

Impact of Safeguarding Activity in Luton



The Yearly Report for Luton Safeguarding Children Partnership

2025/2026

September 2026 – Final

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FOREWORD

INDEPENDENT SCRUTINEER STATEMENT

“Independent scrutiny should drive continuous improvement and provide assurance that arrangements are working effectively for children, families, and practitioners. It should also consider learning from local child safeguarding practice reviews, national reviews and thematic reports. The independent scrutineer or scrutiny group should be able to demonstrate knowledge, skills and expertise in the area being scrutinised and consequently add value to the work of local agencies.” – Working Together 2023

The role of Independent Scrutineer is to act as a ‘critical friend’ to provide rigorous, evidence-based challenge and assurance across strategic and operational levels. The LSCP undertook a robust recruitment process to appoint Jon Brown as their Independent Scrutineer from May 2025. As LSCP Independent Scrutineer, Jon has offered the following analysis and reflections on the effectiveness of the LSCP over the last year.

Luton continues to demonstrate a mature safeguarding partnership that is steadily growing in confidence. It is characterised by constructive relationships, shared purpose, a focus on equality, equity and inclusion, and a clear commitment to improving outcomes for children and young people. The partnership’s ethos remains one of collaboration, equity, respectful challenge, and solution-focused practice, supported by strong engagement from statutory partners and a capable Business Unit.

Overall assessment of partnership effectiveness

Across the year, LSCP has shown a steady strengthening of multi-agency coordination, clearer strategic alignment, and improved grip on core safeguarding functions. Partners have engaged consistently in governance, audit and review activity, and learning processes, and there is growing coherence between operational practice, strategic priorities, and lived experience feedback.

The partnership’s footprint and culture continue to support effective multiagency working, with in the main, good contribution from police, education, health, and voluntary sector partners. The front door and early help pathways have benefited from clearer structures and improved cross agency communication. While analytical capacity remains developing, partners demonstrate increasing discipline in using evidence to understand impact rather than activity. The voice and impact of children and young people is yet to be seen clearly in the day to day work of the partnership

Significant achievements

- **Improved stability and leadership visibility** within Children’s Services, contributing to renewed confidence and more consistent oversight.
- **Strengthened early help integration**, supported by clearer preventative pathways and better alignment with locality based working.
- **Growing maturity in contextual safeguarding**, with improved multiagency responses to risk outside the home and stronger links with community partners.

- **Positive development of case review arrangements**, with recent Rapid Reviews demonstrating disciplined analysis, proportionate learning, and constructive engagement with national bodies.
- **Enhanced partnership culture**, including more confident professional challenge, improved attendance at governance forums, and clearer shared ownership of safeguarding priorities.
- **A strong and responsive Business Unit** that provides the engine room for the Partnership

Areas requiring improvement

- **Participation and lived experience** are not yet embedded systematically across governance, assurance, and planning; youth scrutiny and structured feedback loops need to be strengthened. This needs to be improved and will be a scrutiny priority for the forthcoming year
- **Data and analytical capability** has developed, however remains insufficient to support robust scrutiny, impact evaluation, and shared learning; development plans must be delivered at pace.
- **Quality assurance and learning cycles** need greater consistency and clearer translation of learning into measurable improvement across agencies to achieve and demonstrate impact
- **Cross partnership alignment** with Youth Justice, Community Safety, Corporate Parenting, and Safeguarding Adults requires further ongoing strengthening to ensure coherent oversight of shared risks.

Confidence in safeguarding arrangements

Overall, I am confident that LSCP has sound foundations, a strong partnership ethos, and a clear trajectory of improvement. The challenge now is to maintain momentum, deepen further strategic leadership, and ensure that activity consistently translates into demonstrable impact for children and families. With clear and disciplined prioritisation, shared accountability, and continued focus on impact and lived experience, Luton is well placed to further strengthen its safeguarding arrangements over the coming year.

Jon Brown

Independent Scrutineer Luton Safeguarding Children Partnership

LEADERSHIP REFLECTION BY THE LEAD SAFEGUARDING PARTNERS

This report provides an overview of the impact and effectiveness of safeguarding arrangements across Luton. It covers the statutory period from 1st April 2025 to 31st March 2026. During 2025/26, Luton Safeguarding Children Partnership continued to strengthen its focus on demonstrating not simply what the partnership has done, but what difference partnership activity has made to safeguarding practice and to the experiences and outcomes of children and young people.

This has been a year of considerable change. The partnership continued to implement the reforms introduced by Working Together to Safeguard Children 2023, supported the development of Families First for Children in Luton, implemented revised governance arrangements, strengthened quality assurance and scrutiny, responded to learning from local

and national reviews and continued to test how effectively safeguarding practice is working at the frontline. The revised Strategic Business Plan for 2025-27 retained a clear focus on children being safe at home, safe in the community and safeguarded through effective systems and processes.

The partnership entered 2025/26 with strong foundations but also with identified areas requiring further improvement. The previous yearly report highlighted continuing challenges around neglect and GCP2, child sexual abuse, cultural competence, transitional safeguarding, domestic abuse, performance management and quality assurance, and the consistent embedding of learning from reviews into frontline practice.

During 2025/26, the LSCP continued to support the implementation and embedding of Luton's Families First for Children Pathfinder, moving from the earlier test-and-learn phase towards a locality-based Family Help model that brings social workers, family support practitioners and multi-agency partners including health and police together around children and families. The approach is intended to provide help earlier, reduce unnecessary transitions between services and strengthen the use of family networks so that families experience greater continuity and are less likely to have to repeat their story.

The evidence gathered during 2025/26 demonstrates both progress and continuing challenge. There is robust evidence of strong partnership working, clearer governance, improvements in some areas of safeguarding performance and better use of data and audit. However, repeat learning from reviews has also demonstrated that having policies, guidance and training in place does not in itself guarantee consistently good practice. This has been particularly evident in relation to neglect, professional curiosity, information sharing, escalation, transitions and the application of safeguarding tools.

A significant external validation of the partnership improvement journey came through the ILACS inspection of children's social care in March 2026. Luton Children's services were judged 'Good' overall. Importantly for the safeguarding partnership, the Ofsted report contained many references to the strength of partners' contribution and multi-agency partnership working, providing independent evidence of the strength of multi-agency arrangements in Luton.

[Luton ILACS report](#) concluded: *"Strategic partnerships are strong and mature. The Safeguarding Partnership Board provides strategic oversight and has effective governance arrangements to ensure that statutory partners meet the needs of children and their families, with children's safety paramount. The partnership is committed to the delivery of the social care reforms. This commitment is reflected in the presence of key partners in the multi-agency teams"*.

The partnership is proud of this progress, and recognises that while much progress has been made there is still more work to do. The quality assurance programme during the year has repeatedly asked the more difficult question: are changes in structures, policies, training and procedures consistently changing what children and families experience?

Bedfordshire Luton Milton Keynes Integrated Care Board

During 2025/26, Bedfordshire, Luton Milton Keynes Integrated Care Board (BLMK ICB) continued to provide strategic leadership and professional safeguarding expertise across Luton and the wider Bedfordshire health system, with a particular focus on the voice of the child, early intervention, information sharing, learning from reviews and improving the coordination of care for children with complex needs.

We strengthened our approach to hearing and responding to children's lived experience through corporate parenting arrangements and co-production, including Care, Education and Treatment Reviews for children and young people with learning disabilities and/or autism. Children and young people also contributed to the refreshed Local Transformation Plan, helping to influence priorities for crisis care, home treatment, eating disorder provision and digital access to services.

For children in care, partnership work with the local authority included the development of a health and wellbeing survey and use of feedback through corporate parenting arrangements to understand children's experience of health services. This has helped ensure health provision is increasingly informed by children's experiences rather than being designed solely around organisational pathways.

The ICB has also strengthened how the health system responds to children whose needs cross organisational boundaries. A coordinated multi-agency approach to children affected by significant childhood trauma has provided a shared space for health, education and social care to identify risk, challenge one another and jointly plan intervention. The Trauma Panel has strengthened oversight of children outside education, improved CAMHS engagement and escalation, supported safer medication management and provided greater continuity when children move placement or geographical area. The learning from individual children has also been used to identify gaps and inform wider commissioning priorities, including early help, family-based support and contextual safeguarding.

Improving information sharing has remained central to our contribution. During the year, safeguarding professionals worked with primary care and NHS digital leads to implement Child Protection Information Sharing (CP-IS) Phase 2. This has strengthened the visibility of vulnerable children across organisational and local authority boundaries and supports health professionals to make better-informed safeguarding decisions because relevant child protection information is available when children present for care.

Learning from reviews has been translated into targeted workforce development. Following the national Sara Sharif CSPR, the ICB and local authority Home Education Team delivered a specific primary-care session addressing children who may be hidden from universal services, checking school attendance and the possibility that withdrawal from school can reduce professional visibility of a child.

Following local learning on child sexual abuse, the ICB also led training with Public Health and Sexual Assault Referral Centre practitioners for 328 GPs and practice staff, strengthening knowledge of sexual abuse indicators and referral pathways. Importantly, there is evidence

beyond attendance at training: the SARC subsequently reported an increase in referrals from GPs. A health safeguarding Community of Practice and safeguarding GP forum have provided further mechanisms for embedding learning, reflection and professional challenge.

There is independent evidence that the health contribution is visible within children's outcomes. Ofsted's 2026 inspection found that children and families receive the right help at the right time and that health partners based within the MASH share information to support timely decision-making and that strategy discussions include relevant agencies and use information well. Children's health needs in care are prioritised through regular and up-to-date assessments with access to universal and specialist health services when required. Importantly, inspectors found that the presence of partners within multi-agency arrangements contributes to timely and proportionate safeguarding decisions.

Our challenge for 2026/27 is to sustain this place-based safeguarding focus during wider organisational change within the health system as we continue our transformation to the NHS Central East ICB. Increasing complexity, workforce capacity and transition between children's and adult services remain significant challenges. A challenge after this year will be sustaining our contribution to ensure effective discharging of safeguarding responsibilities including ICB engagement in the FFC Pathfinder programme. We will therefore continue to support shared multi-agency learning and seek greater consistency in safeguarding training across agencies, while using review learning, audit and outcomes to demonstrate that improved professional knowledge results in better experiences for children.

Bedfordshire Police

During 2025/26, Bedfordshire Police played a key role in supporting the development of Luton's Multi-Agency Child Protection Team (MACPT) by seconding an experienced police officer into the service. This brought valuable investigative expertise, strengthened multi-agency working arrangements, and helped shape the team's operational model, ensuring effective information sharing, joint decision-making, and a coordinated response to safeguarding children at risk of harm.

There is encouraging early evidence that this is making a difference to children. For children receiving a MACPT police-led intervention following a missing episode, 37.5% went missing again within three months compared with 57.6% in a comparator cohort without MACPT police involvement. The cohort and follow-up period mean this should be treated as emerging rather than definitive impact evidence, but the direction of travel suggests that earlier integrated intervention may be helping to reduce repeat missing and associated exposure to exploitation and other harm.

This aligns strongly with the findings of Ofsted's 2026 inspection. Inspectors found that strategy discussions bring together a wide range of relevant partners, that information is shared well and that risks and children's lived experiences inform proportionate decision-making. Inspectors also found that purposeful multi-agency interventions for children who go missing or are at risk of exploitation are helping children keep safe and reduce risk.

We have strengthened the quality and accountability of our safeguarding practice through the Investigation Standards Delivery Board and systematic dip-sampling of higher-risk and older investigations. The Public Protection team undertakes ten dip samples each month, allowing the force to identify why investigations drift and take targeted action rather than relying on generic improvement messages. Recurring causes have included changes of investigating officer, long-term sickness and workforce turnover.

Safeguarding referral quality has also been strengthened through multi-agency referral audits and internal dip-sampling. In the most recent sample cited in the partner return, only one of 25 referrals required amendment. Against the previous audit sample of four requiring amendment this provides positive assurance about the quality and timeliness of police information entering the safeguarding system.

The workforce has been strengthened alongside this assurance activity. The number of qualified and trained detectives increased by 11%, 54 officers completed specialist child abuse investigation development training and 100 officers and staff were trained in Achieving Best Evidence interviewing. This investment increases the capability of officers to investigate complex child abuse and engage appropriately with vulnerable children and witnesses.

A particular focus has been placed on ensuring that children are more visible in police records and practice. Following Voice of the Child training and strengthened expectations, recorded Voice of the Child entries on Athena increased from 91 to 407 over a six-month period. This has been complemented by listening circles with youth councils, including activity commencing in Luton in early 2026, and Bedfordshire's first *Hope Hack*, enabling 13 to 17-year-olds to influence approaches to issues such as gender stereotypes, consent, online safety and harmful social norms.

Preventative work had significant reach through the Education and Diversion Team, '*PolEd*'¹ resources, and partnership activity, as police staff have worked directly with schools and young people on exploitation, online safety, violence and vulnerability. *The Lost Boys* child criminal exploitation campaign reached more than 9,000 young people across 102 locations. This was accompanied by increased intelligence concerning drugs, organised crime groups, gangs and antisocial behaviour, with the highest volume of CCE-related intelligence submissions since monitoring began. This provides evidence that awareness activity is not only reaching young people but is contributing to greater identification and reporting of exploitation concerns.

*Operation Encompass*² has continued to ensure that schools are notified promptly following domestic abuse incidents so that children can be supported following events at home, while implementation is being extended across post-16 provision. The *Philomena Protocol*³ has similarly strengthened the information available when vulnerable children go missing, enabling

¹ <https://www.bedfordshire.pcc.police.uk/support-services/funded-organisations/bedfordshire-police---poled/>

² <https://www.gov.uk/government/publications/information-sharing-duty-operation-encompass>

³ <https://www.beds.police.uk/police-forces/bedfordshire-police/areas/about-us/about-us/philomena-protocol/>

more informed risk assessment, faster lines of enquiry and greater involvement of carers in prevention and initial enquiries.

The central challenge for 2026/27 remains sustaining this improvement in the context of high safeguarding demand, complex investigations and workforce pressures. The priority will be to extend effective MACPT approaches, sustain improvements in investigation quality and supervision, deepen meaningful Voice of the Child practice and ensure innovations designed to reduce administrative delay release professional capacity for risk assessment, investigation and direct safeguarding of children.

Luton Children's Social Care

2025/26 has been a year in which significant structural change began to translate into clearer evidence of improved experiences for children and families. The most important development has been implementation of the *Families First for Children Pathfinder*, with services reorganised into locality-based Family Help arrangements alongside multi-agency teams and Lead Child Protection Practitioners. The intention has been to provide earlier support, reduce unnecessary hand-offs between services, strengthen family networks and maintain relationships with children and families when their level of need changes.

The strongest independent evidence of impact comes from Ofsted's January 2026 inspection of Luton local authority children's services. Overall effectiveness was judged as "Good", improving from "Requires improvement to be good" in 2022. The experiences and progress of children needing help and protection, children in care and the impact of leaders were all judged Good. Services for care leavers were judged "Requires improvement to be good", providing a clear area for continued improvement.

Ofsted found that the Family Help model had resulted in "*improved, seamless and timely support*" for children and families who require help and protection. Children and families were found to be receiving the right help at the right time and benefiting from consistent practitioners who can build trusted relationships. Importantly, when risk escalates, the model enables families to continue receiving support from practitioners they already know while social workers undertake child protection enquiries. This provides important independent evidence that the reform has begun to change the experience of families rather than simply changing organisational structures.

The quality of safeguarding assessment and decision-making was also positively evaluated. Inspectors found assessments to be timely and generally of a high standard, incorporating children's circumstances, holistic needs and family history. When risk escalates, managers and Lead Child Protection Practitioners convene strategy discussions involving relevant partners, with good information sharing, attention to the child's lived experience and culturally competent practice. Child protection enquiries were described as comprehensive, with chronologies helping professionals identify patterns and cultural genograms supporting understanding of family relationships, parental capacity and intergenerational trauma.

Family Network Meetings have become an integral component of this approach. Ofsted found that wider family support is considered early and that practical and financial help through the

Family Network Support Packages Fund has enabled many children to remain living within their families and their circumstances to improve. This represents an important outcome from the Families First approach: supporting families to make sustainable change while avoiding care where children can safely remain within their family network.

There is further evidence of improved safeguarding beyond Family Help. Inspectors found that children at risk of exploitation or who go missing receive coordinated interventions that reduce risk; numbers of children missing education have reduced through multi-agency work addressing barriers to attendance; oversight of children who are electively home educated is well organised; and disabled children and their families benefit from coordinated support that, in some cases, has improved family relationships and reduced the risk of family breakdown.

