Medway Safeguarding Children Partnership

Safeguarding Medway's children together

Medway Safeguarding Children Partnership

Annual Report of 2025-2026

Kent Police

Medway Council

Serving You

NHS

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Foreword

We are pleased to present the annual report of the Medway Safeguarding Children Partnership (MSCP) that provides an overview of the multi-agency safeguarding activity from April 2025 to March 2026.

Our goal, through the effective multi-agency working of the MSCP, is that all children living, cared for and spending time in Medway are safe, protected and thriving, free from harm, abuse, exploitation and neglect where they are.

Our purpose is to create a cohesive, child-centred approach that enhances multi-agency working, professional practice and community involvement in the MSCP, to safeguard children in Medway.

The annual report sets out the structure of the Medway multi-agency safeguarding arrangements, along with key decisions made by Lead and Delegated Safeguarding Partners in 2025-2026.

In line with our child-centred approaches the report sets out the ways in which safeguarding partners have sought and utilised feedback from children and families, along with evidence of how this has influenced service provision.

The report also provides an assessment of our work over the last year including themes from emanating from reviews, multi-agency audits and preparations for joint targeted areas inspections as well as progress against the priority themes in our strategy plan. The report also reflects on areas where further progress is needed and to be prioritised in 2026-2027.

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Chief Executive
Medway Council

Adam Doyle
Chief Executive
Kent and Medway ICB

Tim Smith
Chief Constable
Kent Police

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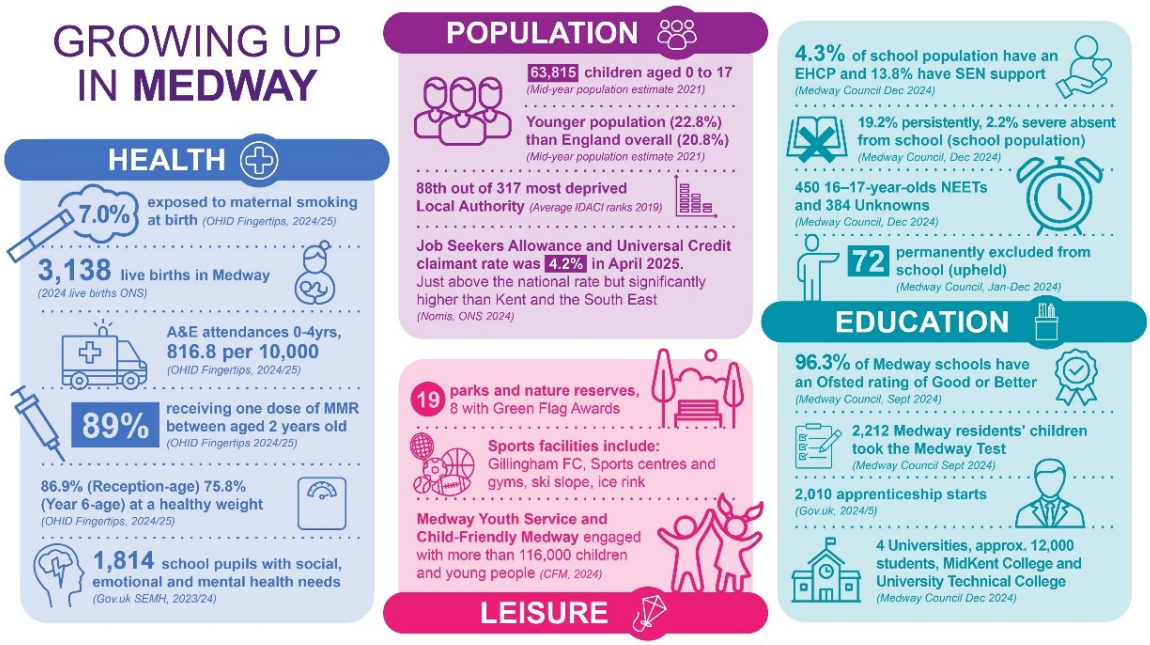
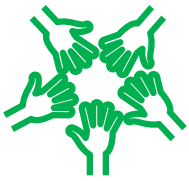
Section One – About Medway Children and Families

Medway is set around the river Medway within the Thames Gateway Growth Area. There are 5 main towns in the area: Chatham, Gillingham, Rochester, Strood and Rainham, as well as significant rural areas.

Between the last two censuses (held in 2011 and 2021), the population of Medway increased by 6.0%, from around 263,900 in 2011 to around 279,800 in 2021. The population increased by a smaller percentage than the overall population of the Southeast (7.5%), and by a smaller percentage than the overall population of England (up 6.6% since the 2011 Census) (ONS, 2023)

In 2021, 5.6% of Medway residents identified their ethnic group within the "Black, Black British, Black Welsh, Caribbean or African" category, up from 2.5% in 2011. In 2021, 84.3% of people in Medway identified their ethnic group within the "White" category (compared with 89.6% in 2011), while 5.9% identified their ethnic group within the "Asian, Asian British or Asian Welsh" category (compared with 5.2% the previous decade).





Section Two – The Partnership

Medway Council, Kent Police and NHS Kent and Medway (ICB) are the three safeguarding partners that make up the MSCP. The MSCP acknowledges the support from relevant agencies with their participation in groups, delivery of training and engagement with multi-agency audits and case reviews. A full list of relevant agencies can be found in Appendix One.

Strategic Leadership and Accountability

The Accountable Officer group is made up of the Lead Safeguarding Partners (LSP), as defined in Working Together to Safeguard Children from the statutory safeguarding partners. Accountable Officers have continued to meet twice yearly to review the performance and impact and shape the future direction of the partnership.

Accountable Officers chair the meetings on an annual rotational basis. There was a change of LSP for NHS Kent and Medway this year and the multi-agency safeguarding arrangements (MASA) were updated.

Each Accountable Officer has appointed a Delegated Safeguarding Partner (DSP) to work together to ensure oversight of the quality and compliance of the delivery of agreed purpose, goal and themes.

Delivering Multi-Agency Safeguarding Arrangements

The Executive group is made up of the three DSP's who share joint responsibility to ensure effective multi-agency safeguarding arrangements. DSPs chair the partnership on a yearly rotational basis. The Kent Police DSP changed this year and the MASA was updated.

Formal representation from primary and secondary head teacher forums at the Executive group has continued in 2025 – 2026 enabling schools to shape the safeguarding agenda and engage wider school leadership in the partnership. Post-16 education representation has also continued along with the children's services Assistant Director of Education further strengthening links with education partners. Public Health are also members recognising the population-level perspective on prevention, early intervention and wider determinates of health that impacts children's safety and wellbeing.

As set out in the MASA there is a structure of groups leading on the statutory requirements and shared priorities, reporting to and seeking feedback from the Executive group on their work and impact. These groups are chaired by the statutory safeguarding partners and made up of representatives from relevant agencies across the children's workforce in Medway.

