KEY STEPS for 2026-27 - Continue to develop offers and resources of bite sized learning alongside face-to-face training, which are needs led and primarily informed by multi-agency quality assurance and safeguarding review activity - Implement ongoing learning offers in respect of Best Practice in Building Trusting Relationships within Children & Families and Engaging with Men - Review and updated the Multi-Agency Neglect Toolkit - Undertake impact evaluation of the Every Sleep is a Safer Sleep Training and implement its findings - Develop a partnership workforce development offer on Child Sexual Abuse within the Family Environment	

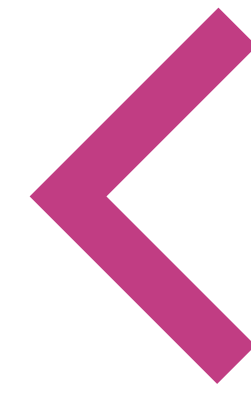
Function of the SEG		
Oversees the multi-agency effectiveness of the partnership and individual services work in relation to safeguarding children through data analysis, assurance activity and procedure.		
Key Areas of Development		What impact has this made?
1 Overseeing progress in strengthening arrangements in respect of child sexual abuse within the family environment	1.1	Through a task and finish group, the progress made to date in respect of child sexual abuse within the family environment includes: - Four multi-agency audit sessions reviewed 15 children’s cases, identifying both effective safeguarding practice and opportunities to further improve outcomes for children - Feedback from recent audit activity highlighted stronger partner engagement and a collaborative, reflective audit process that supports learning, challenge and continuous improvement - Joint Police and Children’s Social Care dip-sampling exercise was undertaken to strengthen responses to intra-familial child sexual abuse and address themes identified through audit activity
	1.2	In addition to system and practice improvement, Joint Targeted Area Inspection (JTAI) processes were developed and tested out as part of preparation, this included developing JTAI Inspection Preparation Terms of Reference, a case tracking process and guidance
2 Undertaken an audit on multi-agency responses to the early identification of neglect	2.1	The audit identified strong progress has been made in the take up and continued use of the neglect toolkit since it launched in 2022. However, it can be enhanced further by focusing on strengthening the promotion, use, and impact of neglect training and the Neglect Toolkit, alongside embedding a more coordinated partnership-wide approach through the Learning & Development Sub-Group.
3 Reviewed and updated several safeguarding procedures, protocols and guidance	3.1	The partnership has progressed the finalisation of the Child Abandonment Process , with agreement in principle subject to minor amendments, including clarifying expectations around parental contact and notification, and ensuring the guidance can be adapted across different organisational contexts.
	3.2	Multi-agency action has focused on strengthening information sharing between health services and GPs, including the introduction of a standardised pathway for identifying and flagging children at risk of exploitation, along with seeking to improve approaches to tasking and communication overseen by the Health Assurance and Improvement Group which continues to be an ongoing development.
	3.3	Learning from a multi-agency learning circle has driven the development of a coordinated bereavement pathway for children affected by sudden death and serious incidents, including those impacted by another child’s attempted suicide.
KEY STEPS for 2026-27		
- Continued assurance activity to include the current Child Sexual Abuse within the Family Environment and upcoming theme of Neglect (under 8s) for the next JTAI Inspection - Undertake the biennial Section 11 audit - Learning from reviews considered at CSPRG and the National Southport Inquiry will be used to inform future SEG action plans, ensuring emerging themes and risks are systematically identified, tracked, and addressed through partnership priorities		

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Function of the Safeguarding Advisor for Education

Provides safeguarding advice, support, and training to all schools and colleges in the Wakefield district.

Key Areas of Development



What impact has this made?



1

Maintained delivery of an extensive range of high-quality safeguarding education training in schools and colleges:

- **Safeguarding Basic Awareness Refresher – 42 schools**
- **Safer Working Practice – 50 schools**
- **Strategic Governor Training – 9 sessions**
- **Designated Safeguarding Lead (DSL) Training – 22 sessions**
- **Internal DSL Training for Local authority staff – 2 sessions**

1.1

Regular feedback of the training has been extremely positive, this has included ... “Valuable knowledge and insight into a complex and vital area of education, delivered in a safe environment to explore”... “Detailed and informative training with excellent opportunities to discuss cases and access high-quality resources” ... “Clear and well-structured training which significantly increased confidence and understanding of safeguarding procedures” ... “An incredibly comprehensive refresher course with practical strategies to implement in school”.