For children in care, Ofsted found that children generally enter care at the right time, family options are explored and most children live in homes where they thrive and their needs are met. Children's health and education are supported through effective multi-agency arrangements, while longer-standing relationships with social workers provide greater continuity. Children's voice is increasingly influencing their care, including through the All In This Together group, whose members told inspectors they feel listened to, respected and able to influence corporate parenting.

The inspection also provided important evidence about the effectiveness of the wider safeguarding partnership. Ofsted described strategic partnerships as "strong and mature" and found that the Safeguarding Partnership Board provides effective strategic oversight and governance, with partners committed to the delivery of social care reforms and actively participating in multi-agency teams. The quality assurance framework was described as comprehensive and robust, providing leaders with a clear line of sight into the quality of practice and children's experiences and demonstrating an emphasis on "*completing the loop*" from learning to improvement.

We are clear, however, that the Good judgement also means that we need to go further to ensure we consistently achieve good support for every child. For example, Ofsted identified that cumulative neglect is not always addressed sufficiently in children's plans; intervention for children subject to supervision orders requires improvement; the timeliness of some kinship arrangements needs strengthening; and care leavers do not yet consistently experience the quality of pathway planning and relationship-based support that they should.

Our priority is therefore to consolidate the improvements made while celebrating the considerable progress made by our leadership, staff and partners. The evidence from 2025/26 shows that Children's Social Care, working alongside partners, has moved from demonstrating improvement activity to demonstrating tangible improvements in children's experiences: earlier help, greater continuity of relationships, stronger family networks, more informed multi-agency decision-making and better coordination of risk. The next stage is to ensure that this quality is consistently experienced by every child, particularly children experiencing cumulative neglect, those subject to supervision orders and young people preparing to leave care.

Overall partnership reflection

Taken together, the three statutory partner contributions and reflections to the report demonstrate the collective impact, progress and remaining challenges. The ICB strengthened health intelligence, clinical safeguarding expertise and learning brought into multi-agency arrangements; Bedfordshire Police has increased early operational safeguarding input, investigative capability and preventative work; and Children's Social Care has redesigned the service through which much of that collective activity reaches families.

Independent inspection evidence provides particularly important triangulation where Ofsted found that partners share information effectively, multi-agency safeguarding decisions are timely and proportionate, children at risk of exploitation receive coordinated intervention, and Luton has strong and mature strategic partnerships.

The contribution of the statutory safeguarding partners during 2025/26 has strengthened the safeguarding system around children, and has begun to produce measurable and independently evidenced improvements in the timeliness, continuity and effectiveness of the help and protection that children and families receive. We also recognise the challenges and the opportunities afforded to us and the need to sustain positive as we move forward with organisational transformation from BLMK ICB to NHS Central East, Bedfordshire Police's delivery plans and Luton Children's Social Care commitment to sustain and build on the good progress and delivery of services where 'love' is evident and informs the work we do.

Signed by Lead Safeguarding Partners and Delegated Safeguarding Partners

Luton Council – *Mark Fowler: Chief Executive - Lead Safeguarding Partner*



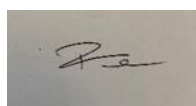
Luton Council – *Dheeraj Chibber: Director of Children's Services - Delegated Safeguarding Partner and Partnership Chair*



Bedfordshire Police – *Detective Chief Superintendent: Zara Brown - Delegated Safeguarding Partner*



NHS Central East Integrated Care Board – *Pól Toner RN Director of Safeguarding and Complex Care - Delegated Safeguarding Partner*



ABOUT THE LUTON SAFEGUARDING CHILDREN PARTNERSHIP

The LSCP Strategic Board is the key statutory mechanism to ensure local organisations and agencies are clear about how they collaborate to protect children and promote their welfare. Its main objective is to assure itself that safeguarding arrangements in Luton act to protect children from abuse and neglect. We do this by ensuring the safeguarding partners and relevant agencies work together collaboratively to coordinate their safeguarding services, identify and respond to the needs of children in Luton, commission and publish local child safeguarding practice reviews and provide scrutiny to ensure the effectiveness of the arrangements.

LUTON MULTI-AGENCY SAFEGUARDING ARRANGEMENTS

The safeguarding arrangements in Luton are led by the three statutory safeguarding partners:

- Bedfordshire Police,
- Bedfordshire Luton and Milton Keynes Integrated Care Board (BLMK ICB) (*which became NHS Central East Integrated Care Board on 01 April 2026*,
- and Luton Council (the Local Authority)

The three Chief Officers are accountable for the safeguarding arrangements as the Lead Safeguarding Partners with each organisation also having a Delegated Safeguarding Partner. The Director of Children's Services (DCS) retained the statutory role of Partnership Chair throughout this reporting year. The LSCP Independent Scrutineer was recruited to their role in May 2025 and work with safeguarding partners and relevant agencies to offer scrutiny on the effectiveness of our arrangements and their impact on outcomes for children and their families.

As part of their scrutiny activity the Independent Scrutineer has held the LSCP partners to account for their financial contributions, training uptake and delivery of services to safeguard children and also challenged areas of practice such as Child Sexual Abuse where the LSCP had not previously held this as a themed priority. They have also had oversight and scrutiny of any concerns or items requiring risk management.

The partnership has continued to work collaboratively to bring schools, colleges and early years providers into the partnership as equal partners, alongside its relevant agencies of health services, probation, housing, voluntary sector organisations and others to safeguard and promote the welfare of children. The partnership also maintained a focus on needs of children and young people within Luton Borough aligned to the [Luton 2040 Child Friendly Town](#).

Throughout 2025/26, **Luton Safeguarding Children Partnership (LSCP)** has operated under its published [Multi-Agency MASA Arrangements](#) with the three safeguarding partners, having a shared and equal duty, ownership and accountability. The LSCP also kept the LSCP MASA arrangements under continuous review to ensure they remained compliant with Working Together 2023 and other statutory guidance. They were also revised to ensure they were consistent with the requirements of *Families First for Partnerships* national guidance.

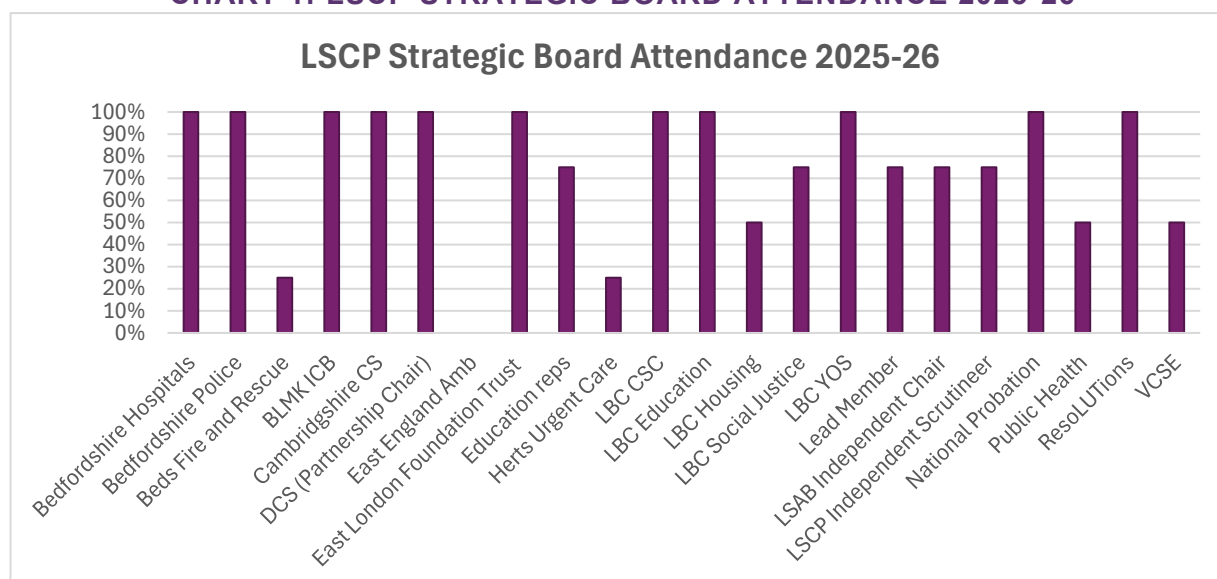
LUTON SAFEGUARDING CHILDREN PARTNERSHIP MEMBERSHIP

During 2025/26 the LSCP Strategic Board was made up of the following partners and relevant agencies. The LSCP currently does not have any lay members but does have members from the Voluntary, Community and Social Enterprise sector (VCSE).

	Bedfordshire, Luton and Milton Keynes NHS Integrated Care Board (BLMK ICB)
	Bedfordshire Fire and Rescue Service (BFRS)
	Bedfordshire Police
	Bedfordshire Hospitals Foundation NHS Trust (BHFT)
	Cambridgeshire Community Services NHS Trust (CCS)
	Department of Work and Pensions
	East of England NHS Ambulance Trust (EEAS)
	East London Foundation Trust (ELFT)
	Education representation including from early years, primary school, secondary schools and further education establishments
	Herts Urgent Care NHS Trust (HUC)
	Luton Council including Children, Families and Education, Housing, Public Health & YOS
	National Probation Service - Bedfordshire
	Voluntary, Community & Social Enterprise Sector including NSPCC and ResoLUTiONs CGL

The LSCP meets at least five times a year with a themed agenda linked to the LSCP priorities including an annual development day. As shown in the chart below safeguarding partners and relevant agencies attendance at LSCP Strategic Board was good.

CHART 1: LSCP STRATEGIC BOARD ATTENDANCE 2025-26

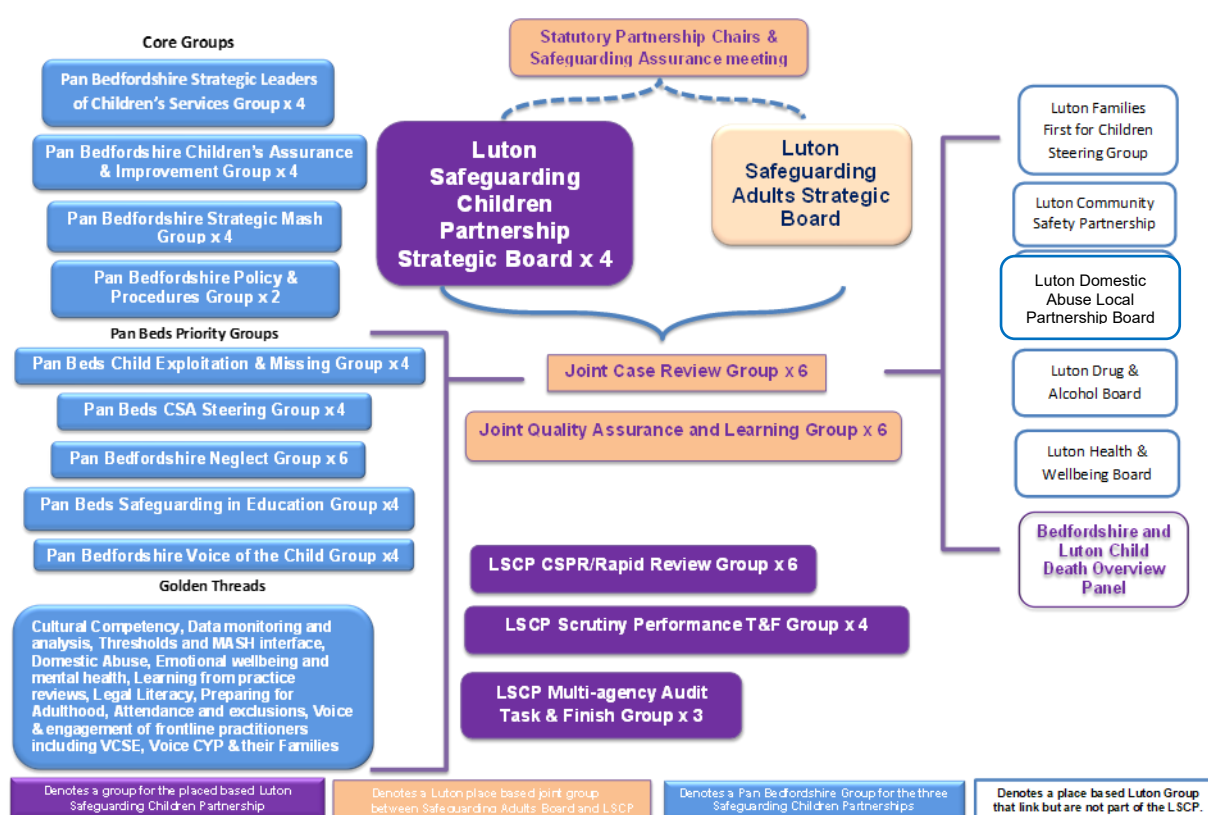


While some regional agencies such as BFRS, EEAS and HUC did not fully attend the Strategic Board meetings, they did receive Board papers, provided commentary and contributed to LSCP learning activities including statutory reviews, audit activity and Pan Beds Section 11 review.

LSCP STRUCTURE AND PARTNERSHIP LINKS 2025 – 2026

The LSCP is also part of a wider network of strategic partnerships, which exist in different forms across Pan Bedfordshire and includes the Luton Domestic Abuse Local Partnership Board, Health and Wellbeing Partnership as well as the Luton Safeguarding Adults Board. The LSCP multi-agency safeguarding arrangements and relationship with the Pan Bedfordshire SCB subgroups and also shows the relationship with wider strategic partnerships as of April 2025.

FIGURE 1: LSCP STRUCTURE

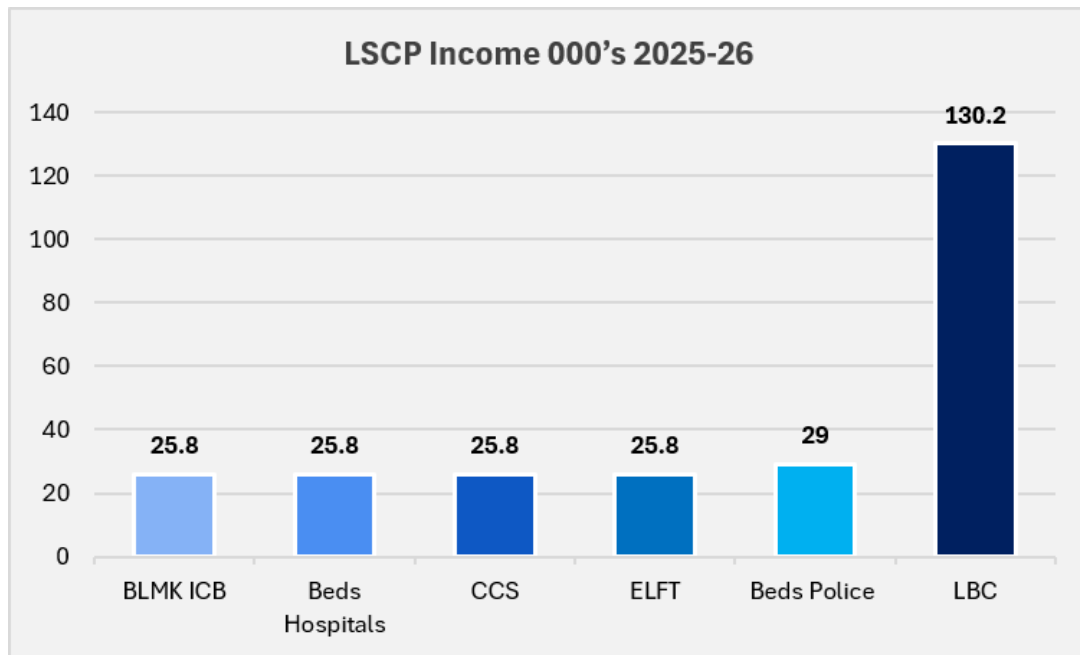


As detailed in the section on *Governance, Structure and Processes* the LSAB/LSCP Statutory Partners Chair and Safeguarding Assurance Group undertook an independent review of their structure, governance and business arrangements. As a result of this review an implementation plan and a new LSCP structure was agreed for implementation starting in 2025/26. Further information can be found in the section on LSCP Governance, Structure and Processes.