Key Decisions
The Accountable Officer group has provided shared oversight and approval of the following documents and arrangements:

- strategic plan
- partnership structure
- updates to the MASA
- annual report
- 2025-2026 partnership resources and forward planning for equitable contributions
- secure estate safeguarding

The Executive group have made the following decisions:

- developed a revised partnership structure to support the strategic plan.
- approved the report for Local Child Safeguarding Practice Review (LSCPR), the Neglect Strategy, and the Contextual Safeguarding Strategy.
- reviewed learning from the Sara Shariff LCSPR alongside Medway LCSPRs and multi-agency audits; agreed to adopt two local recommendations and identified further assurance requirements from partnership groups.
- established a Joint Targeted Area Inspection (JTAI) preparation group, initially focused on child sexual abuse (CSA) in the family environment; commissioned a CSA audit, approved a supporting data project, and agreed the CSA strategic position statement.
- established a task and finish group to align threshold guidance with families first partnership programme delivery expectations.
- merged secure estate and safeguarding scrutiny roles to strengthen oversight across MSCP.
- move to a biannual Section 175/157 safeguarding audit for education settings, alternating with the Section 11 audit.

Key Relationships

The MSCP has a joint protocol for working with the Medway Health and Wellbeing Board, Kent and Medway Safeguarding Adult Board and the Medway Community Safety Partnership. DSPs and Executive group representatives are also members of key partnerships including Kent and Medway Domestic Abuse Partnership, and the Kent and Medway Prevent Board. The Executive agreed that the protocol should be reviewed and this will be a priority for 2026-2027.

Section Three – Scrutiny and Assurance

The MSCP is committed to ensuring that independent scrutiny provides assurance, through monitoring and challenge, in judging the effectiveness and quality of multi-agency arrangements to safeguard and promote the welfare of children in Medway including those children who reside within the secure estate at Oasis Restore.

Secure Estate Safeguarding – Oasis Restore

Oasis Restore is a secure 16–19 academy providing care and education for children deprived of their liberty. It aims to support children to address harmful behaviours, develop strengths and prepare for progression into education, training, employment or, where necessary, further custodial settings. During the reporting period, the establishment remained in the early stages of operation, with capacity not yet fully utilised.

Independent scrutiny of safeguarding within the secure estate has been maintained through established arrangements, including quarterly Secure Estate Safeguarding Assurance Group meetings, direct engagement with safeguarding leaders, and periodic site visits. During the year, I assumed the role of Chair of the Secure Estate Safeguarding Assurance Group, ensuring continuity of independent oversight following the retirement of the previous scrutineer.

Scrutiny activity has included ongoing liaison with key safeguarding leads, review of safeguarding data and incidents, and direct examination of practice, including the initial review of CCTV footage relating to restraint. This has enabled triangulation of assurance between partnership activity, internal reporting and external inspection findings.

During the reporting period, Oasis Restore was subject to an Ofsted inspection which identified significant weaknesses. All judgement areas were assessed as requiring improvement to be good, with the effectiveness of leaders and managers judged to be inadequate (June 2025). The partnership's scrutiny activity was consistent with, and reinforced by, these findings.

Several safeguarding concerns emerged over the course of the year, including ongoing issues with internal door security first identified in March 2025. Despite mitigating actions taken by leaders, these issues persisted and resulted in continued risks within the environment. A series of incidents further raised concerns regarding the capacity of the setting to safely manage risk and meet children's needs.

In June 2025, the Secure Estate Safeguarding Assurance Group undertook a focused review of restraint practice through CCTV analysis and reported findings to the provider and safeguarding partners. This work identified areas requiring improvement and contributed to the wider assessment of safeguarding effectiveness within the setting.

In July 2025, formal assurance was sought from the Chair of the Board in relation to the identified safeguarding concerns. Subsequently, in August 2025, a decision was jointly taken by Oasis Restore, the Youth Custody Service (YCS) and NHS England to decant all children from the setting. The establishment remains closed to children while required remedial works and service improvements are undertaken, including resolution of environmental risks and response to the findings of external inspection.

The decision to decant children represents a significant safeguarding intervention and demonstrates an appropriate prioritisation of children's safety. It also reflects the seriousness of the concerns identified and the limitations of mitigation within the existing arrangements.

From a scrutiny perspective, there is clear evidence that safeguarding risks were identified, escalated and acted upon, with appropriate involvement of statutory partners. The use of multiple sources of assurance, including direct observation of practice, strengthened the partnership's understanding of risk and supported timely escalation.

However, this period also highlights areas where further strengthening is required. In particular, there is a need to continue to develop the clarity of multi-agency accountability and ensure shared oversight arrangements provide early and robust challenge where risks emerge. It is essential that the partnership is able to clearly evidence the timeliness and effectiveness of escalation, and that governance arrangements across all involved organisations operate cohesively.

There is also a need to ensure that learning from this period is systematically captured and embedded. This includes strengthening understanding of the lived experience of children within the setting, the effectiveness of early identification of environmental and organisational risks, and the responsiveness of systems to emerging safeguarding concerns.

Looking forward, the partnership has identified a number of areas to strengthen safeguarding assurance when the setting reopens. These include enhanced safeguarding indicators, regular feedback from children facilitated through their home local authorities, and more routine audit of incidents, including continued use of CCTV review.

In summary, the events at Oasis Restore during this reporting period represent a significant safeguarding challenge. The partnership has demonstrated active, responsive scrutiny, and has taken appropriate action to protect children. The next phase must focus on embedding learning, strengthening accountability and ensuring that future arrangements provide consistently safe, effective and child-centred care.

Annual Review of Safeguarding and Restraint

The Independent Scrutineer and secure estate safeguarding assurance group oversee the annual review of restraint and production of a stand-alone report. Production of the 2025-2026 annual report is in progress and once approved

will be submitted to the Youth Justice Board, the Youth Custody Service, and His Majesty's Inspectorate of Prisons as per Working Together to Safeguard Children.

Independent Scrutiny: Multi-Agency Safeguarding Arrangements
This has been my first full year as Independent Scrutineer for the Medway Safeguarding Children Partnership (MSCP). Over this period, I have continued to observe a partnership that is committed, reflective and increasingly mature in its approach to multi-agency safeguarding.