1.2

Post-training evaluations (3–6 months) indicate sustained impact, with respondents reporting tangible changes to policy, practice, and confidence levels:

- 93% of participants reported training as extremely useful to their role
- Increased confidence among DSLs and staff in managing complex safeguarding concerns
- Strengthened safeguarding policies and procedures within schools
- Greater integration of safeguarding into ongoing staff development (e.g. safeguarding briefings and quizzes)
- Improved quality and currency of online safety information shared with parents

2

Continued to deliver a wider safeguarding support offer for all schools and colleges in the districts, which includes standalone [safeguarding school and college section on the WSCP website](#), free to access safeguarding template policy, school and college safeguarding audit and key policy updates with a focus on Harmful Sexual Behaviour.

2.1

Schools and colleges accessed an updated safeguarding policy and templates ensuring consistency in the quality of guidance schools and colleges follow in respect of safeguarding children and local service information for Wakefield.

2.2

All schools and colleges in the district completed the school safeguarding audit. Schools commented on the value in being able to self-assess themselves against the audit, which draws from national and local guidance, to ensure they have all appropriate arrangements in place to safeguard children. Once submitted schools and colleges received feedback from the Safeguarding Education Advisor and appropriate guidance on how to develop areas requiring strengthening. Assurance has been further sought during the year in undertaking follow up visits with selected schools where evidence has been provided as to how they have self-assessed themselves against the compliance factors.

2.3

Delivered six half-termly DSL Forums, which continued to provide a range of safeguarding topic tops ups from local and national experts, including annual UK Safer Internet Centre session, NSPCC, Papyrus and Zarach bed poverty support. Followed by a DSL opinion form sent to all schools every half term which collects general themes of what’s working well and what can be improved.

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Key Areas of Focus for
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2.4

Delivered six face to face DSL peer support meetings for DSLs in secondary schools, colleges and independent schools in the district

2.5

Provided six peer support meetings for DSLs in secondary schools, colleges, and independent schools

2.6

Supported schools and colleges in multi-agency audit activity, and provided representation of education on WSCP sub-groups feeding back to schools via the DSL Forums to ensure two-way communication is effectively maintained

2.7

Involvement in multi-agency quality assurance and safeguarding review activity with direct feedback to schools and education settings where required, alongside representation at multi-agency sub-groups helping to ensure the link with the partnership and education is strong. Created a specific template for schools when contributing to safeguarding reviews which has led to better quality information and analysis being received

KEY STEPS for 2026-27

- **Continue to support schools in line with changing national and local guidance for education, including:**
 - Responding to legislation relating to serious crime and youth violence
 - Addressing emerging risks linked to artificial intelligence and social media use/restrictions
 - Supporting implementation of the Family First Partnership reforms
 - Continuing delivery of DSL forums, incorporating local and national expertise
 - Continuing delivery of internal courses to assist in understanding of roles and responsibilities across agencies.
 - Strengthening peer support networks across education settings
 - Maintaining high-quality training and safeguarding resources

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Communication and Engagement

WSCP has continued to effectively communicate the work the partnership undertakes. This year seen several key developments in the partnership’s communication and engagement

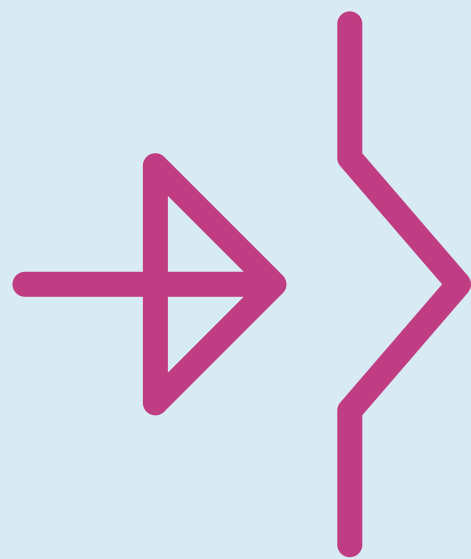


Overview of what has been achieved

During 2025/26 the [WSCP website](#) has continued to be the primary function as to how the partnership communicates all of the work it produces and where those who work or volunteer with children and families visit to access safeguarding children resource, training and information.