PARTNERSHIP FUNDING CONTRIBUTIONS & EXPENDITURE 2025/26

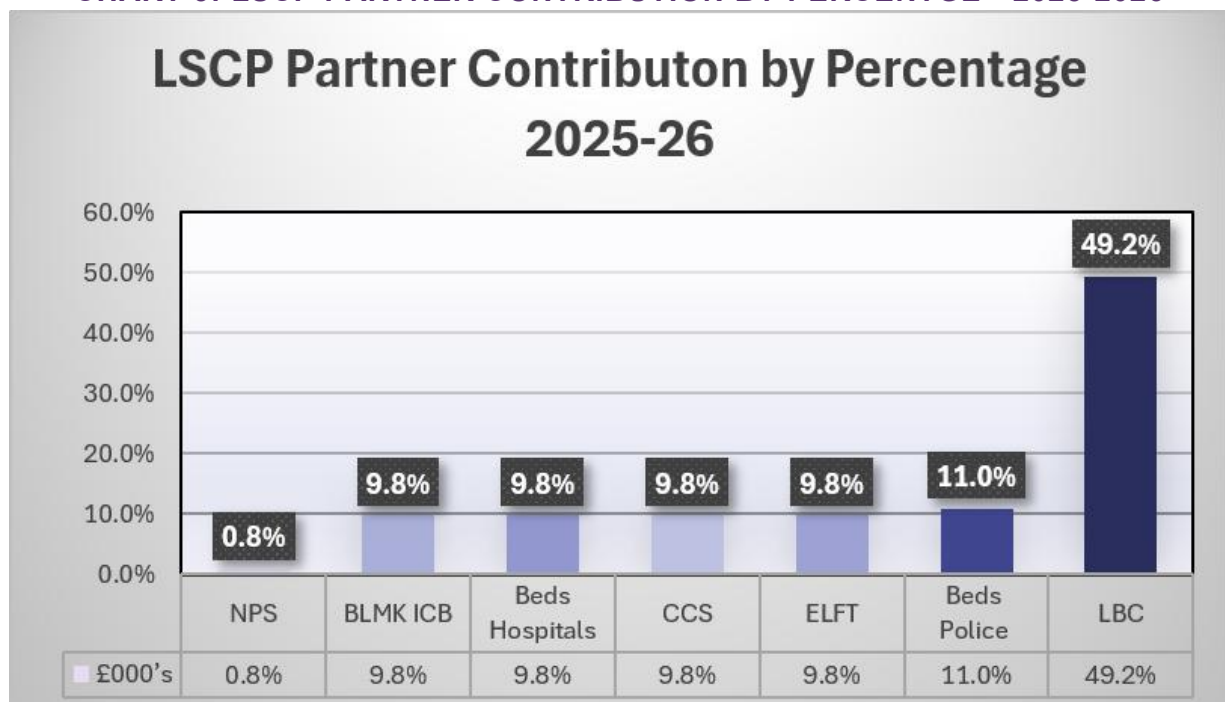
The LSCP annual budget for 2025/26 was set at the same level as 2023-24 at £264,600 with no additional growth and disinvestment in some areas to achieve a balanced budget. The statutory partners and health relevant agencies agreed the following financial contributions from the safeguarding partners in the amounts set out below:

CHART 2: LSCP INCOME IN 000'S - APRIL 2025 - MARCH 2026



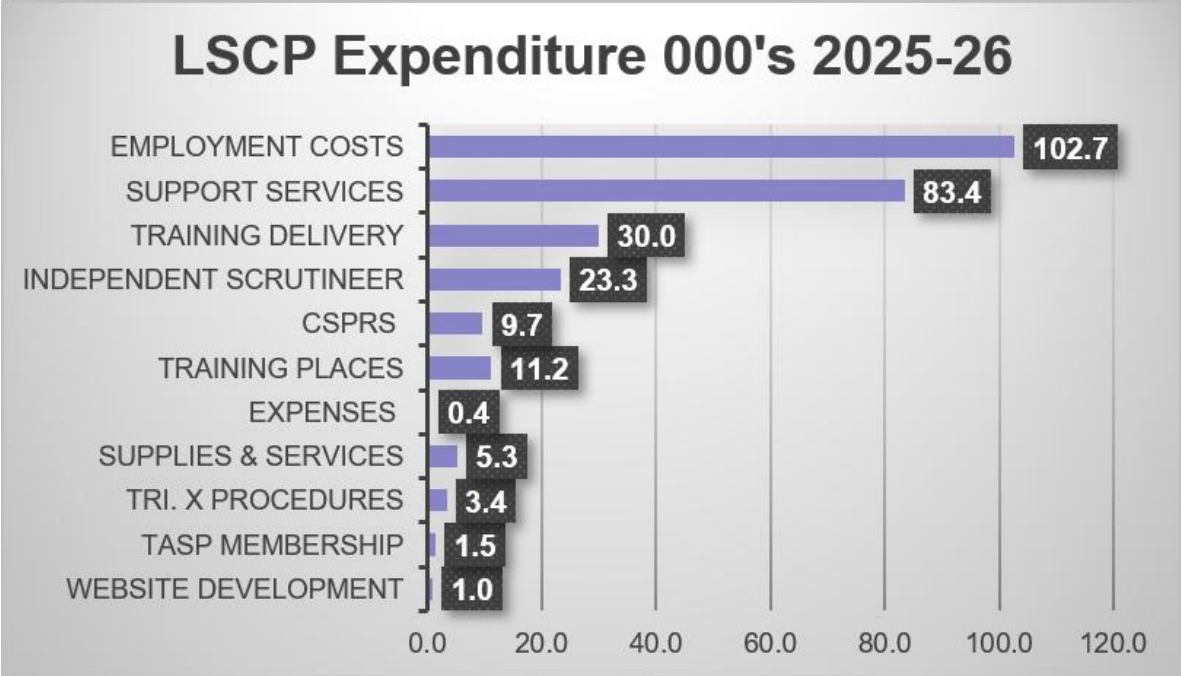
In reducing the contributions to keep expenditure within the previous expenditure envelope it was highlighted that it may require an additional contribution in the event of further CSPRs or learning activity from rapid reviews within the year. There was also significant discussion regarding the partner contributions by percentage as the local authority contribution is **49%** of total budget, BLMK ICB and other health partners including BLMK ICB is **39%** with the Police contribution **11%**. Although Working Together 2023 requires partners to contribute on an equitable basis the other statutory partners have not been in a position to change their contribution levels to a more equitable level.

CHART 3: LSCP PARTNER CONTRIBUTION BY PERCENTGE - 2025-2026



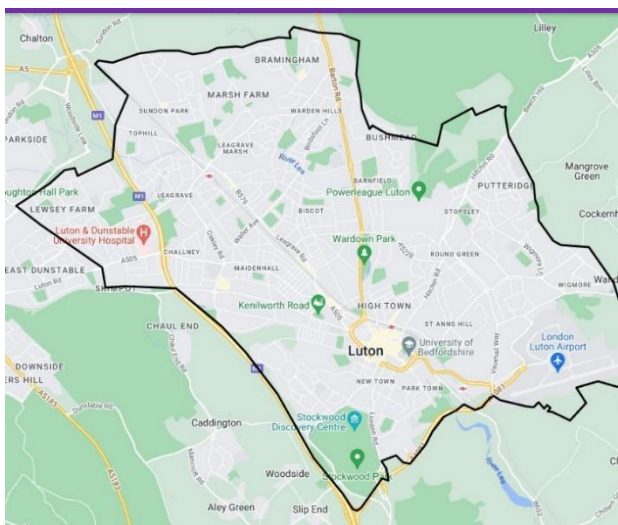
These contributions cover the total Business Costs of the LSCP including staffing, provision of training, Child Safeguarding Practice Reviews, practice improvement, chairing and scrutiny costs, communications, LSCP development initiatives, office costs, website and multi-agency procedures. The chart below shows the actual expenditure in 2025/26.

CHART 4: LSCP PARTNER EXPENDITURE 000'S - 2025-2026



The biggest LSCP expenditure in 2025/26 is on employment costs at £102,700 which accounted for **38%** of its budget. For 2025/26 the staff budget included a staff role which was removed in the restructure to a single LSCP Business Unit. The Local Authority also provide the LSCP Business Support Officer and Business Apprentice as a central function at no additional cost to the LSCP. However, these costs have also been supported through a historic underspend. The cost of the LSCP training function equates to **15%** of expenditure. With CSPR costs accounting for **4%** of total spend in 2025/26. There was an overspend on the independent scrutiny function which was also supported by an underspend from the Business Unit restructure and previous years budgets which was utilised to ensure a balance budget in 2025/26.

LUTON IN NUMBERS



Luton Safeguarding Children Partnership (LSCP) is one of three safeguarding partnerships, which operate within the County of Bedfordshire.

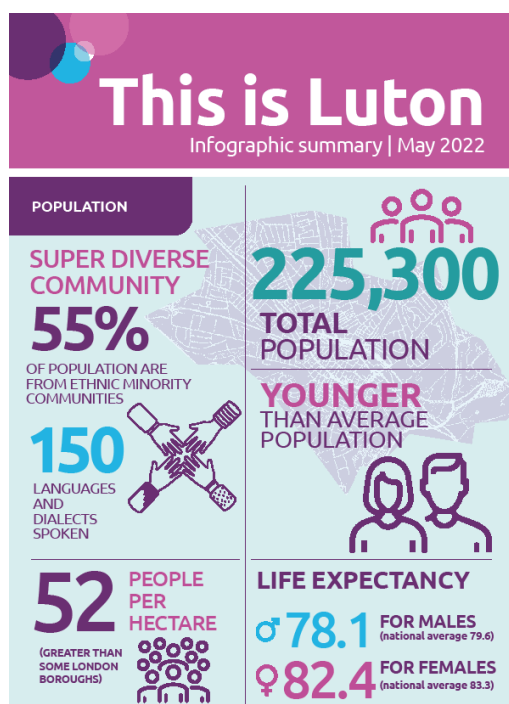
The demographic of Luton is unique when compared to the rest of Bedfordshire and is detailed in the section on population.

Population 2021

- ❖ **225,300** residents in the town up by **10.9%** Higher than overall increase for England (6.6%),
- ❖ One of the youngest populations in the country – **27%** of residents aged below 18.
- ❖ Super diverse town – **55%** non-White-British.
- ❖ Approximately **50%** population churn since 2011. 225,300 in 2021. where the population grew by nearly 3.5 million to 56,489,800.

Economy

- ❖ Luton economy worth **£7.2** billion per year prior to the pandemic.
- ❖ **Among the worst-impacted places in the country during pandemic** – second highest number of vulnerable jobs during the pandemic of major towns and cities.
- ❖ Claimant count of **8.4%** - up from **3.4%** in March 2020 – the sharpest rise in the country.

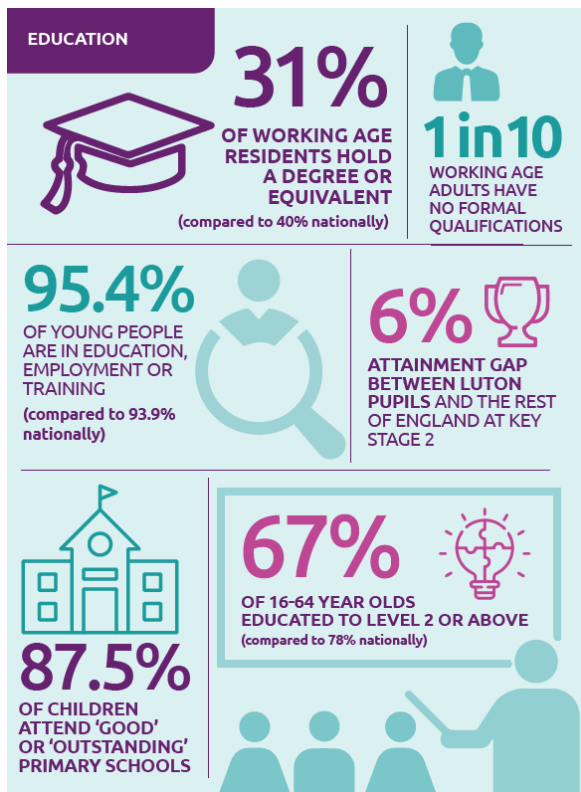


Employment

- ❖ **75.3%** working age adults in employment.
- ❖ **24.7%** of working age adults economically inactive.
- ❖ **More than 1 in 4 workers** earning below the Real Living Wage.
- ❖ **23,000 employees on zero-hour** and agency contracts.

Education

- ❖ **1 in 10** working age adults have no formal qualifications.
- ❖ **67% of 16-64 year olds** educated to level 2 or above compared to 78% nationally.
- ❖ **6%** attainment gap between Luton pupils and the rest of England at key stage 2.



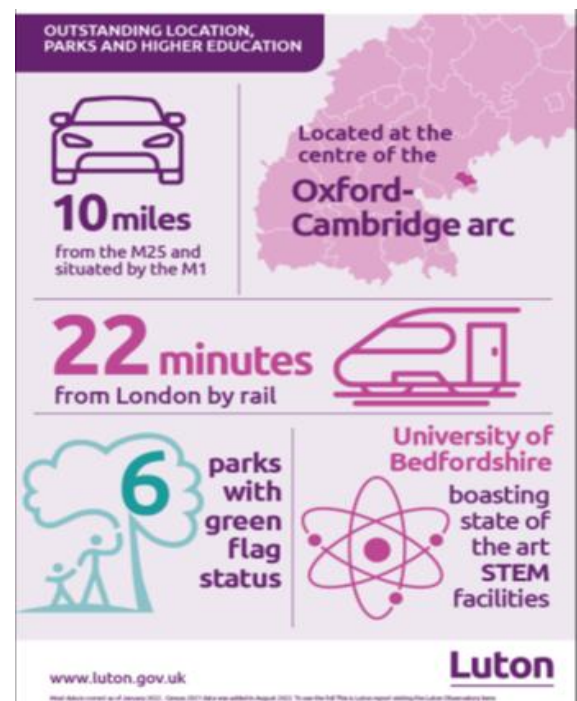
Housing

- ❖ The median house price in Luton is **£258,000 – 34%** increase since 2015.
- ❖ The Median house price is **8.5 times** the median gross annual earnings for residents.
- ❖ **22%** of Luton households are in the private rented sector.
- ❖ **15,000** additional homes required by 2031.



Outstanding Location

- ❖ Located at the centre of the Oxford-Cambridge arc.
- ❖ 22 minutes from London by rail.
- ❖ 10 miles from the M25 and situated by the M1.
- ❖ Home to London Luton Airport – the international gateway to England's Economic Heartland.



London Luton Airport

- ❖ 5th largest airport in the UK.
- ❖ Over 17 million passengers per year prior to the pandemic – down to 5.4 million in 2020/21.
- ❖ Contributes £1.8 billion per year to the UK economy.
- ❖ Provides more than 11,000 jobs directly, with more through supply chains.

Poverty

- ❖ **30.4%** of children growing up in relative poverty in March 2025.
- ❖ **6th** most deprived area in East of England by Indices of Multiple Deprivation.
- ❖ **4** wards in Luton are within the **10%** most deprived in the country.
- ❖ **26%** of working households in relative poverty.

Skills

- ❖ **36%** of Luton businesses have skills gaps in their existing workforce.
- ❖ **29.7%** of workers are in level 4 occupations, but only **23.6%** of employed residents are in these jobs.
- ❖ **48%** of vacancies in Luton are in Level 2 occupations.

Health and Wellbeing

- ❖ Life expectancy gap of **6.9** years between women in Luton's most deprived and most affluent wards, for men this gap is **5.1** years.
- ❖ Male life expectancy in Luton one year less than the national figure.
- ❖ **381** children in care in Luton as of March 2022.
- ❖ **26%** of 10-11 year olds in Luton are obese.

CHART 5: CHILDREN'S DEMOGRAPHICS – 2020 - 2025

Percentage of children aged under 16 in relative low-income families	2020/21	2022/23	2023/24	2024/25
United Kingdom	18.0%	18.0%	19.0%	18.7%
Luton	31.7%	30.8%	32.3%	30.4%
Neighbouring Local Authorities				
Bedford	17.8%	17.1%	17.9%	16.7%
Milton Keynes	15.3%	15.7% ¹	16.3%	15.4%
Huntingdonshire	11.8%	11.8%	12.2%	11.8%
Central Bedfordshire	11.7%	11.1%	11.4%	11.2%
Buckinghamshire	11.0%	10.9%	11.4%	11.0%
Dacorum	11.3%	10.6%	11.1%	10.7%
North Hertfordshire	10.6%	10.0%	11.4%	10.6%
South Cambridgeshire	8.6%	8.2%	8.9%	7.9%
St Albans	7.3%	7.0%	7.5%	7.5%
Luton wards with highest relative low income percentage				
Dallow	18.10%	18.00%	18.10%	**
Biscot	14.90%	17.10%	14.90%	**
Northwell	13.00%	12.00%	13.00%	**
Farley	11.20%	12.40%	11.20%	**
South	10.80%	11.40%	10.80%	**

Source: DWP *Children in Relative Low-income families (Before Housing Costs)* rates⁴

The table above shows that for 2024/25 the relative low income rate for Luton at **30.4%** is now below the rate in 2022/23. However, Luton still has the highest level of relative poverty across all neighbouring local authority areas. At 30.4% the Luton rate is almost twice that of Bedford (16.7%) and nearly three times the rate in Central Bedfordshire (11.2%).