The strengths of the partnership have continued to be built on. In particular:

- **Self-aware partners**: Partners are highly self-aware and can critically assess both their progress and the impact of their arrangements on multi-agency practice and outcomes for children. There is clear evidence of a partnership that is willing to reflect, learn and adapt.
- **Experienced and knowledgeable Executive Group**: The Executive Group demonstrates strong commitment to collaborative working, providing oversight of quality and compliance in delivering the partnership's priorities. There is a clear sense of shared responsibility and collective ownership.
- **Ambitious lead partners and a positive partnership culture**: The lead partners continue to demonstrate ambition for the partnership and for the children and families of Medway. This is reflected in a collegiate and constructive culture, which has remained strong despite wider system changes, including those relating to integrated care boards.
- **Clear strategic direction and partnership development**: The partnership has made good progress in establishing and communicating its revised strategic priorities and partnership structure. The development of the Executive Assurance Framework and the revised multi-agency safeguarding arrangements provides a stronger foundation for oversight, challenge and accountability.
- **Strengthening use of data and learning**: There is growing evidence of more structured use of data, audit and learning to inform improvement activity. The partnership is increasingly able to demonstrate how learning from reviews, audits and national developments is informing changes to policy, practice and service delivery.
- **Commitment to multi-agency collaboration and prevention**: The report evidence strong engagement across statutory, education, health and voluntary sector partners, alongside an increasing emphasis on prevention, early help and community-based safeguarding.
- **Commitment to child voice**: The partnership continues to demonstrate a clear commitment to hearing and responding to the voices of children and families. There is evidence of a broad range of mechanisms being used to capture children's experiences, including direct feedback through casework processes, participation events, school-based forums, and targeted engagement activity across police, health and community settings and the partnership has clear examples of how this feedback has informed service development and practice improvement, including changes to communication, engagement approaches and service

accessibility. The increasing integration of children's voice within audit activity and review processes is also a positive development.

- **Effective business unit**: The partnership benefits from a skilled partnership manager who leads an effective and pro-active team who are passionate about multi-agency safeguarding.

Alongside these strengths, and recognising the progress made, there are a number of areas where further development and focus are required to strengthen the partnership's effectiveness and impact.

A key area for development is the **clearer articulation of impact on children's outcomes**. While the report provides comprehensive evidence of activity, development and system change, it is less consistently able to demonstrate the measurable difference this is making to children lived experiences. The development and embedding of child-centred measures of success is therefore a critical next step.

Related to this, the partnership would benefit from **greater analytical rigour and evaluative clarity** in its reporting. There is increasing use of data and trend information; however, the analysis can at times be descriptive. Stronger evaluation, including clearer articulation of what is working well, what is less effective and why, will strengthen assurance and support more targeted improvement.

There is also a need to ensure **greater consistency in the level of professional challenge and self-assessment across the partnership**. While some areas, for example, the JTAI preparation group, demonstrate strong critical reflection, this is not yet consistent across all priority themes. A more balanced and systematic approach to identifying both strengths and areas for development will enhance the partnership's overall self-awareness.

The partnership has made progress in developing its performance and assurance arrangements; however, **the performance framework is not yet fully embedded**. Progress in some areas has been slower than anticipated, and further work is required to ensure that the framework provides timely, robust and outcome-focused oversight. This includes addressing **gaps in the completeness and consistency of multi-agency data**, where variability in partner contributions continues to limit the ability to evidence impact and identify variation in practice.

The report demonstrates positive work in engaging with diverse communities and recognising children's different experiences. However, there is scope to strengthen the partnership's **focus on inequality and disproportionality**, including more systematic analysis of how different groups of children experience safeguarding services and outcomes.

While there is growing evidence that children's views are being captured, there remains a need to strengthen the systematic collation, analysis, and use of this evidence to demonstrate impact at a strategic level. In particular, the partnership should continue to develop its ability to evidence how children's

lived experiences influence decision-making and lead to improved outcomes, ensuring that the child's voice remains central to both operational practice and strategic assurance.

The report is transparent in setting out financial contributions and pressures and notes an analysis of the potential implications and work in progress to address them to provide clarity on **financial sustainability and resourcing**, including how the partnership will ensure equitable and sustainable contributions from all partners going forward.

Area of Good Practice to Highlight

The JTAI working group has been tasked to develop inspection readiness at a strategic level and specifically in relation to Child Sexual Abuse in the Family Environment. The Executive commissioned scrutiny of the partnership's response to the recommendations of the National Review – I wanted them all to notice. This will include practitioner insights and will be reported in 2026/2027.

Section Four – Progress Against Priority Themes.

The partnership recognise that effective collaboration is a critical factor in identifying and responding effectively to all types of child abuse and harm. Also, how the quality of inter-agency practice impacts on outcomes for children and families. This, underpinned by a child-centred approach and recognising the role of communities in keeping children safe, has seen the emphasis of the strategic plan shift to shared responsibility, stronger partnership working, and consistent ways of operating across agencies.

Child-Centred Approaches (Executive Sponsor Kent Police)

Seeking and utilising feedback from children and families, how this informs work and service development.

Children's Services' practice development service has delivered an annual family feedback event for the past three years, with the latest in August 2025 contacting 100 families/carers and receiving 51 responses. Feedback is also gathered through end-of-work arrangements, children in care reviews, child protection conferences and audit activity.

Where concerns are identified, these are escalated to managers to address practice issues and undertake restorative work where appropriate; in some cases, this has resulted in additional provision for families. Key themes included unreturned calls/messages and limited engagement with fathers, which have been addressed through updated practice standards, regular communications and targeted training.

As feedback is often case-specific and less effective in evidencing overall impact, service managers will now collate and review themes across services through the service manager forum to inform improvement.

Public health and commissioned providers use a range of accessible and inclusive methods to gather feedback, including surveys, direct engagement, end-of-intervention measures, and ongoing informal feedback, ensuring approaches are child-friendly and accessible.

Feedback is systematically reviewed to identify themes and inform service development, quality assurance, and improvements to communication, referral processes, and accessibility. This has led to tangible improvements, including increased accessibility, enhanced engagement approaches, clearer information, and services better aligned to current needs and lived experience. Overall, feedback supports a culture of continuous improvement, ensuring services remain responsive and effective for children, young people, and families.

For school partners pupil voice has been sought through groups such as School Council and other pupil ambassador groups. Across Medway, schools

have promoted initiatives such as Child Friendly Medway, which have offered opportunities for child's voice to be heard.

Kent Police's Control Strategy places child-centred policing at the core of its response to vulnerability. In the past year, over 2,000 crimes involving child victims were recorded in Medway, alongside more than 16,000 safeguarding notifications to Kent and Medway local authorities, highlighting both demand and improved identification through enhanced risk assessment processes.

Children's voices are captured through initiatives such as the cadet programme, Violence Against Women and Girls (VAWG) engagement, Walk and Talk events and wider learning events such as Violence Reduction Unit (VRU) activity. These opportunities have enabled children to share their experiences and shape safeguarding and prevention work.

Feedback from these activities have informed planning and operational delivery, contributing to a more targeted and child-centred approach, including increased visibility in identified risk areas. Also strengthened police professional practice, reinforcing a focus on hearing the child's voice, promoting victim-centred approaches, and eliminating victim-blaming language, in line with inspection findings and ongoing improvement activity.