During the year a number of resource pages have been added, including:

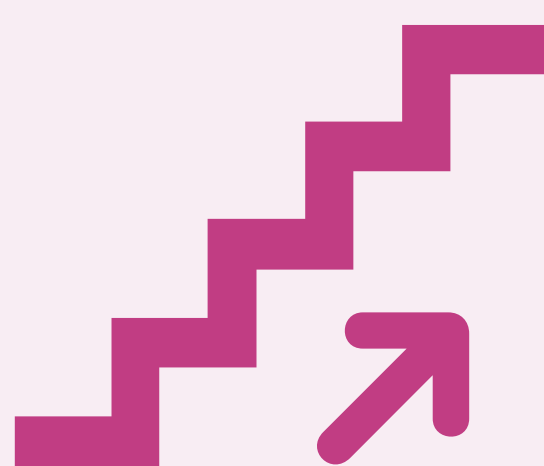
- [Emotional Abuse](#)
- [Bereavement Support](#)
- [Multi Agency Supervision](#)
- [Building Trusting Relationships](#)
- [Water Safety updates](#)
- [New Practitioner Essentials Toolkit](#)



The impact of the website

From the website analytics overall user engagement has remained strong. Below is a summary breakdown:

- There were 70,853 total amount of page views across the year, by 7,832 people, nearly 77% of those were returning visitors, with 23% being recorded as people who have first visited the site
- The home page (14%), knowledge hub training section (12%), section (11%), worried about a child (10%), neglect toolkit (8%) resources section (7%) and schools section (8%) were the top pages visited. The remaining 32% was in the main made up of visits to safeguarding topic pages which consisted of the Speak Up, Stand Up, Stop Exploitation, SEND Toolkit, Water Safety, One Minute Guides and Understanding Sexual Behaviours



Key steps for 2026-27

- Create new sections of the Speak Up, Stand Up, Stop Exploitation section on the WSCP Knowledge Hub for parents and carers
- Continue to review current content, with a view to continuing reindexing some sections and pages to ensure despite the volume of information, the website remains easy to access and navigate
- Create an Engaging with Men resource hub which will include a toolkit and launch as part of a campaign in 2026/27



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Overview of what has been achieved

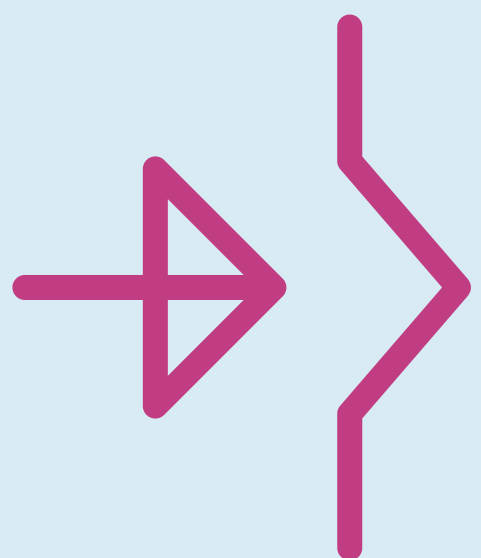
WSCP’s [free monthly e-bulletin](#) continues to be a key approach in communicating all the latest local and national safeguarding resources, training, information and developments to provide anybody who subscribes (currently - 1,486 subscribers which is an increase of 137 since last year).

In total 12 editions were produced and disseminated throughout the year on a monthly basis.

Subscriber lists were cleansed and all bounce back email addresses were removed to help ensure accuracy in being able to analyse how information is being received and engaged with, hence below there may appear to be reductions in subscriber rates by service area.

Subscriber breakdown by service area (with 2024/25 comparisons):

- Adult Services: 10 (11)
- Children and Young People Services: 268 (266)
- Early Years: 162 (153)
- Education: 564 (493)
- Fire Service: 1 (1)
- Health: 137 (103)
- Housing: 4 (4)
- Other: 254 (249)



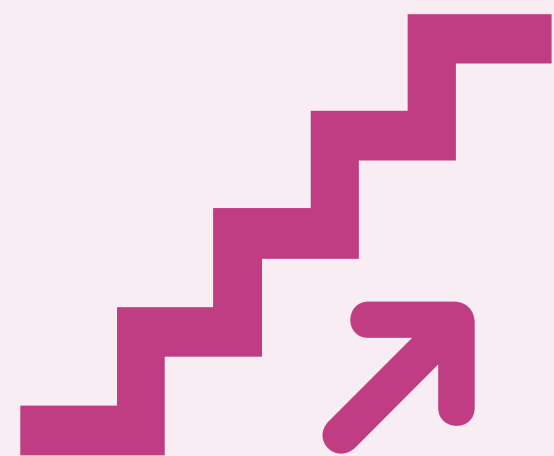
The impact of the e-bulletin

The e-bulletin continues to be a key component in how WSCP directly communicates to a wide audience. The steady increase and retention of subscribers month-on-month highlights how valuable the content is that is produced.