Because ward-level data requires intricate address-matching from tax credits and Universal Credit records, official 2025/26 ward numbers are locked until the Spring 2027 data drop. However, local authority modelling projections indicate that Dallow and Biscot continue to record the town's highest child poverty density (*remaining above 30% BHC*), while Northwell tracks closely behind but stays elevated above the wider regional averages.

SAFEGUARDING PERFORMANCE – SAFEGUARDING SNAPSHOT 2025-2026:

Following assessment of activity and impact the safeguarding partners recognised the need for stronger performance intelligence in 2025/26 to support scrutiny, assurance and decision-making. Partners hold significant amounts of safeguarding data individually, but there is

⁴ <https://www.gov.uk/government/collections/children-in-low-income-families-local-area-statistics>

variation in how information was collected, analysed and presented across Luton and Pan Bedfordshire, although Luton held the most evolved and embedded scorecard process.

These variations in data and narrative limited the LSCP's ability to identify shared trends, understand emerging risks and to evaluate the impact of safeguarding activity across the wider system. Feedback from the strategic leaders, independent scrutineer together with partnership review activity, consistently highlighted the need for a more sophisticated approach to performance scrutiny and review with the need for greater emphasis on understanding outcomes for children rather than monitoring activity alone. Discussions throughout the year increasingly focused on the question: *"How do we know this has made a difference for children and families?"*

To strengthen the partnership's intelligence capability, a dedicated Pan Bedfordshire Senior Safeguarding Data Analyst post was created to support development of existing metrics, scorecard narratives and themed Data Profiles. The appointment to this role in December 2025 represented a significant investment in understanding safeguarding performance and improving the partnership's ability to use data to drive improvement. The role which is hosted in Luton supports the three safeguarding partnerships to focus on Pan Beds and place-based data and provide greater consistency in performance reporting, data analysis and identification of emerging themes.

Substantial work was undertaken to further develop the LSCP Safeguarding Scorecard. This involved reviewing existing performance measures, strengthening the quality of data available to safeguarding leaders and creating greater consistency in reporting across partnership agencies. The Independent Scrutineer also led bi-monthly Scrutiny and Performance meetings with safeguarding and business intelligence leads to ensure robust scrutiny and analysis of the data and identification of emerging patterns and trends for further exploration.

The scorecard therefore increasingly brought together information from safeguarding partners to provide a clearer picture of:

- safeguarding demand
- child protection activity
- neglect
- exploitation
- missing children
- domestic abuse
- workforce development
- multi-agency performance
- safeguarding outcomes.

The partnership also used their annual LSCP Strategic Development Day to critically review the effectiveness of performance information. Partners challenged themselves to move beyond counting activity and instead focus on understanding impact, outcomes and lived experience. This resulted in important discussions regarding training effectiveness, neglect assessments, domestic abuse, contextual safeguarding and children's experiences of services.

What difference did this make?

The introduction of a dedicated analytical function has strengthened the partnership's ability to understand safeguarding risk and identify emerging themes across Bedfordshire. Strategic discussions are increasingly informed by evidence rather than anecdotal information, enabling leaders to identify areas of concern more quickly and target improvement activity where it is most needed.

The enhanced scorecard has improved the quality of challenge, scrutiny and assurance provided by safeguarding leaders and independent scrutineers. During the year, performance information supported strategic discussions regarding:

- reduction in Section 47 enquiries
- domestic abuse trends
- missing children
- neglect assessment activity
- safeguarding training uptake
- effectiveness of Families First reforms
- MASH performance and referral quality.

The work has also improved transparency and accountability across the partnership. Agencies are increasingly able to understand how their contribution impacts the wider safeguarding system, while safeguarding leaders have greater confidence that emerging risks are being identified and discussed appropriately.

The partnership has strengthened its approach to performance management through continued development of the LSCP Safeguarding Scorecard and a dedicated Pan Bedfordshire Senior Safeguarding Data Analyst. The scorecard increasingly combines data and narrative from Children's Social Care, Health, Police, Education, Safeguarding Reviews, Quality Assurance activity, workforce development programmes and Voice of the Child engagement. This has enabled safeguarding leaders to move beyond monitoring activity alone and develop a richer understanding of safeguarding need, emerging risks, partnership effectiveness and improved outcomes for children and young people.

Remaining Challenges

The partnership recognises that this work is still developing. While significant progress has been made, further work is required to:

- improve consistency of data collection across agencies
- strengthen multi-agency performance measures
- improve understanding of Equality, Diversity and Inclusion (EDI) data
- better evidence outcomes for children and families
- incorporate data from voluntary and community sector partners
- strengthen the use of qualitative information alongside quantitative performance data.

The renewed focus on data and analysis supported by the Pan Beds Senior Safeguarding Data Analyst represent important foundations for a more intelligence-led safeguarding partnership. Together with the continued development of the LSCP Safeguarding Scorecard is providing

stronger assurance that decisions and improvement activity are informed by evidence. There is evidence of learning and an increasingly sophisticated understanding of local safeguarding need and demonstrate improved outcomes for children and families.

Year in Review: Data on children and young people

- During 2025/26 the partners made **13,006** contacts and **4,108** referrals in the MASH
- This is a slight increase from 2024/25 however, it is **22.5%** less than in 2021/22
- The number of referrals from Schools increased from **27.6% to 34.2%** and education settings continued to make the highest number of referrals into MASH
- Police referrals were the second highest at **26.6%** but reduced from **27.73%** last year
- Domestic Abuse remains the most common reason for referral at **24.8%** and has continued to rise year on year since 2021/22 (**19.1%**)
- Referrals for physical abuse remains the second highest reason for referral but has reduced from **20%** of referrals in 2023/24
- The age range of **10-15** continues to be the highest age range at referral at **35.6%** with under ones continuing to account for less than **10%** of children referred to MASH.

During 2025/26, sampling of strategy meetings held suggests that the threshold is being applied appropriately in considering whether a strategy meeting is required. However, as the rate of section 47 enquiries that do not conclude in a conference has also reduced this suggests that the MACPT is being effective at assuring that children are only being subjected to child protection plans when they absolutely need to be and when their needs cannot be met as a child in need. Further evaluation is taking place but initial findings would indicate that agencies are continuing to embed the Families First for Children modelling and are holding risk effectively within other parts of the system.

Further information can be found in the LSCP Safeguarding Snapshot which can be found at [Appendix A Data Snapshot](#).

IMPACT AGAINST LSCP STRATEGIC PRIORITIES

The LSCP undertook significant work to review and evaluate its work against its strategic priorities during 2025-26. During Quarter 1, the LSCP held an in person development day to assess its progress, measure change and consider the impact of priorities previously set. This included a review of the work undertaken across the three Pan Bedfordshire Safeguarding Children Partnerships as well as cross cutting work being undertaken with the Luton Safeguarding Adults Board within our Joint Structures.

WHY DID THE LSCP CHOOSE THESE PRIORITIES?

The LSCP Strategic Business Plan reflects the different environments, systems and practice themes in which children need to be safeguarded. During 2025/26 the LSCP continued to focus its work around three strategic priorities: *Safe at Home*; *Safe in the Community* and *Safe*

Governance, Structure and Processes. These priorities provided a framework through which the Partnership could consider both the effectiveness of multi-agency safeguarding arrangements and the difference these arrangements make to the lived experiences of children and young people in Luton.

Safe at Home: remained a priority because children can experience a range of interconnected risks within their family and home environments, including neglect, domestic abuse, emotional and mental health needs, poverty and online harms. The data and discussion highlighted increasing domestic abuse and MARAC referrals alongside concerns about whether neglect is being consistently identified and assessed. Partners also recognised the need for practitioners to understand the wider circumstances affecting families, including poverty, trauma, culture and barriers to accessing services.

Safe in the Community: reflects the increasing complexity of harm experienced by children outside their family environment, including exploitation, serious youth violence, children going missing, children missing education and online influences. The significant increase in children reported missing and the increase in Children Missing Education, together with concerns about young people carrying knives because they feel unsafe and the likely under-identification of children affected by gangs and county lines, reinforced the importance of retaining a strong contextual safeguarding focus.

Safe Governance, Structure and Processes: recognises that effective safeguarding depends upon strong leadership, clear accountability, good multi-agency arrangements, appropriate thresholds, effective information sharing, a skilled workforce and a culture which learns and improves. The Development Day reinforced the importance of moving beyond measuring whether safeguarding activity has taken place towards understanding its impact. This was particularly evident in discussion about safeguarding training, where increased participation was positive but partners repeatedly asked the important question of “*What difference this has made?*” and how the Partnership knows learning has translated into better practice and improved outcomes for children.

WHAT HAVE WE DONE WELL?

A key priority during 2025/26 was strengthening the partnership's ability to understand the quality and effectiveness of safeguarding practice. Through a coordinated programme of multi-agency audits, thematic reviews, performance analysis, practitioner engagement and learning activity, the partnership sought not only to identify good practice, but also to understand where systems could be improved to achieve better outcomes for children and young people.

The partnership increasingly adopted a culture of constructive challenge, encouraging agencies to move beyond compliance-based assurance and focus on how safeguarding practice was experienced by children, young people and families. Learning identified through audit activity was routinely reported through governance structures and translated into action plans, workforce development and service improvement activity.

NEGLECT

Neglect remained a strategic priority throughout 2025/26 following learning from audits, reviews and frontline practice that highlighted the significant and often cumulative impact of neglect on children's safety, health and development.

To raise awareness and strengthen practice, the partnership delivered a comprehensive Pan Bedfordshire neglect campaign. This included the development of a campaign identity and logo through direct engagement with children and young people, helping to ensure that the campaign reflected the voices and experiences of children. The campaign increased the visibility of neglect across the partnership and reinforced the message that identifying and responding to neglect is everyone's responsibility.

A dedicated neglect section was developed on the Safeguarding Bedfordshire website, creating a single location where practitioners could access guidance, assessment tools, learning resources and support materials. Additional resources were developed for members of the public, including leaflets signposting families and communities to local support services and sources of help before concerns escalated.

The partnership also delivered a programme of bite-sized learning events and webinars covering themes including neglect awareness, adolescent neglect, educational neglect and hoarding. This approach recognised that neglect presents differently across childhood and that practitioners require confidence to identify neglect in a variety of contexts.

The impact of this work extended beyond awareness raising. Neglect became more visible within safeguarding discussions, audit work and partnership governance arrangements. Practitioners reported increased confidence in discussing neglect with families and greater awareness of available tools and resources. The campaign also helped identify continuing challenges within practice, particularly around the consistent use of neglect assessment tools and recognising cumulative harm. This enabled the partnership to focus future improvement activity on the areas where practitioners required the greatest support.

Training evaluations demonstrated improved practitioner confidence in identifying and responding to neglect, while feedback consistently highlighted the value of learning that focused on children's lived experiences. The development of dedicated neglect resources, assessment tools and guidance has improved practitioner access to information and promoted greater consistency across agencies.

The **Stop: Think, Neglect** campaign also helped the partnership develop a stronger understanding of barriers affecting implementation of neglect assessment tools and interventions. This has enabled future improvement activity to be more targeted and evidence-led. Whilst it is too early to demonstrate a direct reduction in neglect-related safeguarding

concerns, the partnership is confident that neglect is now being discussed, challenged and considered more routinely across the safeguarding system.

FIGURE 2: NEGLECT CAMPAIGN GRAPHICS



As highlighted in the section *Learning from Experience* the partnership undertook a number of rapid reviews and other case scoping that gave us learning around Neglect.

Impact and outcomes

Partner evaluations provide evidence that the Partnership's focus on neglect is increasingly being translated into frontline health practice. EECH (formerly CCS) reports that community health safeguarding recording arrangements were redesigned so that identification of neglect prompts practitioners to consider relevant assessment tools, including GCP2, the neglect screening tool, clutter scale and obesity safeguarding tool. Safeguarding supervision was also strengthened, with practitioners encouraged to bring cases involving neglect and large sibling groups for review, focusing on care planning, children's lived experience and whether concerns require escalation. Regular safeguarding caseload reviews have subsequently identified cases where neglect required further escalation.

This is important evidence of impact because the Partnership's neglect work is not confined to campaigns and training. It can increasingly be identified within clinical recording, assessment, supervision and case review. Community health has also introduced tools such as "A Day in the Life" and APPLE⁵ to strengthen practitioners' understanding and recording of children's lived experience, including development of a specific Day in the Life tool for children with disabilities.

Acute health assurance provides further evidence of learning being incorporated into practice. BHFT reports that learning regarding the need to consider the impact of parental drug and alcohol use on children was taken directly into Emergency Department medical-team briefings and Level 3 safeguarding training. The Trust also identifies improved referral quality, earlier identification of risk, better recording and more consistent application of Think Family principles as areas of impact from its safeguarding training and assurance arrangements.

⁵ APPLE (*Appearance, Presentation, Patter, Likes and Dislikes, Environment*) is an observation and assessment framework primarily used by integrated 0–19 children's health and safeguarding teams in the UK.

CCS partner assurance also reinforces the continuing challenges identified through local reviews. Community health services identified that differences in professional assessment of neglect, particularly medical neglect, can result in drift. This triangulates with recurring review findings concerning cumulative harm, professional curiosity, family history and escalation. The Partnership therefore remains focused not simply on increasing completion of GCP2 assessments, but on whether the multi-agency network develops a shared understanding of children's circumstances, intervenes sufficiently early and can evidence improvement in children's lived experience.

When considered with the partnership neglect campaign, reported increased GCP2 activity and learning from local reviews, there is evidence of greater professional visibility of neglect and stronger infrastructure to support its identification. However, the partnership recognises the need to remain cautious about equating improvements in processes, recording or use of tools with improved outcomes until there is consistent evidence that children's day-to-day circumstances have improved.

What did reviews featuring neglect tell us?

Alternative Learning Reviews for Family Smith, Family Hamza and other rapid reviews during 2025/26 demonstrated striking similarities to earlier learning from the Integrated CSPR Family T published in 2024/25. Recurring issues included:

- cumulative neglect not being sufficiently recognised
- insufficient professional curiosity
- children living in poor home conditions without timely escalation
- adult or parental mental health needs obscuring the impact on the child
- inadequate consideration of history
- over-reliance on parental engagement
- gaps in information sharing
- inconsistent use of GCP2 and clutter-rating tools
- police protection powers ultimately being required after earlier opportunities for intervention had been missed.

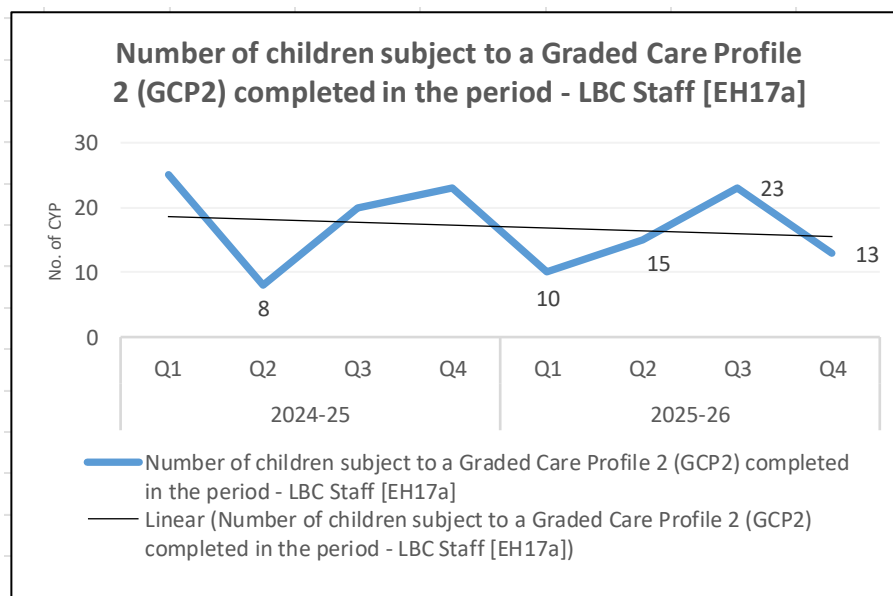
This is important evidence for the partnership as it demonstrated that awareness of neglect is not the same as consistently effective practice in identifying and assessing neglect. The Family Hamza alternative review identified a "starting again syndrome", where new referrals and assessments did not consistently incorporate the significance of a ten-year family history. Direct and meaningful work with the children was also limited and safety planning was insufficiently robust.