NHS Kent and Medway have gathered feedback from children and families through multiple routes this year, including child death review processes, audit activity, and wider engagement. Work to capture bereaved family experience has strengthened how family voice informs child death reviews and system improvements.

Child-centred audit and review activity has identified practice gaps and informed safeguarding action plans, with feedback shaping pathway development, including sexual abuse and Sexual Abuse Referral Centre (SARC) services, and ensuring governance is informed by lived experience as well as performance data.

Engagement with diverse groups, including kinship carers, unaccompanied asylum-seeking children, and community partners, alongside multi-agency workshops, has further strengthened how family voice informs service review, development and safeguarding improvement.

Responding to multi-agency audit and local reviews evidence of how children's voice and lived experience is sought, 'heard' and acted on has this year been included in the template for agency involvement for rapid reviews.

Strengthening Community Engagement in Children's Safeguarding (Executive Sponsor Medway Children's Services)

Championing Community Organisations

Public health recognises the vital role commissioned and delivered community-based services play in safeguarding by providing early identification of need and risk, beginning from the antenatal period, continuing through routine contact points. Commissioned and delivered services are expected to demonstrate robust safeguarding arrangements, including well-trained staff, designated safeguarding leads, and clear escalation pathways. Crucially, community services work collaboratively within a multi-agency framework, enabling coordinated responses and effective information sharing to protect and support children and families.

Work took place in 2025-2026 to successfully commission the Medway Therapeutic Alliance, led by the voluntary sector and bringing together a range of organisations to help families find the right mental health support for their child and importantly includes access to support through one clear pathway.

This year Medway Voluntary Action joined the Early Help Partnership Board to strengthen relationships with the voluntary and community sector in line with early help and prevention strategy system leadership for partnership working priority.

Build a well informed and proactive safeguarding community.

To support community organisations in their safeguarding role the MSCP makes the training programme accessible to voluntary, community and faith groups. This includes unlimited access to 60+ e-learning courses, virtual and in person training.

In 2025-2026 360+ e-learning courses were completed by those identifying as working in the voluntary, community and/or faith sector representing a 35% increase from 2024-2025. This represents 4% of completions across all sectors, comparable with 2024-2025.

This year the MSCP Training Lead delivered basic safeguarding children training to staff and volunteers at one of the local Mosque. As a result of the training participants reported being able to respond to children in a more informed way, clarity around where to report concerns, responsibility to raise awareness of safeguarding children and responding at the earliest opportunity.

A social media plan was delivered in line with the MSCP communication strategy and strategic plan which has driven increased reach and engagement as set out in Table 1.

Table 1 – social media platform performance

		Followers			Posts		
Platform	**Start date**	**24-25**	**25-26**	**Trend**	**24-25**	**25-26**	**Trend**
Twitter/X	October 2015	745	710	5% reduction	655	699	7% increase
LinkedIn	December 2023	195	365	88% increase	330	358	8.5% increase
YouTube	October 2022	14	33	135% increase	13	19	46% increase

The MSCP utilised national and local community campaigns to raise awareness of issues arising from local reviews and audits including:

- Child Accident Prevention Trust Child Safety Week (June 2025)
- Kent and Medway Domestic Abuse Partnership 16 Days of Action (November 2025)
- The Lullaby Trust Safer Sleeping Week (March 2026)

Police have supported campaigns promoting children's safety and wellbeing in Medway, including Your Police UK resources and targeted online content on risks such as exploitation, sexual messaging and image sharing.

Feedback from participation events has informed work on public space safety, school inputs and safeguarding responses, helping to better target prevention activity. The child-centred policing team increased community engagement across schools, early years and local events including a large-scale mental health event in February 2025 reaching over 1,000 children, providing opportunities to discuss online safety, wellbeing and support services.

In line with the strategic plan Kent Police have this year supported prevention campaigns, including 'Don't Leave Yourself Exposed' materials co-produced with young people, strengthening awareness of online harm and exploitation risks.

NHS Kent and Medway have strengthened safeguarding through partnership and community engagement, including leadership of the Families First Health Steering Group, work with primary care, community providers, kinship carers and services supporting vulnerable groups. Progress this year included increased health representation in partnership activity, and stronger links between safeguarding, primary care and community services. Targeted work on domestic abuse, including GP champion training and awareness campaigns, has further enhanced practice.

The impact has been greater health visibility within safeguarding arrangements, improved early identification and information sharing, and stronger alignment between health, local authority and partnership priorities, supporting more effective multi-agency responses to vulnerability.

Enhanced Multi-Agency Working and Communication (Executive Sponsor Primary and Secondary Head Teacher Representatives)

Consistent and effective handover and escalation of concerns.

A multi-agency task and finish group was established to review the threshold guidance. To strengthen practice expectations terminology was updated from 'level of need' to 'indicator of need' to avoid implying a hierarchy of support and services and reinforce responding to children's needs as they arise, rather than waiting for them to reach a defined 'level'. In addition to clearly connect the indicators of need with the child these were rewritten from the child's perspective i.e. I am not reaching my potential as I am not in education, employment or training.

Learning from previous physical abuse multi-agency audit the strengthening professional practice group agreed a piece of work to understand and establish consistent responses to incidents of 'smacking', applying thresholds, and assessing ongoing needs and risks. National reviews highlight similar issues identified locally, including professionals feeling unsupported to address 'smacking' and physical abuse, inconsistent use of local procedures, and limited understanding of the impact and associated risks for children and families. A practitioner survey was developed to inform the groups work and was completed by 156 practitioners across 11 agencies.

Findings included:

- commitment to hearing the child's voice and taking children seriously
- mix of views across and within agencies about what UK law says about smacking and what 'reasonable punishment' means (CA 2004).
- awareness of families requiring support and educative opportunities for managing unwanted behaviours and some knowledge on local services that could help
- variance of views about what action would be taken following a child reporting being 'smacked'

As a result, the group agreed to develop and issue a multi-agency physical abuse workforce guide, including video explainer and briefing that will be taken forward in 2026-2027.

Schools report that early help co-ordinators provide invaluable and prompt support including community early help advice to Designated Safeguarding Leads (DSLs) in early years and schools' settings for individual children and families. In addition, regular locality-based family hub partnership sessions have been provided throughout the year supporting efficient and proactive networking. Feedback from schools has included that they "get an in-depth knowledge of services in the local area, especially the new Medway Therapeutic Alliance" and "the sharing of information has allowed me to already consider some more targeted support we can offer families in need".

DSLs have access to a dedicated TEAMS channel provided the education safeguarding team for sharing key updates, documentation and training. The team have continued to provide individual and group supervision to three local authority schools, depending on need and preferences. This has been positively received by DSLs and their teams, reporting it is an effective offer, and is a service development priority to continue to work toward implementing a traded offer available to academies, free and independent schools.