In October 2025 the partnership circulated a survey, seeking feedback on the ebulletin, the survey received a high level of response. Overall feedback continued to be positive with over 80% of the respondents reporting they found the content of the e-bulletin either very useful or useful. This feedback is consistent with the findings from 24/25. While feedback indicates that some editions can be lengthy and content-heavy, results confirm that subscribers regularly find articles of interest that support their practice

The e-bulletin consists of a range of information relevant to children’s safeguarding, health, and wellbeing, this can include:

- WSCP training opportunities and that of partner agencies relating to a range of safeguarding areas
- Policy and procedure updates & developments, both locally and nationally
- Child Safeguarding Practice Reviews along with key recommendations identified



Key steps for 2026-27

- Undertake a follow up survey in 26/27 with subscribers to ensure they are receiving the e-bulletin when it is disseminated, and enquire if there are any suggestions, they can make for what they would to see included/ways to improve it
- Continue to target service areas who have a low subscription rate to increase numbers
- Create a brief monthly video to accompany the ebulletin summarising the content of that month’s edition
- Re-share the ebulletin in the middle of the month to re-promote it, in case it was missed and overlooked when first released, with a view to further increasing readership

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Key Areas of Focus for
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- Police: 17 (15)
- Probation: 9 (9)
- Public Health: 15 (14)
- VCS: 34 (28)
- Youth Offending: 3 (3)
- Sports Clubs/Associations: 8 (new in 2025/26)

Most sectors have seen steady growth during 2025/26, with notable increases in Health and Education. A targeted email campaign to GP practices in 2025 contributed to higher sign-up rates in the Wakefield district. There has also been positive engagement from sports organisations. The “Other” category has grown slightly and may include subscribers from across various sectors who did not specify their service area.

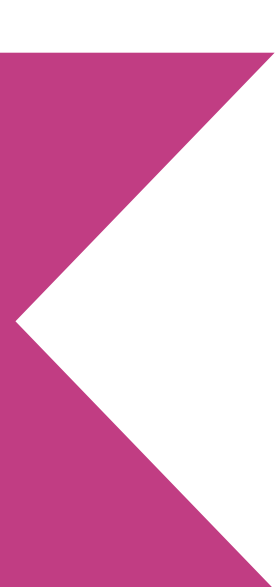
To subscribe to the e-bulletin and view previous editions, visit the [WSCP e-bulletin page](#) on the WSCP website.

- Safety advice and safeguarding campaigns such as water safety advice, online safety, safer sleep advice, button battery dangers, child exploitation and neglect
- Activities for children and families taking place within the local district.
- Mental Health support for children

In response to incidents of drowning of children in open water in the district in recent years, the ebulletin has committed to having a strong and consistent focus on water safety to constantly raise awareness. Between April 2024 – March 2025 water safety articles have featured in all but three editions highlighting key water safety messages specific to winter, summer and the home environment, and detailing what resources are available to share with children and young people.

A key feature of the e-bulletin is its ability to respond quickly to emerging safeguarding issues and share information across the partnership. For example, rising concerns around children’s use of mopeds and e-scooters were addressed promptly by sharing road safety advice through the e-bulletin, with a request for this to be passed on to children. WSCP also launched a targeted campaign on children’s road safety, aimed at helping parents and carers understand the risks and legal responsibilities associated with mopeds and e-scooters. This campaign was promoted via the e-bulletin.

The analytics for the e-bulletin averaged a reader rate of 27.8% for the year (42% year high in November), which despite how low this may initially be viewed, is classed as a good rate based on the gradings of the council’s corporate communication team.