By January 2026, the partnership was clear that similarities between Family T, Family Smith and Family Hamza meant it was necessary to triangulate the cases rather than create another isolated action plan. This resulted in clear evidence of progress in workforce development, better identification of neglect and the number of children subject to child protection plans. The data for this can be seen in the safeguarding snapshot at [Appendix A Data Snapshot](#).

Grade Care Profile 2 (GCP2)

Usage of GCP2 use remains a particular challenge which was first identified in the 2024/25 yearly report. During 2025/26 there was improvement, with 23 GCP2s completed by LBC staff during Q3, the highest quarterly number in the first three quarters of the year, and 61 completed by the end of Q4.

CHART 7: USAGE OF GCP2 ASSESSMENTS – MARCH 2024 TO APRIL 2026



However, scrutiny in February 2026 found some continuing agency uncertainty regarding:

- who should lead on a GCP2
- whether it is genuinely understood as a multi-agency tool
- the time required to complete it whether all sections need to be completed
- how repeat assessments are recorded
- inconsistent messages about whether it can be completed as a desktop exercise;
- practitioner capacity and confidence;
- whether completion is incorporated into Child in Need and Child Protection planning.

Challenges that remain: A potentially important issue with data validity was identified as practitioners may sometimes update their original GCP2 form rather than opening a new assessment, meaning repeat use may not be visible in the current performance data.

Partner evidence strongly reinforces the conclusions from local safeguarding reviews. EECH identifies continuing concerns about drift and different professional assessments of neglect, particularly medical neglect, alongside challenges in maintaining objectivity where practitioners have worked with families for long periods. It also identifies occasions when the timely receipt of safeguarding meeting minutes affects assessment of risk.

This triangulates with the recurring learning from Family T, Family Smith and Family Hamza regarding cumulative harm, professional curiosity, family history and escalation. The principal challenge is therefore no longer simply ensuring that neglect tools and guidance exist. The

Partnership needs assurance that agencies develop a sufficiently shared understanding of neglect, use history and children's lived experience effectively and escalate concerns before chronic neglect becomes entrenched.

While the LSCP can evidence greater strategic grip and a better understanding of the causes of low recorded GCP2 use, the partnership cannot yet conclude that GCP2 is consistently embedded across frontline practice. For this reason the focus for 2026/27 will continue and will move from promoting the tool to demonstrating: *Are neglect tools being used with the right families, at the right time, by the multi-agency network, and contributing to measurable improvement in children's lived experience?*

CHILD SEXUAL ABUSE

Child Sexual Abuse remained a priority for the Luton Safeguarding Children Partnership during 2025/26, reflecting both local learning and the wider national focus on improving the identification of and response to sexual abuse. Delivery is supported through the *Pan Bedfordshire Child Sexual Abuse Steering Group*, implementation of learning from the NSPCC CSA Snapshot work, development of appropriate guidance and training, and assurance that learning is translated into practice. CSA sits alongside cultural competence, voice and lived experience, information sharing and learning from reviews as important cross-cutting themes.

Community health assurance provides further evidence that the Partnership's focus on Child Sexual Abuse is being translated into frontline services. Specialist CSA training was provided to safeguarding leads, the CSA identification policy supporting child protection medicals was updated and access to Child Protection Information Sharing systems was extended within relevant services to strengthen practitioners' access to safeguarding information. Safeguarding supervision and advice arrangements provide practitioners with additional support when sexual abuse is suspected or disclosed.

The partnership continued to invest significantly in workforce development relating to Child Sexual Abuse. Recognising that confidence remains one of the biggest barriers to identifying and responding to Child Sexual Abuse, the partnership worked with specialist organisations to commission and deliver dedicated face-to-face learning opportunities.

This included the delivery of the accredited *Developing an Understanding of Child Sexual Abuse (DUCSA)* programme, delivered by locally trained practitioners who had completed NSPCC accreditation. In addition, the partnership commissioned specialist *Technology Assisted Child Sexual Abuse (TACSA)* training delivered by the Marie Collins Foundation, responding to the increasing role of technology within exploitation, grooming and abuse. This training provided practitioners with a deeper understanding of how abuse presents, the impact of technology on children's experiences and the practical steps professionals can take to improve identification and intervention.

There is particularly useful evidence of health-sector implementation. Following local learning, the ICB worked with Public Health and Sexual Assault Referral Centre practitioners to deliver joint CSA and sexual assault pathway training to **328 GPs and primary care staff**. The training

strengthened awareness of potential indicators of child sexual abuse, the role of the SARC and how primary care should respond when abuse is suspected. Importantly, there is some evidence of practice change following the intervention as the SARC subsequently reported an increase in referrals from GPs.

The Partnership has also strengthened links between CSA and exploitation rather than treating them as entirely separate forms of harm. Performance scrutiny during 2025/26 identified an apparent inconsistency between recorded CSE crime and the proportion of children's assessments identifying sexual exploitation as a presenting factor. In Q3, CSE was recorded as a presenting factor in only 0.9% of assessments, while there was not a corresponding reduction in recorded CSE crime. Rather than interpreting the low assessment figure as evidence of reduced risk, the Partnership challenged whether exploitation was being consistently recognised and recorded. This has informed the continuing quality assurance focus on child exploitation and group-based child sexual abuse.

During the year Bedfordshire Police reported an 11% increase in qualified and trained detectives, with 54 officers completing specialist child abuse investigation development training and 100 officers and staff trained in Achieving Best Evidence interviewing. This represents a significant investment in specialist investigative capability which strengthen the professional infrastructure required to investigate abuse and obtain evidence from vulnerable children in an appropriate and child-centred way.

There is also evidence of broader improvement in making children's experiences more visible within policing. Following focused work on the Voice of the Child, recorded Athena Voice of the Child entries increased from **91 to 407 over a six-month period**. Although this measure is not specific to CSA and therefore should not be presented as a direct CSA outcome, it is relevant to the conditions required for effective sexual abuse practice: children need meaningful opportunities to describe their experiences and professionals need to record and act upon what children tell them.

Together with the CSA audit findings, this work has helped create a stronger and more informed workforce, better equipped to recognise abuse, undertake effective assessments and contribute to multi-agency safeguarding planning.

What difference has this made for children?

There is emerging evidence of impact, particularly in professional capability and identification. More primary care practitioners have received specific training in recognising CSA and navigating specialist pathways; an increase in GP referrals to SARC has been reported following that training; specialist police capability has increased; and the Partnership is now auditing case practice to establish whether children experiencing sexual abuse and exploitation are being recognised and responded to effectively.

Scrutiny of the data has resulted in a further move towards testing frontline practice. In March 2026, the new *Quality Assurance, Learning and Scrutiny* arrangements agreed a multi-agency audit of child exploitation and group-based child sexual abuse. A proposal has been agreed for

fifteen cases to be examined through single-agency review followed by multi-agency moderation, considering referral, assessment, planning, management oversight, supervision, multi-agency working and the voice of the child. This is an important development as it will support the partnership in testing whether policy and training are visible in the actual practice experienced by children, rather than relying on completion of training as evidence of impact. The audit will take place in Q1 in 2026/27 and its findings will inform ongoing CSA work.

Challenges that remain

Partner self-evaluation identified continuing challenges, including confidence in holding and assessing risk in complex CSA cases. This supports the Partnership's conclusion that training and increased professional knowledge are important but remain intermediate outcomes. Further audit, supervision and quality assurance are required to demonstrate that improved knowledge is resulting consistently in earlier recognition, effective professional curiosity and escalation, robust safety planning and commissioning improved support and recovery for children experiencing sexual abuse.

The Partnership recognises that increased training and referrals are intermediate outcomes, and its next priority is to demonstrate through audit, data and children's lived experience that these changes are resulting in earlier identification of abuse and improved safety and recovery for children.

DOMESTIC ABUSE

Domestic abuse remains embedded within the LSCP's performance monitoring rather than being viewed solely as an adult safeguarding or criminal justice issue. The inclusion of police data on domestic abuse incidents alongside children's safeguarding measures supports greater scrutiny of the potential impact of domestic abuse on children and of the interface between policing and children's services.

Domestic abuse continues to be the most frequently recorded MASH contact issue and is closely connected to several other partnership priorities.

- In Q3 2025/26, Luton recorded **1,613 domestic abuse incidents**, up from 1,557 in Q2 and 1,389 during the equivalent quarter in 2024/25
- For 16 and 17-year-olds, there were **48 victims in both Q2 and Q3**, demonstrating the continued importance of recognising older teenagers as victims of domestic abuse in their own right
- A key area of continued concern is repeat MARAC referrals. The rate reached **39% in Q3 2025/26**, the highest recorded since this measure began in 2022/23
- The average MARAC referral numbers over the first three quarters of 2025/26 was **37%**, compared with a quarterly average of **27%** during 2024/25
- BHFT provided evidence of their work on domestic abuse in that:
 - **142** maternity information-sharing forms concerned domestic abuse
 - **22** police notifications were received
 - **12** maternity cases were considered at MARAC

The partnership has sought to move beyond reporting of figures for this indicator and has commissioned further thematic analysis to understand whether the pattern relates to repeat coercive control, release of perpetrators, insufficient ongoing support after crisis intervention, service capacity or other causes such as issues with data collection and validity.

The health partner evaluations demonstrate that domestic abuse is increasingly being considered through a family safeguarding lens. BHFT describes closer working between adult, children's and maternity safeguarding teams, enabling practitioners to identify the potential impact on children when an adult presents with safeguarding concerns. Within maternity services, routine enquiry about domestic abuse continues throughout pregnancy, supported by information exchange between maternity safeguarding, Police and wider safeguarding arrangements.

Community health practitioners similarly undertake healthy-relationship discussions with families and use DASH assessments where domestic abuse is disclosed or suspected, supporting referrals to MARAC, Children's Social Care and Early Help where appropriate. EECH also describes development of an electronic Think Family referral mechanism, strengthening the expectation that practitioners consider children, parents, fathers and other significant adults as part of a family system rather than viewing the presenting individual in isolation.

This provides evidence that Think Family is becoming an operational safeguarding principle across health services and supports the Partnership's continued links with adult safeguarding around domestic abuse, parental mental health, substance misuse and other vulnerabilities affecting children's safety.

Learning from the Adult Rani Integrated Safeguarding and Domestic Abuse Review also identified system issues relevant to children and adults, including front-door pathways, information recording, risk-sharing arrangements, carer information and coordination between mental and physical healthcare.

Challenges that remain

The volume of incidents alone cannot describe and evidence children's lived experiences of domestic abuse and other forms of assurance are required to evidence this. A key question for the LSCP is how effectively child level information about domestic abuse is shared, assessed and translated into the right support and protection for children, particularly where domestic abuse coexists with neglect, poverty, substance misuse or other vulnerabilities.

Community health practitioners report that opportunities to discuss healthy relationships can be constrained when both parents are present, particularly within specialist services where the focus may primarily be medical. Acute health also identified changes and reduced on-site availability within the Luton hospital IDVA arrangements during the year, requiring continuing consideration of how victims access timely specialist support.

These findings reinforce the wider LSCP challenge around domestic abuse. The partnership needs stronger assurance about whether children affected by domestic abuse receive timely and sustained support, particularly where abuse coexists with neglect, parental mental health, substance misuse or poverty, and whether interventions reduce recurrent harm.

The new Quality Assurance, Learning and Scrutiny arrangements therefore agreed a multi-agency audit of domestic abuse alongside the LSAB. A proposal was agreed for cases to be examined through single-agency review followed by multi-agency moderation, considering referral, assessment, planning, management oversight, supervision, multi-agency working and the voice of the child. However, this audit was delayed due to the need to progress other audit work in relation to learning from reviews and will now be prioritised by LSCP in 2026/27.

There is also a need to deep dive the referrals and outputs from MARAC to ensure the partnership is assured that the right cases where children are involved are being managed through this process effectively. Assurance is also needed from the Domestic Abuse Luton Programme Board that commissioned services also show impact in safeguarding children.

MENTAL HEALTH AND EMOTIONAL WELLBEING

Mental health and emotional wellbeing remain an important safeguarding priority for the Partnership, recognising both the impact of children and young people's own mental health needs and the effect that parental mental ill-health can have on children. These needs frequently intersect with domestic abuse, substance misuse, neglect, exploitation, school attendance and wider family pressures, requiring a coordinated whole-family and multi-agency response.

What did we do

In March 2026 the LSCP Strategic Board held a themed discuss on Mental Health and Wellbeing supported by information available through the partnership's quality assurance and performance arrangements. This was also directly informed by the Luton SHUE survey, providing an important source of lived-experience evidence from children and young people.

This provided assurance that partners across Bedfordshire are delivering a comprehensive whole-system response spanning prevention, early help, targeted intervention and crisis support. Strong collaboration was evident across CAMHS , Children's Services, Police, Fire and Rescue, Probation and community services, alongside a strategic shift towards earlier intervention, community-based provision and a "no wrong front door" approach.

Provision includes Mental Health Support Teams in schools, parenting programmes, digital support, therapeutic interventions, and targeted youth and rehabilitation services. Importantly, the evidence demonstrated impact rather than activity alone.

What difference did it make?

Children and young people receiving support showed improved emotional wellbeing and resilience and measurable progress through therapeutic interventions. Earlier and preventative

support was also contributing to some children and families being supported without escalation to statutory intervention. This provides encouraging evidence that investment in earlier, community-based support is beginning to improve outcomes and help prevent needs escalating.

The discussion also demonstrated a broader system impact, with mental health increasingly being addressed as a shared safeguarding responsibility rather than solely a health issue. Multi-agency scrutiny, audit, review and outcome tracking are strengthening partners' collective understanding of need and enabling areas requiring improvement to be identified. The increased focus on prevention, early intervention and accessible support provides an important foundation for reducing escalation into crisis.

What challenges remain?

The evidence also identifies that increasing demand, complexity and capacity pressures are limiting the consistency of the outcomes experienced by children, particularly at the crisis end of the pathway. Delays in access to some mental health provision, including Mental Health Treatment Requirements and Section 136 handovers, workforce pressures, fragmented commissioning, and inconsistencies in information sharing remain areas requiring further improvement.

There is also a need for stronger and more consistent outcome data so that the Partnership can demonstrate not only how many children receive support, but whether support was timely, what changed for the child and whether improvement was sustained.

PROGRESS WITHIN SAFE IN THE COMMUNITY

Health services continued to strengthen their contribution to contextual safeguarding during 2025/26. Acute hospital safeguarding teams monitor presentations involving assault, weapon-related injury and substance misuse so that children's wider vulnerabilities can be considered alongside their immediate clinical needs. The Emergency Department Navigator service also resumed in Luton during 2025/26 following an earlier suspension associated with staffing constraints, restoring an additional opportunity to engage young people presenting to hospital where exploitation or extra-familial harm may be a concern.

Community health practitioners contribute to exploitation and missing arrangements and have access to the exploitation assessment tool and multi-agency information-submission processes. Youth Justice Nurses also undertake health-needs assessments for children and young people entering the youth justice system, providing further opportunities to identify unmet health and safeguarding needs. Together, these arrangements help create additional points of identification for children who may present to services because of the consequences of exploitation rather than directly disclosing exploitation itself.

Importantly, partners did not consider individual datasets in isolation. The LSCB Development Day identified apparent differences between recorded CSE crime and increases in assessments where CSE was identified as the main factor, prompting further questions about whether the

Partnership's data provides a complete picture of risk. This willingness to triangulate information is a positive foundation for developing a stronger partnership intelligence picture.

The Partnership identified a decrease in recorded CSE crimes across the three local authority areas and a 15% increase in completed Return to Home interviews during 2025/26. There has also been positive work involving children missing education, contextual safeguarding and community safety activity.

CHILD EXPLOITATION AND CONTEXTUAL SAFEGUARDING

During 2025/26 Child Exploitation remained an important area of partnership focus. Place based weekly Multi-Agency Child Exploitation (MACE) meetings have continued to take place to consider locations of concern, other intelligence, return home interviews and cases that need to be escalated or additional safety planning. The Pan Beds Child Exploitation and Missing Operational Group has continued to meet monthly with a Pan Beds focus on the processes for exploitation and missing children and intelligence on local cases and localities.

Learning from the Thematic Serious Youth Violence rapid review in September 2025 concerning the murder of a local man reinforced the importance of cross-boundary safeguarding. The review identified weaknesses when children placed outside their home local authority were not consistently pulled into local contextual safeguarding arrangements. Subsequent audit activity identified an individual failure to process an out-of-area notification and led to changes designed to create a single route for such notifications and ensure children are correctly flagged on systems. Cross border work has taken place to address these issues.

What difference has this made for children? During 2025/26, Bedfordshire Police strengthened its contribution to protecting children from exploitation by bringing police intelligence and decision-making closer to multi-agency safeguarding practice. The embedding of a dedicated police lead within the Multi-Agency Child Protection Team (MACPT) meant that police information and professional judgement were available earlier when partners were assessing risk and planning intervention. By the end of January 2026, the arrangements had involved 409 individual children, with police attendance at strategy discussions reaching 46 during January alone.