Partners are well informed and there is a proactive safeguarding environment.

Establishing a centralised multi-agency data-sharing platform to facilitate real-time information exchange from practitioners through to senior leadership level forms part of the strategic plan. A single view of the child data project has been initiated this year as part of the Medway family first partnership programme.

At operational and strategic level partners have maintained a range of mechanisms to strengthen multi-agency working and communication between members to ensure seamless support for children. This has included representation and participation across statutory partners in domestic homicide reviews, Local Child Safeguarding Practice Reviews (LCSPRs), multi-agency case file audit, Multi-Agency Risk Assessment Conference (MARAC), PREVENT and Child Death Overview Panel.

Public health has attended the local safeguarding clinical network and has named domestic abuse, child sexual exploitation and PREVENT leads within the service to ensure priorities, lessons learnt, and recommendations are actioned and disseminated within the directorate. Examples of work informed by learning reviews in 2025-2026 include:

- framework and assessment pathway for obese and overweight children in Medway, developed with colleagues from safeguarding, health, and education.
- development of local harmful sexual behaviour multi-agency training

Children's services have established the strategic partnership practice manager as a permanent role this year to ensure a consistent point of representation for children's social care, support continuity, relationship-building and more effective follow-through across partnership activity. This has included seeking feedback from partners on children in need procedures following learning from multi-agency case audits and local reviews.

NHS Kent and Medway have provided health leadership and oversight across partnership groups, escalation routes, audits and assurance processes. They have also supported development of joint pathways, including the paediatric Sexual Assault Referral Centre (SARC) pathway, and used formal internal assurance reporting to align risks, actions and partnership priorities across safeguarding assurance and partnership working.

Progress over the year included clearer escalation processes, more structured partnership meetings, routine health input into Medway safeguarding activity, and practical work to improve information sharing through the MARAC hub, GP Child Protection-Information Sharing rollout, joint case audits, partnership benchmarking and development of communication plans for system leads and partnership workstreams.

The impact has been improved coordination between agencies, stronger health contribution to multi-agency decision making, better visibility of safeguarding risks, and clearer escalation where pathways or services were not working well enough for children. Supporting to improve the consistency of information-sharing and escalation through clearer multi-agency pathways and strengthened alignment across NHS-commissioned services and safeguarding partners.

Strong, collaborative relationships, enhancing safeguarding practice and collective impact.

The JTAI preparation group commissioned a multi-agency data project, using the Centre of Expertise on Child Sexual Abuse (CSA Centre) guide on improving data on child sexual abuse. The project included a data audit, highlighting variation across partners in how consistently CSA information is recorded in structured, reportable fields.

The group approved several recommendations aimed at strengthening the partnership's ability to produce child-level data, including children's services introducing a CSA identification question at contact and referral stage and developing a dedicated work step in the case recording system Mosaic. To transition the project to 'business as usual' the multi-agency performance assurance group will assume responsibility for implementation in 2026-2027.

For 2025–2026 the multi-agency performance assurance group's priorities were to align the dataset with revised priority themes and adopt a new framework for data review, analysis and reporting. Progress has been slower than anticipated, with further work required in 2026–2027. The group has introduced the 'alert, advise, assure, appreciate' framework, which now needs to be embedded into its workplan.

The group have continued to monitor and review multi-agency data to inform decisions as follows:

Professional Challenge and Escalation:

The group monitors the use of the policy, as set out in table 2, and reviews annually. As with last year, education partners raised the most escalations and children's service received the most escalations. In addition, as with last year the main reason for escalation was lack of action.

The group agreed timeliness of escalation responses must improve in 2026–2027 in line with policy. No escalations to or from police or health providers were recorded this year; these partners will ensure staff and managers are aware of and use the policy.

Table 2 – recorded use of escalation policy

Escalation Stage	2023-2024	2024-2025	2025-2026
Stage 1	1	5	13
Stage 2	5	11	12
Stage 3	1	3	0
Stage 4	0	0	0
TOTAL	*7*	*19*	*25*

Graded Care Profile 2 (GCP2) for neglect:
The GCP2 is the agreed partnership tool to assess and plan interventions for reducing neglect and training is funded by the MSCP. The group receives data on staff trained to use the tool and completed with families, as set out in table 3.

Table 3 – recorded use of GPC2 with families.

Year	No. of GCP2s completed
2023-2024	165
2024-2025	277
2025-2026	508

The rise in data this year was primarily the result of use by children's services. Due to the lack of data evidence from other partners the group have requested updated implementation plans and other evidence of use with families for assurance.

Response to MASH Requests
The timeliness of partner responses to information requests is tracked with police responses remaining consistent, along with the youth justice service achieving 100% each quarter. Response times by probation improved in 2025-2026 and education response dropping in the last 2 quarters.

Initial and Review Child Protection Conferences
The group receives data on multi-agency invitations, attendance and reporting to child protection conferences. It has been identified that there are aspects of the data which are not providing an accurate picture of performance or oversight of conference effectiveness and further work is needed.

In respect of individual partner development in November 2025, Police introduced a streamlined child protection referral process, making it easier for frontline staff to identify concerns and submit them to the Central Referral Unit (CRU). The revised question set reflects learning from safeguarding reviews, including consideration of consent, domestic abuse and exploitation, and supports improved staff confidence when engaging with children.

Initial audit findings show strong impact, with the new question set used in 88% of cases and information quality rated good or very good in 76% of reports. CRU decisions were consistently well recorded and assessed as appropriate in all cases. The process has improved integration with crime

recording systems, strengthened capture of the child's voice, and enhanced the quality and consistency of information shared with partners.

A revised Operation Encompass process was also introduced, enabling officers to notify schools directly to provide timely support for children affected by domestic abuse. Training and ongoing refreshers, informed by audit findings, have supported implementation.

Strengthened Professional Practice and Workforce (Executive Sponsor NHS Kent and Medway)

Culture of continuous improvement and excellence, ensuring consistently high standards of practice.

Kent and Medway Safeguarding Children's Partnerships have a joint policy and procedure group responsible for the development and review of local policies, procedures, and guidance.

The following were reviewed in 2025-2026:

Policy/Procedure	Review Trigger
Child exploitation identification tool	Workplan
Safeguarding children at risk of abuse through female genital mutilation (FGM)	Workplan
Pathway for child sexual abuse (CSA) medicals	Request from MSCP Executive
Pre-birth procedures	Workplan and learning from multi-agency audit.

Following an MSCP rapid review further assurance on the use of the child exploitation identification tool was sought from partners this year (see section six).

Feedback from partners has informed the development and review of children's social care policies and procedures this year, recognising that these are not developed in isolation but need to reflect the interdependent working relationships, responsibilities and expectations across the wider safeguarding partnership.