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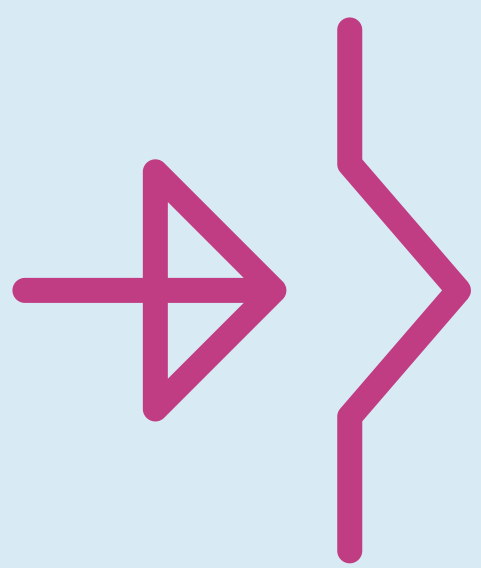
Overview of what has been achieved

WSCP’s X (formerly Twitter) account - [@Wakefield_scp](#) provides regular safeguarding children updates on local and national developments, resources, initiatives, policy, and guidance.

The account is nearing 630 followers (increase of 23 followers since last year) and continues to grow. Followers predominately consist of practitioners and services who work or volunteer with children and families. WSCP’s feed is used to provide important information such as updates to policies and procedures, promotion of learning events and links to new safeguarding information and resources.

WSCP’s Instagram account - [@_keepyamatesafe_](#) has continued to build a presence focusing on sharing awareness raising of safeguarding topics direct to children as part of the partnership’s campaign. It currently has 101 followers, which is a steady increase on last year’s figure.

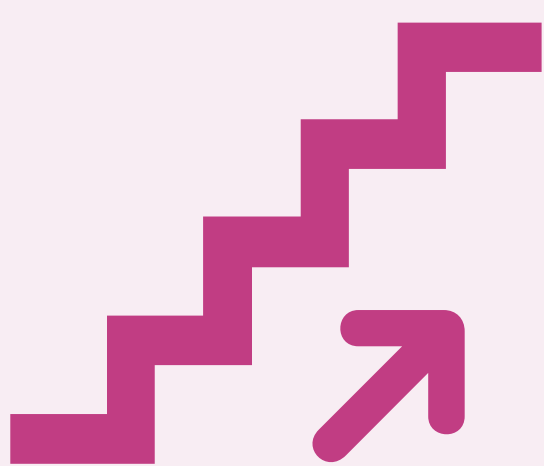
[WSCP LinkedIn account](#) has continued to grow this year. Followers have increased to 606 (increase of over 400). Similarly to X, LinkedIn has provided an additional medium to share information directly with those who work or volunteer with children and families.



The impact of social media

Changes to the way in which analytics can be accessed on X and Instagram have limited the information which can be understood given there is a requirement to have paid accounts. Highlights of the posts made have included:

- Children’s Mental Health Week
- Promotion of a range of multi-agency learning and development offers, such as the suite of child exploitation learning exchanges and Safeguarding Week 2025
- Water Safety and Drowning Prevention Week
- Safer Sleep Week
- Online Safety
- Keeping Your Child Safe in Sport Week
- Child accident prevention information
- Launch of new resources and campaigns such as SEND Toolkit and Practitioner Essentials pages
- Monthly e-bulletins



Key steps for 2026-27

- Continue to establish WSCP presence on existing social media platforms
- Continue to consider establishing a presence on other social media platforms to extend reach to members of the public
- Explore new approaches in creating online content which is interactive to highlight the work WSCP does and awareness on safeguarding topics

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Key Areas of Focus for 2026-27

Key Areas of Focus for 2026-27

The partnership has continued to make significant progress across a range of multi-agency safeguarding areas. Alongside the next steps already identified throughout this report under respective groups and areas, the partnership’s new delivery plan will provide the key areas of focus for 2026-27:

- Educational neglect is identified and responded to effectively
- Children who are victims of domestic abuse receive effective support
- Risks posed outside of the home are well understood, identified and responded to effectively
- Strong arrangements are in place to protect and support children who are victims of intra familial child sexual abuse
- Children on the cusp of adulthood who require continued support in relation to their risk and vulnerability, experience good transition to services who support adults

In addition to these local priorities, WSCP will oversee the local responses and implementation of national reform work concerning safeguarding children along with responding to any matters related to the ongoing Group / Gang-based Child Sexual Exploitation National Inquiry and be led by the voice of children and their families in further shaping the work of the partnership.