There is emerging evidence that this more integrated approach is reducing repeat harm. Among children receiving a MACPT police-led intervention following a missing episode, **37.5%** went missing again within three months, compared with **57.6%** in a comparator group without MACPT police involvement. The size of the cohort and follow-up period mean that this should not be treated as definitive causal evidence, but it provides an encouraging indication that earlier police involvement alongside partners may be helping to reduce repeat missing episodes and, consequently, children's exposure to exploitation and other extra-familial harm

Within Youth Justice, reduced first-time entry, low subsequent conviction following Early Intervention and reduced use of secure remand provides measurable evidence of difference.

Health services continued to strengthen their contribution to contextual safeguarding during 2025/26. Acute hospital safeguarding teams monitor presentations involving assault, weapon-related injury and substance misuse so that children's wider vulnerabilities can be considered alongside their immediate clinical needs. The Emergency Department Navigator service also resumed in Luton during 2025/26 following an earlier suspension associated with staffing constraints, restoring an additional opportunity to engage young people presenting to hospital where exploitation or extra-familial harm may be a concern.

In several other areas, including neglect, CSA and workforce development, there is good evidence of changed systems and professional practice but less direct evidence that children's circumstances have improved as a consequence. The Partnership's challenge for 2026/27 is therefore to close this evidence gap and demonstrate more consistently that changed practice produces earlier identification of harm, effective intervention, sustained reduction in risk and improved lived experiences for children.

The LSCP Scorecard data

The scorecard monitors both the number of children and young people with an exploitation flag and the proportion of assessments in which child sexual exploitation is identified as a presenting factor and shows:

- Children offered a Return Home Interview (RHI) has improved over recent years, up to **97.4%** in Q4.
- The Average RHI offered rate for 2025/26 was **96%**, notably higher than the 2023/24 average of **76%**.
- However average acceptance of RHI has dropped to **61%** in 2025/26, was **64%** the year prior and **72%** in 2021/22).
- CSE recorded crimes for Luton have dropped from **37** in 2024/25 to **29** in 2025/26. This raises the question as to whether this represents a genuine improvement in children subject to CSE and whether we have identified the right children
- The number of children recorded with an exploitation flag reduced from **36** in Q1 to 32 in Q2 and **20** in Q3 2025/26. Data cleansing and a revised methodology, including the exclusion of children whose cases were closed, contributed to the change.
- CSE was recorded as a presenting factor in only **0.9%** of assessments in Q3, while recorded CSE crimes did not show a comparable decline. This apparent mismatch has led the partnership to question whether exploitation is being consistently recognised and recorded within assessments as such.
- Front-door data identified particular concern regarding 13-year-olds going missing and exploitation, including intelligence around young people drawing peers into risky networks. This intelligence was being managed through SPOC, MACE and partnership tasking arrangements.

Workplans also show:

- Strengthening of mapping and MAGPan processes for exploitation and missing children.
- Work to raise awareness of indicators and risk had been delivered to services, schools and other education settings.

- The longer-term commentary within the scorecard identified the improved embedding of contextual safeguarding in Luton as influencing how exploitation is recognised and recorded.
- Recruitment of a Pan Beds Child Exploitation Lead from January 2026 who undertook a review of existing processes for CEM and how we capture the voice of the child in assessments.

Remaining challenges

The increase in children reported missing and variance in RHI offered and accepted has caused concerns. Alongside concerns about exploitation and serious youth violence which require greater partnership attention, including understanding why children carry weapons or go missing and what makes them feel unsafe. The continuing challenge is to establish whether falling CSE and exploitation indicators represent reduced harm or under-identification, and to strengthen the triangulation of Police intelligence with information from missing children, Return Home Interviews, health, education, Youth Justice and Children's Social Care.

The LSCP Strategic Board concluded that, although operational oversight of child exploitation and contextual safeguarding continued during 2025/26, strategic oversight and pace of delivery were not sufficiently strong or consistent throughout the year. Changes within the Pan Bedfordshire Child Exploitation arrangements contributed to gaps in strategic coordination and workplan delivery. The partnership has therefore identified strengthening strategic oversight of risk outside the home, including exploitation and group-based child sexual abuse, as an immediate priority for 2026/27. The LSCP Development Day for 2026/27 will have a thematic focus on these issues.

SAFEGUARDING IN EDUCATION

The partnership continued to strengthen the role of education in 2025/26 as a core safeguarding partner, recognising that schools and education settings are often the professionals with the most regular contact with children and are therefore uniquely placed to identify changes in behaviour, presentation, attendance and family circumstances. The Pan Bedfordshire Safeguarding Education Group has provided a mechanism for education representatives and safeguarding partners to share learning, identify emerging concerns and ensure that education was connected to wider work on neglect, exploitation, domestic abuse, children missing education, elective home education and professional escalation.

There is evidence that this increasingly integrated approach is making a difference. The Ofsted ILACS inspection of children's social care found that the number of children missing education in Luton had reduced, attributing this to a multi-agency approach to understanding the barriers to attendance. Importantly, the impact was expressed in terms of children's outcomes and children were being supported to successfully obtain and maintain school places. Inspectors also found that oversight of children who were electively home educated was well organised and effective, with partners collaborating to ensure that children's needs and safety were understood and prioritised.

During 2025/26 particular assurance activity included:

- school safety and security following Family X and in the light of Martyn's Law
- elective home education in the light of the Sussex CSPA Sara Sharif
- review of exclusions and complementary education provision
- the role of education in contextual safeguarding
- the role of schools and education settings in professional escalation
- children missing education in the light of the rapid review for Child Tahmina
- identification of children who may be "hidden" from universal services.

The partnership's focus has extended beyond school attendance to ensuring that education is an active participant in safeguarding assessment and decision-making. Evaluation of the developing Family Help arrangements identified positive examples of timely information being provided by education to support children's assessments. During 2025/26, Education played a key role in the Multi-Agency Child Protection Team (MACPT) by seconding an experienced teacher into the service to bridge any gap in information sharing, understanding of education risks between home, schools and the other safeguarding partners.

This is important because information held by schools about attendance, behaviour, presentation, relationships and family circumstances can provide a longitudinal picture of the child's lived experience that may not be available to individual services seeing a child less frequently.

CHART 8: EDUCATION DEMOGRAPHICS

Luton Education Indicators	n Jan 2026	% Jan 2026
Pupils in Luton schools	40,831	
% minority ethnic background	34,869	85.4%
FSM eligible	12,168	29.8%
Receiving FSM on census day	10,249	26.1%
Receiving FSM on census day: Primary		25.1%
Receiving FSM on census day: Secondary		32.4%
SEN Support (without an EHCP)	5,676	13.9%
Education Health Care Plans (EHCP)	1,715	4.2%
Total SEND pupils	7,391	18.1%

- **Ethnic Diversity:** The proportion of pupils from minority ethnic backgrounds is significantly higher than the town's general population profile, with roughly **85.4%** of school-age children coming from minority backgrounds.⁶
- **Free School Meals (FSM):** Nearly **30%** of all students are actively registered as eligible for Free School Meals, reflective of localized economic pressures across urban census tracts.

⁶ <https://ukdemographics.co.uk/places/luton/>

- **Special Educational Needs (SEN):** Rates for standard school-based SEN Support and formalised Education, Health and Care Plans (EHCPs) have aligned with upward national trends, reflecting an increased demand for specialized provisions.⁷

There is also evidence that schools' safeguarding concerns are increasingly influencing partnership assurance. During 2025/26, education partners raised concerns about the effectiveness and timeliness of responses at Stage 1 of the professional escalation process. Rather than relying on the apparently positive reduction in higher-stage escalations, the partnership challenged whether some disagreements were not progressing because practitioners were experiencing difficulty obtaining a response at the first stage. QALS consequently agreed to improve the collection and scrutiny of Stage 1 escalation information. This demonstrates education increasingly acting not simply as a recipient of partnership safeguarding arrangements, but as an active source of professional challenge and intelligence about how well the multi-agency system is working.

The learning from Child Tahmina highlighted the potential vulnerability of a child who was not known within the education system despite a sibling attending school and raised the wider system question of how children who are outside education can be prevented from becoming hidden from the safeguarding network. This learning and the recommendations from this review were presented to the Pan Beds Safeguarding Education Group with a key question of how education settings can support identification of hidden children. The learning has also strengthened the focus on connections between education, primary care and the Healthy Child Programme and reinforces the principle that absence from education must not mean absence from safeguarding oversight.

Education has also played an important role in building the safeguarding capability of the wider workforce. Education continued to represent a substantial proportion of engagement with the Safeguarding Bedfordshire learning programme during 2025/26. The strong engagement of education practitioners provides an important route for disseminating learning from reviews and reinforcing practice around areas including neglect, child sexual abuse, domestic abuse, exploitation and thresholds.

Education practitioners also remained a significant part of the Safeguarding Bedfordshire learning programme as Luton education settings was the largest audience within the programme. Although these figures demonstrate strong engagement and increased knowledge, the partnership recognises that attendance and reported confidence are intermediate measures rather than evidence that children's outcomes have improved. The next step is to triangulate this information with audit, review findings, supervision and children's experiences to establish whether learning is changing safeguarding practice.

What difference did this make?

- **95%** of children in Luton attend schools graded as "Good" by OFSTED

⁷ <https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england/2025-26>

- Education strategies were rewritten and launched with trauma-informed practices to address disruptive behaviour and prevent exclusions
- The number of referrals from Schools increased from **27.6% to 34.2%** and education settings continued to make the highest number of referrals into MASH
- Fewer children were missing education, with Ofsted linking the reduction directly to multi-agency work on barriers to attendance.
- Children missing education were being supported to obtain and sustain school places, providing evidence of an outcome rather than simply activity.
- Oversight of electively home-educated children was independently judged effective, with partners collaborating around children's needs and safety.
- Children in care benefited from coordinated educational support and multi-agency work to remove barriers to learning and re-engage them with education.
- Virtual School support contributed to increased education, employment and training participation amongst care leavers as well as other children with a social worker.
- Education intelligence is increasingly contributing to assessment, safeguarding decision-making and professional challenge across the partnership.

Challenges that remain

Despite this progress, the partnership is not yet fully assured that all children are equally visible through the education and safeguarding system. Child SS demonstrates why children who have never entered school, are electively home educated, move frequently between areas or have prolonged absence require particular attention. Health, education and social care information needs to be connected so that a child does not effectively disappear from professional oversight because they are outside a conventional education setting.

Attendance also needs to be viewed as a safeguarding indicator and not simply an educational performance measure. Persistent or changing absence can coexist with neglect, exploitation, domestic abuse, poor emotional wellbeing or family pressures. The continuing challenge is to improve how education attendance information is triangulated with safeguarding information held by police, children's social care and health.

Resolving professional disputes and escalation is an area requiring further assurance. The concerns raised by education regarding some Stage 1 escalation responses demonstrate that the partnership needs to understand more than the numbers of escalations and whether professional disagreement results in use of all available tools and reconsideration of risk and better decisions and outcomes for children.

PROGRESS WITH SAFE GOVERNANCE, STRUCTURE AND PROCESSES:

During 2025/26, the Luton Safeguarding Children Partnership (LSCP) undertook a significant programme of governance and organisational development. This reflected the requirements of *Working Together to Safeguard Children 2023*, changes within local partnership arrangements and a continuing commitment to ensure that safeguarding structures remain proportionate, effective and focused on improving outcomes for children.

The LSCP Strategic Business Plan 2025-2027 established three overarching ambitions, for children and young people to be safe at home, safe in the community, and safeguarded through effective governance, structures and processes. The partnership has increasingly sought to assess the effectiveness of its arrangements against three fundamental questions:

- What do we know about the quality and effectiveness of safeguarding practice?
- What difference has partnership activity made to frontline practice?
- What evidence demonstrates that this has improved children's experiences and outcomes?

During the year, this resulted in greater emphasis on triangulating performance information with multi-agency audit, safeguarding review findings, inspection evidence, training evaluation, professional escalation and partner assurance. This represents an important development from reporting individual sources of information towards developing a more comprehensive understanding of the effectiveness of the safeguarding system.

The collaborative culture of the partnership remained an important strength. The LSCP Development Day in June 2025 brought together local authority services, health, police, education and voluntary and community sector partners and included children and young people. This provided an opportunity to draw on the considerable safeguarding expertise across the partnership and reinforced the importance of the experiences of children, young people and frontline practitioners informing strategic priorities and decision-making.

During 2025/26, the partnership continued to strengthen the principle that safeguarding is a shared statutory responsibility. This included further consideration of how leadership and chairing responsibilities could be distributed across statutory partners and how the strengthened role of education envisaged within *Working Together 2023* should be reflected within local arrangements.

Independent scrutiny remained integral to the governance framework. Scrutiny during the year included consideration of case review decisions, performance, neglect, GCP2, partnership governance and whether completed actions could be demonstrated to have changed practice. This has supported an increasingly important distinction between completion and impact. The partnership has begun to apply greater challenge where similar learning continues to appear in safeguarding reviews despite previous action, training or procedural change.

The continuing challenge is to ensure that shared accountability is visible throughout the safeguarding system, including through partner leadership of governance arrangements and stronger links between strategic leaders and frontline practitioners. Practitioner forums will have an important role in providing direct intelligence about the effectiveness of multi-agency arrangements and ensuring that operational experience influences strategic decision-making.

Separation of the LSCP and LSAB Business Units

What we did: One of the most significant structural changes during the year was the separation of the previously integrated LSCP and Luton Safeguarding Adults Board (LSAB) Business Unit.

The joint Business Unit had operated since 2018. Since its establishment, the statutory and regulatory expectations placed upon both safeguarding partnerships had increased considerably, alongside growing requirements relating to independent scrutiny, case reviews, quality assurance, data, learning and statutory reporting.

An Organisational Change Assessment was undertaken and, in March 2025, a decision was made to establish two dedicated Business Units, while retaining collaborative arrangements where adult and children's safeguarding responsibilities intersected. Implementation commenced in April 2025. The organisational change process concluded in July, with the final transfer of business arrangements taking place in September 2025 while vacancies within the LSAB Business Unit were addressed.

The purpose of the change was not to separate adult and children's safeguarding practice, but to provide each statutory partnership with clearer accountability, dedicated capacity and a stronger focus on its respective statutory responsibilities and strategic priorities. The change was implemented without increasing the overall level of partner contributions to business support and contributions remained in the same proportions as in 2024/25 with the local authority contributing 49% of the total budget.

What difference did it make? The revised arrangements have provided the LSCP with a dedicated children's safeguarding business function focused on supporting statutory responsibilities, strategic priorities, quality assurance, learning and review activity. At the same time, areas of joint working have deliberately been retained where this adds value. In particular, the Joint Case Review Group continued to consider learning across children's and adult safeguarding. This has enabled partners to maintain a whole-family perspective when considering issues such as domestic abuse, neglect and self-neglect, parental mental health, transitional safeguarding and other areas where children's and adults' safeguarding responsibilities overlap.

The new structure has therefore enabled the partnership to develop a clearer children's safeguarding focus while retaining the benefits of Think Family and whole-family safeguarding.

Challenges remaining: The new arrangements were still embedding at the end of the reporting year and their full impact cannot yet be assessed. A key area for ongoing consideration is the capacity and sustainability of the dedicated LSCP Business Unit, particularly given the reduced resource available alongside increasing expectations in relation to statutory reviews, audit, data and intelligence, learning, scrutiny and engagement.

During 2026/27, the partnership will evaluate whether the revised model provides sufficient capacity and resilience to support its statutory functions effectively and whether the intended improvements in accountability, responsiveness and focus have been achieved. A particular challenge is the continued disproportionate contribution to the LSCP budget and there needs to be further discussion between statutory partners on how to bring more equitability to these.

Quality Assurance, Learning and Scrutiny

What we did: The wider partnership governance structure was also reviewed during 2025/26. Partners identified areas of duplication between the Joint Quality Assurance and Learning Group and the children's Scrutiny and Performance arrangements. Similar information was sometimes considered through several forums before reaching the Strategic Board, increasing demand upon partners without necessarily strengthening the quality of assurance.

The partnership continued to strengthen the principle that responsibility for safeguarding governance is shared across the statutory partners rather than owned by the local authority. During 2025/26 there was continued discussion about distributing chairing responsibilities more equitably across agencies. This included changes to the Joint Case Review Group chairing arrangements and consideration of partner leadership of QALS.