Highly skilled and confident workforce, capable of consistently delivering exceptional safeguarding services.

Kent Police has adopted the College of Policing definitions for child protection and exploitation, improving consistency in how cases are identified and allocated. This ensures specialist investigators focus on children at greatest risk and supports appropriate referral to Children's Social Care. Initial audit findings show 87% accuracy in applying the definition.

Safeguarding training, informed by practice reviews, has been delivered across multiple teams, covering areas such as risk assessment, neglect,

domestic abuse, and professional challenge. Over 3,000 staff received training in 2025/26, strengthening capability across the force.

Specialist training, including Triangle's Forensic Questioning of Children, has improved officers' ability to assess communication needs and make timely, proportionate decisions, reducing delays and enhancing safeguarding and evidential outcomes. Senior leaders have reinforced this through ongoing leadership and development activity.

NHS Kent and Medway have strengthened professional practice and workforce development through a continued focus on safeguarding training, supervision, policy, audit and reflective learning this year. Key activity included monitoring training compliance, enhancing supervision arrangements, and updating core policies such as managing allegations, domestic abuse, Prevent and the Mental Capacity Act. Audit and assurance processes have also been used to promote professional curiosity, accountability and continuous improvement.

Progress this year includes strong training compliance in key areas, improved supervision, more consistent central processes (including an allegations log and complaints procedure), and targeted work on training and contract compliance. Workforce risks, particularly GP capacity and the impact of organisational change, have been actively identified and escalated.

The impact has been stronger oversight and accountability, more consistent practice, and improved use of training, supervision and audit to identify gaps and drive improvement, alongside greater visibility and management of workforce pressures.

Section Six – Learning and Improvement

As set out in the strategic plan the MSCP fosters a culture of professional curiosity, accountability and continuous improvement. The MSCP has in place a Quality Assurance Framework which sets out how the MSCP monitors and evaluates the effectiveness of multi-agency work to safeguard children.

Section 11 (S11) Safeguarding Audits

Section 11 of the Children Act 2004 places a statutory duty on a range of agencies to ensure their functions and services are discharged in ways that both safeguard and promote the welfare of children. The MSCP works with the Kent Safeguarding Children Multi-Agency Partnership to deliver a biannual programme to audit agencies arrangements.

Work began in September 2025 review the audit tool and processes. Building on the outcomes from the last audit, which highlighted some strong areas of practice alongside areas for improvement and drawing on the learning and recommendations from both national and local reviews, across the audit process there will be greater opportunity to seek assurance regarding the use of practice tools and the implementation of learning from LCSPRs.

Section 175/157 Safeguarding Audits

Section 175 of the Education Act 2002 places a legal duty on schools and educational institutions to make arrangements to safeguard and promote the welfare of students.

In 2025-2026 108 education settings covering primary, secondary and alternative education provision in Medway were included in the audit, of which 102 (94%) submitted a fully completed audit.

Audit returns highlighted overall, the quality of safeguarding practice in Medway schools is good or better. A third of governing bodies demonstrated good or excellent scrutiny and challenge, demonstrating an understanding of their strategic responsibility.

Key areas of development from the audit included:

- provision of supervision for safeguarding teams
- more effective use of the professional challenge and escalation policy
- increased awareness and engagement with local training including GCP2
- recognising the impact of bias and discrimination on the reporting and management of safeguarding concerns

Rapid Reviews and Local Child Safeguarding Practice Reviews.

Rapid Reviews.

Rapid reviews are undertaken following the notification of a serious incident as follows:

Year	No. of Rapid Reviews
2025-26	1
2024-25	4
2023-24	3
2022-23	0
2021-22	2

This year's rapid review report was submitted by the deadline agreed with the national child safeguarding practice review panel. This review did not progress to an LCSPR, a local action plan was put in place.

Findings: Areas of Strengths and Improvements

Practice Theme	Strengths
Multi-agency working and communication and communication.	Effective information sharing & multi-agency collaboration*
	Follow up and escalation of child health assessment
Child-centred approach	Growing recognition of child's neurodiversity and adaptation of interventions
	Police protection used appropriately and where necessary
	Child seen face to face at all child and adolescent mental health appointments

Practice Theme	Improvements
Multi-agency working and communication and communication.	Challenges between handover of services
Child-centred approaches	Professional curiosity and child exploitation
	Proactively seeking the voice of the child and understanding their lived experience*

* Denote strengths or improvements identified in previous multi-agency audits and/or learning reviews.

The review also identified the impact of national, interconnecting issues for children who are looked after with complex care needs including the lack of therapeutic placements and multiple changes in placement.

The strengthening professional practice group has oversight of the action plan and at the last review 7 of 8 single agency actions completed and evidence provided and 8 of 9 multi-agency learning actions were completed and/or in progress.

Specific health-system actions, including reminders to ensure children in care are registered promptly with a GP when they move area to maintain a holistic picture of health needs, and consideration of how relevant information can be shared appropriately across agencies have been taken forward.

The multi-agency child exploitation identification tool was reviewed, updated and distributed as per the action plan with the strengthening professional practice group seeking further assurance from key agencies. All responding agencies confirmed mechanisms to raise awareness; while some shared the tool directly, others relied on practitioners accessing it via existing platforms or guidance.

Assurance on consistent use and impact remained limited, due in part to varying levels of direct contact with children, gaps in recording and monitoring systems. Agencies identified actions to sustain or improve practice, and it was agreed for all agencies to report back in six months on progress of actions and provide examples of use and impact. In addition, the tool will be included in the Section 11 safeguarding audit surveys (managers and frontline staff) to seek assurance of wider workforce awareness and use.

Children's services completed 19 exploitation & contextual safeguarding themed reflection and learning tool audits highlighting opportunity to strengthen practice; 95% were graded inadequate or requiring improvement and 5% good. The findings showed some inconsistency in the use of key tools, which were completed in just under half of cases. Encouragingly, direct work with children was a relative strength, with 40% graded good, demonstrating effective and child-focused engagement around exploitation risks. Overall, the audit outcomes provided a valuable baseline for improvement and has directly informed targeted training, learning and service development activity in this area.

Local Children Safeguarding Practice Reviews (LCSPR).

There have been 4 LCSPR ongoing during 2025-2026, with the Executive group agreeing 1 report at the end of the year to be published in April 2026.

Dissemination of learning.

Learning from previously published reviews continues to form the training programme and promoted across the partnership via the video explainers published on the MSCP YouTube. Views of these video explainers continues to increase year on year.

MSCP YouTube Video's	**Published**	**Views** (as of June 2026)
LCSPR: Isabel	September 2023	373
Learning lessons review: Jones family	March 2024	128

LCSPR Laura	February 2025	219
LCSPR Julia	September 2025	89

LCSPR Julia

Two outstanding actions are being followed up by NHS Kent and Medway Looked After Children (LAC) team. Further clarity has been sought from Medway Community Healthcare regarding their transfer of information processes, and an update is being progressed through partnership governance.