The newly established Quality Assurance, Learning and Scrutiny Group (QALS) which brings together responsibilities previously distributed between different groups, including:

- scrutiny of multi-agency safeguarding performance;
- multi-agency audit and assurance;
- single-agency partner assurance;
- learning from safeguarding reviews;
- oversight of partnership priorities;
- training and workforce impact;
- learning from inspection;
- professional escalation and challenge; and
- oversight of evidence of effectiveness and impact required for the LSCP Yearly Report.

The first QALS meeting took place in March 2026 and incorporated the outstanding actions from the previous quality assurance and scrutiny arrangements.

What difference did it make? The revised structure has established a clearer framework through which different sources of safeguarding intelligence can be considered collectively. Performance information, audit findings, case review learning, inspection evidence and professional challenge can increasingly be triangulated to provide a more rounded assessment of safeguarding effectiveness.

The March 2026 QALS meeting explicitly identified the importance of diversity in chairing and of ensuring that responsibility for partnership governance is shared across the safeguarding system. The agreed Terms of Reference established QALS as the partnership's principal forum for considering the quality and effectiveness of multi-agency safeguarding practice before assurance and exceptions are reported to the Strategic Board. The intention of the revised structure is therefore fewer, more purposeful governance meetings, with clearer accountability for what each forum is expected to deliver.

The partners and Independent Scrutineer has provided challenge across the partnership, including scrutiny of case review decisions, performance, neglect, GCP2, partnership

governance and whether the evidence demonstrates impact rather than simply completion of actions. This illustrates a developing maturity within the assurance arrangements, with the partnership seeking to understand the reasons behind performance indicators rather than relying on headline measures alone.

A clear example is the reduction in cases reaching later stages of escalation which could have been interpreted positively, concerns raised by education and health partners regarding responses at Stage 1 prompted further challenge. The partnership therefore agreed to strengthen the collection and analysis of Stage 1 information to determine whether concerns were being effectively resolved at the earliest opportunity.

What challenges remain? As QALS was established towards the end of 2025/26, evidence of its longer-term effectiveness is not yet available. During 2026/27, the partnership will need to demonstrate that scrutiny results in appropriate challenge and action, and that subsequent assurance can evidence improvement in frontline safeguarding practice.

Clear reporting and escalation between QALS and the LSCP Strategic Board will also remain essential to ensure that emerging risks, areas of insufficient assurance and examples of effective practice inform strategic leadership and decision-making. There is also need to ensure that in any review of the arrangements for scrutiny and performance that the Luton place based evidence of impact is not diluted or lost.

Pan Beds Multi-Agency Safeguarding Arrangements Effectiveness Review

What we did:

The partnership has continued to balance local place-based accountability for safeguarding children in Luton with the benefits of collaboration across Pan Bedfordshire. Several statutory and relevant agencies operate across more than one local authority area. Shared arrangements across Pan Bedfordshire therefore provide opportunities to develop common approaches and reduce duplication while maintaining local oversight of the experiences and outcomes of children in Luton.

During 2025/26, the Pan Bedfordshire Strategic Leaders of Children's Services Group commissioned an independent review of the Multi-Agency Safeguarding Arrangements (MASA) across Luton, Bedford Borough and Central Bedfordshire which was undertaken between July and September 2025. The review considered documentary evidence and incorporated stakeholder feedback and frontline practitioner engagement, discussions with young people and a SWOT analysis. Its purpose was to consider how the arrangements could become more effective, reduce unnecessary duplication and strengthen outcomes for children and families.

The review identified strong foundations, including trusted professional relationships, effective governance, Business Unit support, well-organised multi-agency training, innovation and an established culture of shared learning. It also identified areas for further development, including duplication within governance structures, variability in partner engagement, capacity for scrutiny and assurance, inconsistent application of thresholds and a need to improve the

consistency with which learning reaches frontline practice. Cultural competence, knowledge of child sexual abuse, data and intelligence, and meaningful engagement with children, young people and families were also identified as areas requiring further development.

Importantly, the review concluded that future arrangements should be determined not by the pursuit of financial savings, but by measurable, evidence-led and sustainable improvements to the safeguarding system that benefit children and families.

What difference did it make?

During 2025/26, Pan Bedfordshire arrangements supported joint work in relation to neglect and GCP2, safeguarding in education, child sexual abuse, exploitation and missing children, Voice of the Child, transitional safeguarding, Section 11 assurance, policies and procedures and multi-agency workforce development. These arrangements have therefore supported greater consistency for agencies and practitioners operating across local authority boundaries and enabled safeguarding learning, procedures and workforce development to be shared across Bedfordshire.

They have been particularly important as safeguarding issues including exploitation and extra-familial harm do not respect geographical boundaries. The LSCP has remained clear that Pan Bedfordshire collaboration must retain sufficient place-based intelligence and accountability to understand the particular needs and experiences of children in Luton.

The Pan Beds MASA review has also provided an independent evidence base against which the effectiveness and future configuration of Pan Bedfordshire arrangements could be considered. In September 2026, the independent scrutineers identified three potential models, ranging from enhancement of the existing three-partnership arrangements through to a fully integrated Pan Bedfordshire safeguarding partnership. This has enabled the next stage of development to be considered in 2026/27 against effectiveness, impact and the preservation of local intelligence rather than organisational preference alone.

What challenges remain?

The review represents the beginning rather than the conclusion of this work. Any significant structural reform across three safeguarding partnerships will require careful planning, implementation and evaluation. It will be particularly important to ensure that structural reform does not become an outcome in itself. The partnerships will need to demonstrate that any future changes improve the quality of professional collaboration, strengthen scrutiny, reduce unnecessary duplication and ultimately contribute to improved safeguarding experiences and outcomes for children.

Effective Support and Thresholds

What we did: The consistent application of thresholds remained an important area of focus during 2025/26. Learning from audits, reviews and frontline practice continued to identify issues relating to referral quality, understanding of thresholds, Family Help and statutory

intervention, information sharing and consent, professional escalation and recognition of cumulative harm.

A significant element of the governance and systems work involved reviewing the application of thresholds and ensuring children consistently receive the right support at the right time. Development of the Luton Effective Support document moved towards a Pan Bedfordshire approach. By January 2026 the earlier Luton document had been superseded by the [Pan Bedfordshire Effective Support: Meeting the Needs of Children Guidance](#), with a programme of multi-agency launch events agreed for 2026.

This is directly linked to learning repeatedly identified through audits and reviews concerning:

- the quality of referrals and understanding of thresholds
- the role of family / early help and statutory intervention
- the role of resolving professional disputes, escalation and how it is articulated
- the role of information sharing and understanding of consent
- recognition of cumulative harm across children in particular circumstances .

Importantly, the launch across Pan Bedfordshire is being positioned as more than dissemination of another document with place based delivery of face-to face events. Baseline front-door information is also being collated so that the partnerships can subsequently test whether the guidance and associated training have resulted in better-quality referrals, clearer understanding of thresholds and more children reaching the right service at the right time.

What difference did it make? The development of a common Pan Bedfordshire approach provides greater consistency for practitioners and agencies operating across local authority boundaries. Importantly, implementation has been designed to enable impact to be assessed. Baseline front-door information provides a means of subsequently determining whether the guidance contributes to improved referral quality, greater consistency in threshold decision-making and more children receiving appropriate support at the right time.

What challenges remain? As implementation commenced towards the end of the reporting period, it is too early to evidence sustained impact from the introduction of the revised guidance. During 2026/27, the partnership will assess whether practitioners understand and apply the guidance consistently and whether this is reflected in referral quality, decision-making, professional escalation and children's journeys through the safeguarding system.

Strengthening Data, Intelligence and Assurance

What we did: The partnership continued to strengthen its analytical capability during 2025/26. An important development was the recruitment of a Pan Bedfordshire Senior Safeguarding Data Analyst and the continued development of the LSCP Safeguarding Scorecard. Measures were reviewed with partner data leads, definitions clarified and direction-of-travel indicators incorporated. The partnership also strengthened expectations that quantitative information should be accompanied by meaningful professional analysis explaining what the data indicates about safeguarding practice and children's experiences.

What difference did it make? The additional analytical capacity has begun to support a transition from collecting performance data to developing safeguarding intelligence. This has been important when interpreting measures relating to domestic abuse, exploitation, MASH activity and GCP2, where movement in the figures cannot automatically be interpreted as evidence of better or poorer safeguarding performance.

The partnership is also increasingly triangulating performance information with multi-agency audit. Audit findings will form part of QALS assurance alongside planned work on neglect, transitional safeguarding, child exploitation and group-based child sexual abuse.

What challenges remain? Data quality, timeliness and consistency remain areas requiring development. Some indicators are relatively new, methodologies have changed for others, and the completeness of partner contributions remains variable. There is also a need to strengthen the use of qualitative evidence, particularly children's experiences, audit findings and practitioner intelligence, to complement quantitative performance information.

LEARNING FROM EXPERIENCE

The LSCP ensures that its rapid reviews, Child Safeguarding Practice Reviews (CSPRs), audits and other types of non-statutory case reviews yields learning. This includes evidence of good practice and improvements required to enhance and develop practice and service provision. It uses a themed highlight report process to monitor the impact of this learning.

LEARNING FROM RAPID REVIEWS AND CHILD SAFEGUARDING PRACTICE REVIEWS

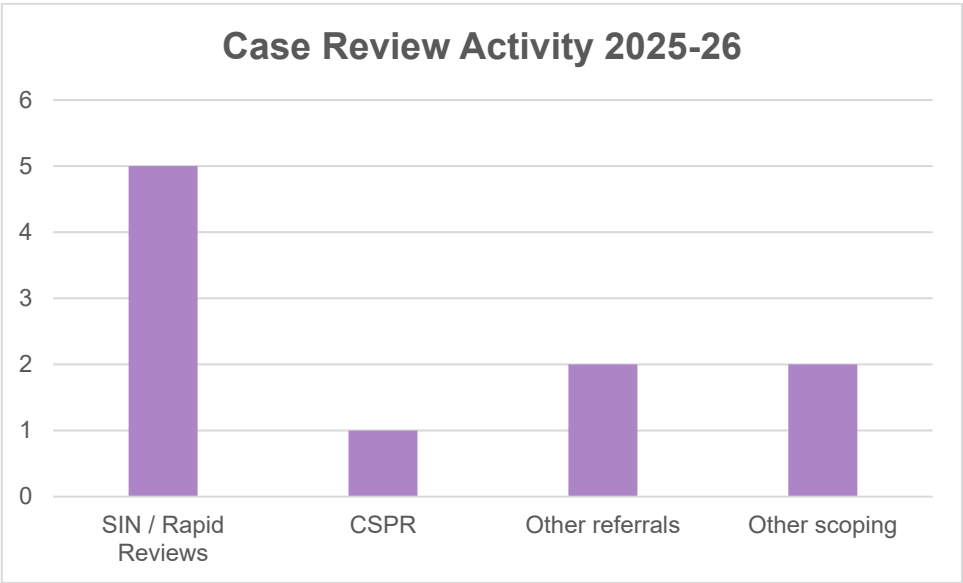
How many?

The partnership has made 5 notifications of Child Serious Safeguarding Incidents to the National Review Panel as required by *Working Together (2023)*. It undertakes timely Rapid Reviews to determine whether a Child Safeguarding Practice Review (CSPR) is required and to identify learning that can strengthen future safeguarding practice.

Learning from reviews remains one of the partnership's most important mechanisms for understanding safeguarding practice, identifying areas for improvement and strengthening the multi-agency response to children and families. Throughout 2025/26, the partnership continued to promote a culture of openness, reflection and learning, recognising that reviews provide valuable opportunities to understand both effective practice and the factors that contribute to children experiencing harm.

The chart below shows how partnership activity around Serious Incident Notifications (SINs) and Rapid Reviews which have increased after a sharp decrease last year. There was also learning undertaken over a range of cases including non-statutory learning activities.

CHART 9: NUMBER OF CASES CONSIDERED BY LSCP – APRIL 2025 – MARCH 2026

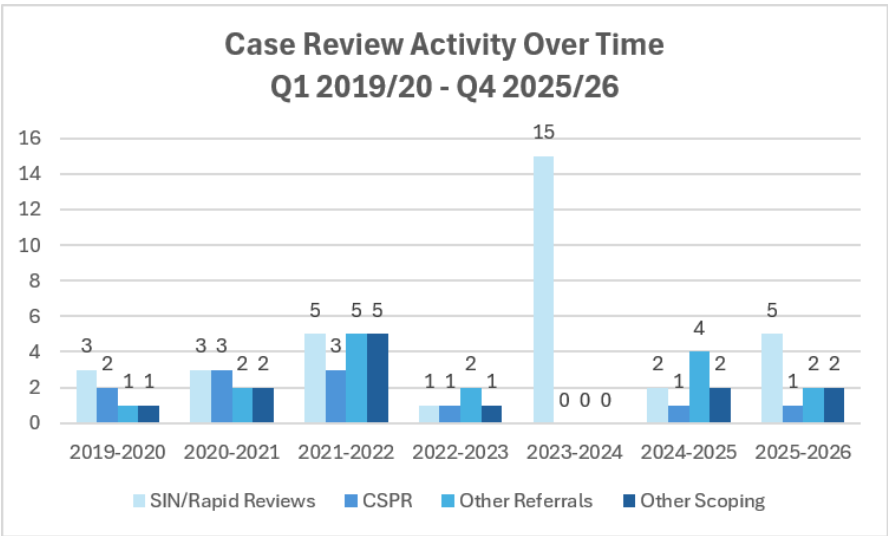


Themes in 2025/26 have ranged from invisible children, neglect, concealed pregnancy and birth and group related serious youth violence. During 2025/26, the partnership completed:

- 5 Rapid Reviews
- 1 Child Safeguarding Practice Review
- 2 Other Referrals
- 2 Scoping Exercises

The decisions made by the LSCP on whether to undertake a local CSPRs have been ratified by the National Review Panel (NRP) in all Rapid Reviews undertaken in 2025/26. The NRP have also welcomed the robustness of the rapid reviews undertaken and their action plans.

CHART 10: CASE REVIEW ACTIVITY OVER TIME – APRIL 2019 – MARCH 2026



The chart above demonstrates that since 2019, the partnership has considered a wide range of safeguarding incidents through Serious Incident Notifications, Rapid Reviews, Child

Safeguarding Practice Reviews (CSPRs), referrals for consideration and scoping exercises. The volume and nature of reviews undertaken over this period reflects not only safeguarding activity within the local area but also changes within national safeguarding arrangements following the introduction of *Working Together to Safeguard Children 2023*.

The partnership has increasingly sought to ensure that learning is proportionate, timely and focused on improving practice rather than solely producing review reports. Between Quarter 1, 2019 and Quarter 4, 2026 the partnership considered:

- **34** Rapid Reviews/Serious Incident Notifications
- **11** Child Safeguarding Practice Reviews
- **16** Other Referrals
- **13** Other Scoping Exercises

THEMES EMERGING FROM CSPRS

Baby Milo

What did we learn? is an unpublished CSPR concerning serious harm suffered by Baby Milo aged 2 months, focusing on the family's background, the incident details, and the involvement of various agencies in the child's case. The themes emerging included practice around:

- Voice of the Child and understanding of lived experience
- Injuries in non-mobile children
- Application of Thresholds, Policies, and Procedures
- Maternal Mental Health and Vulnerabilities
- Father-Inclusive Practice
- Domestic Abuse and Risk Assessment
- Multi-Agency Information Sharing
- Quality of Assessments and Plans

What difference did it make? The CSPR has been completed and plans for publication are on hold due to the ongoing parallel legal proceedings. However, the recommendations and action plan have been progressed as above and learning materials created and updated to ensure the learning informs the multi-agency safeguarding system in Luton and across Pan Bedfordshire. The review made the following recommendations which have been completed:

- review of the Injuries to Immobile Babies pathway and its application in practice.
- enhanced training on mental health and trauma-informed approaches for practitioners.
- the importance of father-inclusive practice and understanding the dynamics of domestic abuse needs to be promoted.
- reviewed single-agency assurance and the recommendations arising from Baby Milo
- reflective practice event for involved practitioners to discuss decision-making and threshold application – this was delivered as a Pan Beds training on section 47.
- key messages disseminated around accidental and non-accidental injuries, the Pan Bedfordshire pre-birth pathway, strategy discussions, information gathering, parental risk and prevention messages.

What challenges remain? Within the recommendations from the review there was an expectation set that all assessments will be conducted face to face. While the partnership has agreed that this should be the expectation there are some challenges for some agencies in terms of their delivery model. Therefore they are providing the LSCP with assurance on how they will ensure that safeguarding non-mobile babies will be kept at the forefront of their service delivery.