Children's services have focused on strengthening practice in matching and placement for children with complex needs, oversight of out-of-area health needs for looked after children, and the consideration of ethnicity, race and culture in assessment and care planning. This has included reinforcing expectations that health partners attend reviews, relevant health reports inform planning, and Independent Reviewing Officer (IRO) oversight remains focused on the child's lived experience, with escalation where statutory requirements (e.g. health reviews and PEPs) are delayed.

Kent Police has strengthened expectations that identity, communication and belonging are actively assessed in risk and vulnerability, rather than assumed to be addressed elsewhere. This has been supported through the Race Action Plan, ongoing continuous professional development and independent advisory input, with greater emphasis on recording protected characteristics, completing victim needs assessments and a person-centred approach. Quality assurance and learning materials have further embedded reflective practice around how identity and need shape risk.

The LSCPR highlighted that process compliance alone is insufficient without a clear understanding of the child's lived experience. This is reflected in police's child-centred approach and revised risk assessment processes, which promote fuller information gathering on children's circumstances, relationships and environment. Overall, the impact has been to strengthen a culturally informed, curious safeguarding approach, enhancing information sharing, decision-making and the ability to recognise how identity and additional needs may increase vulnerability, particularly for children living away from home.

Public health commissioned services include culturally specific perinatal programme including culturally safe, peer-led support models and targeted engagement in ethnically diverse and seldom-heard groups.

LCSPR Laura

Medway Foundation Trust (MFT) midwifery service delivered the findings from a second audit on community midwifery safe sleeping practice and documentation. The findings highlighted improved compliance including:

80% of records demonstrated good quality documentation of discussions with parent/carers on sudden infant death syndrome (SIDS) and safe sleeping, doubling from 2024.

90% of first day visits demonstrated evidence of baby sleeping space being seen by the midwife, an increase from 85% in 2024.

Children's services have implemented specific changes to strengthen pre-birth practice, transfer processes and assessment expectations. This has included reviewing and republishing pre-birth practice guidance, including confirming the availability of transfer in/out child protection conference procedures and local case transfer guidance across teams.

Children's services practice standards have been issued, with clearer emphasis on gathering full address histories and completing cross-boundary checks. In addition, GCP2 has been integrated into Mosaic case recording system with manager oversight and reporting functionality providing evidence of increased use of GCP2 across targeted early help, child in need and child protection.

Kent Police's internal vulnerability pages have been updated to include guidance on key learning themes from the review of neglect, intersectionality and father-inclusive practice. The force-wide change in process for risk assessment and referral also explores the care and support needs of the family more fully, creating a more holistic approach that considers co-occurring factors.

Multi Agency Audits

The MSCP has a multi-agency case file audit group, whose role is to undertake audits to identify good practice and multi-agency learning; it is not designed to be a case management tool. The group focuses on themes agreed with the Executive and works on a rotational basis in order that learning overtime can be considered.

The 2025-2026 themes and outcomes as compared to the last themed audit:

Theme	Outcome
Child sexual abuse (CSA)	Slight improvement
Pre-birth	Slight decrease
Neglect	Slight decrease
Child with disabilities	Slight improvement

After each audit feedback is given to the strengthening professional practice group on the grading and themed learning. These form the basis of any associated action plan the group has responsibility for implementation, monitoring and evidencing impact.

The CSA theme was a standalone audit requested by Executive group and a specific tool was developed to focus on addressing learning from previous local audit and the national review into child sexual abuse within the family environment.

Findings: Strengths and Improvements (across audits)

Practice Theme	Strengths
Enhanced multi-agency and communication	Interagency communication and information sharing across universal, statutory and specialist services*
	Local pathways being followed
Child-centred approaches	Practitioners providing safe spaces for children*
	Direct work with children clearly evidenced*
	Timely response to children's disclosures of abuse
Strengthening Professional Practice	Use of GCP2
	Evidence of improvements to single agency 'was not brought' policies.

Practice Theme	Improvements
Enhanced multi-agency and communication.	Multi-agency use of pre-birth pathway*
	Sharing of single agency investigation outcomes
Child-centred approaches	Impact of neurodiversity consistently considered or recorded.
	Exploring and recording parent's experiences of being parented*
	Reliance on children verbalising thoughts and feelings
Strengthening professional practice	Timely use tools to engage, assess and plan interventions*
	Professional challenge to decision making
	Management oversight

* Denote strengths or improvements identified in previous multi-agency audits and/or learning reviews.

Examples of how safeguarding partners and agencies have acted on recommendations and integrated the findings and outcomes of multi-agency audits include:

CSA audit findings have strengthened frontline Police practice and supervisory oversight, aligning to the JTAI framework and national learning. This has resulted in clearer focus on risk management, evidential quality, and safeguarding outcomes for children where prosecutions are not possible. Improvements include greater use of intermediaries and trained officers, and stronger safeguarding plans when cases do not meet evidential thresholds.

Learning has also informed child protection crime allocation and a new child risk assessment process, enabling a fuller understanding of children's circumstances, voice and ongoing needs. Impact is reflected in demand data: over a three-month period, 2,755 child protection crimes and 2,932 non-crime incidents were recorded, demonstrating that significant risk sits outside

criminal thresholds and requires consistent oversight, effective handovers and robust multi-agency safeguarding.

NHS Kent and Medway translated learning from the CSA audit into the health system learning routes. This included using identified themes (including professional curiosity and the impact of neurodiversity) to support clearer systemwide learning and the development and sharing of resources through system routes, so that learning informed day-to-day safeguarding practice and expectations for NHS-commissioned services. This enabled improved consistency in recognising and responding to CSA through embedding learning into system resources and reinforcing expectations across NHS-commissioned services.

In respect of pre-birth procedures children's services have:

- developed a pre-birth tracker supporting service manager oversight
- practice learning sessions to strengthen risk analysis, use of chronologies and pre-birth planning process.
- increased audit and dip sampling of pre-birth work to provide ongoing assurance and identify themes early
- strengthening managerial grip through supervision, with a specific focus on pre-birth cases including Service Manager oversight on all pre-birth assessments where it is identified that there is no ongoing statutory intervention required.

Child Death Overview Panel (CDOP)

Kent and Medway have a joint CDOP chaired by Kent and Medway Public Health. An independent review of CDOP arrangements was commissioned in 2024-2025, and the findings were shared with the Executive group in November 2025. The headline strengths and improvements are as follows:

Strategic Plan Theme	Strengths
Multi-agency working & communication and communication.	Multi-agency and interdisciplinary relationships
Child-centred approach	Work with out of area End of Life Care systems
	Commitment, passion and desire to learn/develop and deliver more
Strengthening Professional Practice and Workforce	Improved resource and capacity contributions from partner organisations
	Collective understanding of the challenges and solutions required
	Emerging sense of shared purpose and focus on action

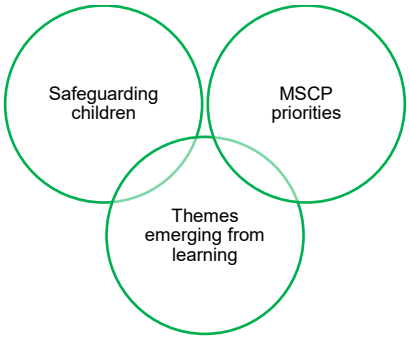
Strategic Plan Theme	Improvements
Multi-agency working and communication	Compliant with legislation, statutory guidance and Kennedy Guidelines.

	Visibility and assurance of the local process and accountability across strategic partnerships i.e. ICB, Health and Well Being Board
Strengthening Professional Practice and Workforce	Quality assurance or follow up process in place to assess quality and completeness of outputs and framing or impact of learning
Strengthening Community Engagement in Children's safeguarding	Representation from bereavement support sector, cultural competence and impact of local bereavement support services

MSCP Training Programme

The MSCP Training Offer.

One of the most immediate ways in which the MSCP influences the effectiveness of safeguarding in Medway is through delivery of a multi-agency safeguarding training programmes for professionals. The programme is planned and delivered around three key areas of training and learning:



Programme Development 2025-2026

In response to local reviews the following was developed and delivered in 2025-2026:

Where does baby sleep: a new course jointly designed by MFT Named Midwife for Safeguarding and MSCP Training Lead, presenting learning from LCSPR Laura and Isabel to increase awareness of evidence based safer sleep and co-sleeping advice, local pre-birth procedure, use of GCP2 and professional challenge and escalation policy.

Domestic abuse, stalking and 'honour based' abuse (DASH) tool: revision by MSCP Practice Development Lead and Public Health, Health Improvement Programme Lead (Domestic Abuse).

Home safety with babies and early years – neglect and harm in local case reviews: a new webinar delivered as part of child safety week, designed by the MSCP Training Lead based outlining learning from LCSPR Julia.

Participation and Evaluation.

We continue to deliver a hybrid training programme with an increase in in-person courses again in 2025-2026.

We continue to achieve 100% post course evaluation completion rate for in-person training.

504 completed in-person training (12.5% increase)	250+ attended a conference
575 completed virtual training (31% decrease)	5,767 e-Learning courses completed (41% decrease)

Impact on Knowledge and Practice.

For some safeguarding partners attendance at training, including the MSCP programme forms part of the staff revalidation process, in which a reflective piece of work outlining learning is submitted, connecting attendance at training events with informed practice.

Through course evaluation and 3month follow up with all delegates the following impact on knowledge and practice was reported:

Confidence in recognising safeguarding concerns
Confidence in evidencing concerns
No barriers to taking safeguarding action
Improved the way practitioners worked
Shared learning with teams

Impact on practice

"Information on pre-birth and threshold guidance. Knowledge of where to go to refer"

"Importance of the strengths approach."

"The videos showing examples of coercive control using the child as part of the domestic abuse was very powerful."

"Excellent course, evidence-based, current, interactive, good opportunity to share stories and experiences and reflect on practice."

"Good resources and the active learning was powerful."

"Recognising safeguarding concerns and what to do/the process"

"Training reinforced knowledge and gained confidence in asking parents difficult questions."

Section Seven – Resources

Partners agree funding contributions at the beginning of the year and whilst the Accountable Officers remain committed to equal partner contributions uncertainty relating to NHS England reforms, Police and Crime Commissioners and local health provider commissioning 2025-2026 percentage contributions were based on previous years.

The funding is used to directly support the work of the partnership including the business unit, independent scrutiny, conducting learning reviews and training programme.

Partners also give resources 'in kind' to support the functioning of the partnership including chairing and participating in groups, task and finish groups, conducting reviews, audits and analysing and submitting data.

The Accountable Officers remain committed to achieving equitable contributions and planning for education partners in the coming year.

MSCP Partner Contributions 2025-2026

Medway Council	69.50%	£150,449
NHS Kent and Medway ICB	3.20%	£6,764
Medway NHS Foundation Trust	3.20%	£6,764
Kent & Medway NHS & Social Care Partnership	3.20%	£6,764
NELFT	3.20%	£6,764
Medway Community Healthcare	3.20%	£6,764
Kent Police and Crime Commissioner	5.85%	£15,434
Probation	2.50%	£5,235
Oasis Restore Secure School	3.30%	£6,996
Kent Fire & Rescue	1.30%	£2,833
Total partner contributions at current levels and other income		**£214,767**
SHORTFALL/ FUNDING FROM MSCP RESERVE		**£31,496.83**

Appendix One – Relevant Agencies

Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. The relevant agencies for Medway have been chosen as organisations and agencies that can work in a collaborative way to provide targeted support to children and families as appropriate.

Agency	How where they involved?
Probation	
Probation Service	Groups, S11 audit, training and learning events
Health	
Kent and Medway Mental Health Trust (KMMT)	Groups, S11 audit, training and learning events
NHS England	Groups
Medway NHS Foundation Trust (MFT)	Groups, S11 audit, training and learning events
Kent Community Health NHS Foundation Trust (KCHT)	Groups, S11 audit, training and learning events
Medway Community Healthcare (MCH)	Groups, S11 audit, training and learning events
Open Road	Groups, training and learning events
Turning Point	Groups, training and learning events
Education	
Medway Primary Schools	Executive representation of Medway Educational Leaders Association (MELA) S175/157 Training and learning events
Medway Secondary Schools	Executive representation of Medway Secondary Heads Association (MSHA) S175/157 Training and learning events Groups (multi-agency audit)
Mid Kent College	Executive representation Training and learning events Groups (multi-agency audit)
Medway Independent Schools	Training, S175/157 audit, training and learning events
Early Years Providers	Training and learning events, champions groups,
Secure Estate	
Oasis Restore Secure School	Groups, training and learning events, S11 audit
Voluntary Sector	
Medway Voluntary Action (MVA)	Groups, training and learning events
MY Trust	Training and learning events
Other Agencies	

Medway Youth Justice Service	Groups, S11 audit, training and learning events
Medway Council - Public Health	Executive, groups, S11 audit, training and learning events
Kent Fire and Rescue Service	Groups, S11 audit, training and learning events
British Transport Police	Training and learning events, S11 audit
Housing Providers	Groups, training and learning events, S11 audit
Children's Homes	Training & learning events
Sports Groups/ Associations	Training & learning events
Faith Groups	Training & learning events