The impact of the above changes to practice guidance, processes, audit and training will continue to be evaluated throughout 2026/27 with the impact of the new arrangements being evaluated through KPIs and assurance rather the creation of new pathway and processes representing the only evidence of improvement.

THEMES FROM RAPID REVIEWS:

Child Tahmina

What did we learn? The rapid review concerning Tahmina highlighted the particular vulnerability of children who can become hidden from universal and safeguarding services. Tahmina was registered with her GP but did not attend an initial health screening or vaccinations. Tahmina not known within the education system despite a sibling attending school, raising an important system question about how agencies identify children who are not visible through the usual education pathways. The learning particularly reinforced the safeguarding role of health practitioners, because a child who is not attending school may nevertheless be known through primary care, health visiting, the Healthy Child Programme, emergency care or other NHS services. The review therefore reinforced the importance of health professionals exercising professional curiosity, considering a child's educational status and wider circumstances, and sharing information where there are indications that a child is insufficiently visible to the wider professional network.

What did we do? The partnership used the review to examine the connections between primary care, the Healthy Child Programme, education and children's social care, recognising that health information can provide a critical opportunity to identify children who might otherwise remain unseen. Health partners reinforced learning with primary care practitioners about children who may be hidden from universal services, including the importance of asking about and checking education arrangements rather than assuming that a child is attending school. This has complemented wider partnership work concerning children missing education and elective home education and strengthened the expectation that health practitioners consider not simply a presenting health need, but the whole child and their visibility across the safeguarding system.

What difference did it make? The learning has strengthened recognition that health practitioners form an important safeguarding safety net for children who may not be visible through education. It has reinforced expectations that health professionals notice and act upon gaps in children's universal-service engagement, ask where and how a child is being educated, use professional curiosity where arrangements are unclear and connect information held by health with that held by other agencies. Wider evidence supports improvement in the system

within which this learning is being embedded. Inspection of Luton local authority children's services found that oversight of electively home-educated children was well organised and effective, with partners collaborating to ensure children's needs and safety were considered and prioritised. It also found that the number of children missing education had reduced because of a multi-agency approach to understanding barriers to attendance, enabling children to obtain and maintain school places.

What challenges remain? The learning also identified a national gap relating to Initial Health Assessments, with implications for the ability of health services to identify and respond to the needs of some vulnerable children. The National Child Safeguarding Practice Review Panel has written to NHS England seeking action to close this gap and requesting assurance about the arrangements. This is significant because learning arising from the case has therefore informed not only local practice and assurance but has also contributed to scrutiny of the national safeguarding framework.

The significance of the Tahmina learning therefore extends beyond an individual case. It has reinforced locally the critical safeguarding role of health practitioners in identifying children who may otherwise remain hidden, strengthened the connection between health and education information, and contributed to national scrutiny by the Child Safeguarding Practice Review Panel of a gap in Initial Health Assessment arrangements. The partnership will continue to seek assurance that the resulting local and national actions lead to earlier identification and protection of children who are not routinely visible to universal services.

Thematic Rapid Review Serious Youth Violence:

What did we learn? The Thematic Rapid Review highlighted important learning about cross-boundary safeguarding and the protection of children placed outside their home local authority, particularly where children are vulnerable to exploitation and extra-familial harm.

The review identified the risk that children living outside their originating authority may not be sufficiently visible within the contextual safeguarding arrangements operating in the area where they are actually living. Effective safeguarding therefore requires more than notification that a child has been placed in another area.

Information about the child's vulnerabilities, exploitation risks, significant relationships and local intelligence needs to be understood and connected to the safeguarding structures in the receiving area. The learning reinforced the principle that a change of placement or geographical boundary must not result in a gap in safeguarding oversight.

The partnership responded by examining the pathway for out-of-area notifications and whether children placed in Luton were being consistently identified and connected with the relevant local safeguarding arrangements. Follow-up audit activity identified an example where an out-of-area notification had not been processed as required. Rather than treating this solely as individual practitioner error, the partnership considered the wider system and process around notifications.

Action was taken to establish a clearer single route for out-of-area notifications and to strengthen the process for ensuring that relevant children are appropriately identified and flagged on systems, reducing the opportunity for important safeguarding information to become fragmented between agencies or administrative processes.

This provides tangible evidence of impact from the review. The learning resulted in a change to the safeguarding pathway rather than simply the production of a learning briefing or action plan. The strengthened arrangements improve the likelihood that children placed in Luton from another area are visible to local services and that professionals are better placed to connect information about placement circumstances with local intelligence about exploitation, peer groups, locations and other contextual risks. This is especially important for children whose risks exist beyond their family home and cannot be effectively managed by the placing authority working in isolation.

The review has also reinforced the partnership's wider focus on contextual safeguarding and exploitation, including the importance of MACE and other multi-agency arrangements having visibility of children who are vulnerable in Luton irrespective of which local authority holds statutory responsibility for them. This supports a more child-centred approach in which professionals ask not simply *“which authority is responsible for this child?”* but *“what risks is this child experiencing here and who needs to know and act?”*

What challenges remain? The most significant learning from the Thematic Rapid Review is that safeguarding responsibility cannot stop at geographical boundaries. The review resulted in a strengthened pathway for out-of-area notifications and greater emphasis on ensuring that children placed in Luton are visible within local contextual safeguarding arrangements. The continuing challenge is to demonstrate that this improved system visibility consistently results in earlier identification of exploitation, better information sharing between placing and receiving authorities and timely multi-agency action that reduces risk for children.

However, improving the out of area looked after child notification pathway does not in itself guarantee effective cross-boundary safeguarding. The partnership still needs assurance that:

- notifications are received
- acted upon and translated into meaningful safeguarding activity
- that children's records are appropriately flagged and
- relevant information reaches operational practitioners and contextual safeguarding forums rather than remaining an administrative notification.

There is also a continuing need for clear communication between placing and receiving authorities, particularly when risk changes following placement, when children go missing or where local intelligence identifies emerging exploitation concerns.

A further challenge is demonstrating outcomes. A more reliable notification process is important evidence of system impact, but the partnership should not yet present this as evidence that exploitation risk for individual children has necessarily reduced. The next stage of assurance should test whether children placed across local authority boundaries are being

identified promptly, incorporated into relevant local risk-management arrangements and receiving timely interventions when risks emerge.

THEMES FROM ALTERNATIVE LEARNING REVIEWS

Family Smith:

What did we learn? The alternative learning review concerned a family where there was a known history of endemic neglect, physical harm and parental mental health concerns. The children were removed from the home due to these concerns by the police utilising their powers under section 46, Children Act 1989.

As the criteria for a serious child safeguarding incident was not met the partnership undertook a proportionate alternative learning review, ensuring that the opportunity for multi-agency learning was retained. The review of Family Smith identified significant learning about the early recognition and response to chronic and cumulative neglect and importance of history. Although professionals had been involved with the family, the children's lived experience and the cumulative impact of concerns over time were not always sufficiently recognised or brought together.

The review reinforced the importance of practitioners using family history to understand patterns of harm, maintaining professional curiosity and ensuring that parental engagement is not mistaken for evidence that children's circumstances have improved. It also highlighted the need for consistent use of the Graded Care Profile 2 (GCP2), effective information sharing, stronger multi-agency planning and timely professional challenge and escalation.

Of particular significance was the similarity between the findings from Family Smith and earlier learning from Family T, which raised a fundamental question for the partnership about why known learning on neglect had not yet become consistently embedded in frontline practice. Importantly, Family Smith was subsequently considered alongside Family T and Child Tahmina, enabling the partnership to identify recurring themes across cases rather than treating each review in isolation.

What difference has this made? Family Smith provided an important test of whether previous neglect learning had become embedded in practice. The recurrence of themes identified in earlier reviews led the partnership to triangulate learning across neglect cases rather than rely on individual action plans.

Assurance has also shifted from measuring whether practitioners have been trained or assessments completed to testing whether intervention produces sustained improvement in children's lived experience. Challenges remain, particularly around the consistent multi-agency use of GCP2 and demonstrating that increased activity is resulting in earlier recognition of neglect and improved outcomes for children. The findings have informed the continuing Pan Bedfordshire neglect programme, scrutiny of GCP2, practitioner learning and wider quality assurance activity.

There is some evidence of progress in use of GCP2 neglect assessments. However, the partnership has been careful not to equate an increase in completed assessments with improved outcomes for children. Subsequent scrutiny identified continuing uncertainty about who should initiate and lead a GCP2, how responsibility should be shared across the multi-agency network, how repeat assessments are recorded and whether the tool is consistently being used to measure changes in children's lived experience.

The Family Smith learning is therefore contributing to a change in the partnership's approach to assurance, with greater emphasis on asking whether GCP2 is being used with the right families, at the right time, whether it informs planning and escalation and, crucially, whether children's circumstances improve as a result.

What challenges remain? The recurrence of similar findings across the Family T CSPA, Family Smith and Child Tahmina demonstrates that the principal challenge is no longer simply ensuring that policies, tools and training are available, but achieving consistent application in everyday frontline practice.

The partnership needs stronger evidence that practitioners recognise cumulative harm, make effective use of family history and professional curiosity, and take decisive action where children's circumstances do not improve. Family Smith also reinforced the distinction between hearing the child's voice and understanding their lived experience. Future assurance will therefore examine whether assessments and plans make visible what daily life is actually like for individual children and whether professional intervention produces sustained changes in their care, safety and wellbeing.

The remaining challenge for 2026/27 is to evidence that this change in approach is resulting in earlier recognition of cumulative neglect, more consistent use of GCP2, stronger multi-agency challenge and timely intervention before children's experiences of neglect become entrenched or reach crisis point.

OVERALL IMPACT:

The Joint Case Review Group has continued to oversee serious safeguarding incidents, rapid reviews, Child Safeguarding Practice Reviews and other learning activity. During the year, greater use was made of proportionate alternative learning reviews where the threshold for a statutory CSPA was not met but there remained important multi-agency learning that needed to be captured and disseminated.

The partnership has also strengthened its approach to recurring findings. Rather than producing separate action plans whenever similar learning is identified, there has been greater emphasis on triangulating learning across cases. This has been particularly important in relation to neglect, professional curiosity, cumulative harm, use of family history, GCP2, escalation and children's lived experience.

This represents a significant body of learning that has informed safeguarding priorities, quality assurance activity, workforce development and service improvement across the partnership. This continued level of activity demonstrates an active and responsive safeguarding partnership that remains committed to understanding incidents, identifying learning and maintaining oversight of safeguarding risk. Importantly, the partnership has increasingly moved away from viewing reviews as isolated events.

Learning from Rapid Reviews, Child Safeguarding Practice Reviews, thematic audits and assurance activity is now more routinely triangulated with performance information, audit findings, practitioner feedback and the views of children and young people. This has enabled the partnership to better identify recurring themes and systemic issues rather than focusing solely on individual practice.

Across recent years, recurring themes emerging from review activity have included:

- child exploitation and contextual safeguarding
- domestic abuse and coercive control
- multi-agency coordination and decision making
- multi-agency information sharing
- neglect and cumulative harm
- physical harm to non-mobile babies
- the importance of capturing the child's lived experience
- the importance of professional curiosity
- understanding of risk and vulnerability – including parental mental health
- understanding risks and processes within transitional safeguarding.

What difference did this make?

These themes have directly informed several strategic priorities of the partnership, including the Neglect Campaign, Child Sexual Abuse Strategy, workforce development programme, Voice of the Child workstream, MASH improvement activity and development of the Pan Bedfordshire Effective Support Framework which was published in January 2026.

The impact of this work can be seen in the partnership's increasingly evidence-informed approach to safeguarding improvement. Learning from reviews has driven the development of new policies, practice guidance, training programmes, quality assurance activity and strategic priorities. It has also strengthened the partnership's ability to identify emerging risks earlier and respond proactively to areas of concern.

A significant area of progress has been the partnership's increasing focus on understanding the lived experience of children. Reviews consistently reinforce the importance of listening to children, understanding their daily experiences and ensuring that safeguarding assessments move beyond procedural compliance to focus on what life is actually like for the child. This learning has directly influenced the partnership's wider Voice of the Child programme, participation activity and quality assurance work.

The partnership has also strengthened arrangements for disseminating learning. Findings from reviews are routinely shared through safeguarding newsletters, learning events, training programmes, practitioner briefings, multi-agency forums and governance groups. This has helped ensure that learning reaches frontline practitioners, managers and strategic leaders, increasing the likelihood that learning results in sustainable practice improvement.

What Challenges Remain?

Whilst significant progress has been made, the partnership recognises that learning from reviews remains an ongoing journey. A continuing challenge is evidencing how learning translates into frontline practice and ultimately improves outcomes for children and families. In response, the partnership has increasingly focused on linking review findings to audit activity, performance measures and quality assurance processes to provide greater assurance that learning is being embedded across the system.

Overall, learning from reviews continues to be a critical driver of partnership improvement. The volume of review activity undertaken over recent years, together with the partnership's commitment to translating learning into action, provides assurance that safeguarding arrangements are characterised by reflection, challenge and a continuous focus on improving outcomes for children and young people.

LEARNING FROM NATIONAL PRACTICE REVIEWS AND SARS

The LSCP has considered how these findings from National Reviews and Safeguarding Adults Reviews (SARs) highlight systemic challenges and opportunities for improving safeguarding practices across cross cutting themes in order to:

- Strengthen multi-agency collaboration and information sharing
- Ensure the voice of the child is central to assessments and plans
- Strengthen approaches to transitional safeguarding
- Improve links between adult and child services
- Address service gaps, including early intervention and support during waiting periods

Learning from national reviews

Responding to the National Review: *Protecting all Vulnerable Babies Better*

The Luton Safeguarding Children Partnership (LSCP) considered the findings from the Child Safeguarding Practice Review Panel's February 2026 national review, *Protecting all Vulnerable Babies Better*, to test and strengthen local arrangements for safeguarding unborn babies and infants. As the review highlights the importance of earlier and stronger pre-birth safeguarding, trauma-informed engagement with parents, effective information sharing between adult and children's services, recognising the risks presented by serious offenders and domestic abuse, and maintaining safeguarding oversight when families move between areas. This work has been aligned to monitoring and evaluating impact from the Baby Milo CSPR2.

There is already evidence of local action consistent with this national learning. Acute health services continued to strengthen application of the Immobile Injury Pathway through audit,

training and increased practitioner awareness, with improvement in compliance reported during 2025/26. In maternity services, the Luton pre-birth tracking arrangements were reinstated in October 2025 on a fortnightly basis in response to the volume and complexity of unborn babies requiring safeguarding oversight. These arrangements strengthen the opportunity for health and children's social care to identify vulnerable babies earlier and agree safeguarding plans before birth. However, continuing pressure around access to community child protection medicals demonstrates that pathway availability and timeliness remain areas requiring system assurance.

However, partner assurance also identified continuing pressures around access to community child protection medicals, with some children being redirected to acute hospital provision where community capacity was unavailable. This can increase waiting times for children and families and place additional pressure on acute paediatric services. The partnership will therefore continue to seek assurance that learning from Baby Milo and the national review is reflected in local pathways, assessment, information-sharing and frontline practice but also in timely and consistently available safeguarding responses for vulnerable babies.

However, during 2026/27, the partnership will seek assurance across Children's Social Care, Health, Police and wider partner agencies that these areas of learning are reflected consistently in local pathways, assessment, information-sharing and frontline practice.

Particular attention will be given to ensuring that parental non-engagement, concealed pregnancy or frequent movement between areas does not result in the needs and safety of the unborn child or baby becoming less visible, and that information held within adult services, including domestic abuse, mental health, substance misuse and offender-management services, informs assessment of risk to children. This reflects the Review's central message that protecting babies requires adult and children's services to work together around the whole family.

The partnership will also consider the Review alongside the Government's July 2026 response, which accepted all eight national recommendations and sets out further action across health, policing, justice, housing and adult and children's social care through an assurance audit. LSCP will therefore use the national learning as both an improvement and assurance framework, identifying where Luton practice is already strong, where further action is required, and how the partnership will evidence that learning has translated into safer and more timely help for vulnerable babies and their families.

Safeguarding Adult Reviews

Luton has established evidence of cross-system learning between the Luton Safeguarding Adults Board and Luton Safeguarding Children Partnership. Learning arising from Safeguarding Adults Reviews has not been confined to adult safeguarding.

It has informed children's safeguarding through whole-family practice, improved identification of young carers, strengthened responses to parental self-neglect and disability, revised neglect

and escalation arrangements, professional-curiosity training, greater involvement of housing, and joint transitional safeguarding arrangements.

The LSCP contributed to a SAR concerning **Adult Kiara**, a 24-year-old South Asian woman who had previously been a looked-after child in Luton. Kiara had not presented with any concerns while in care and had been seen as successful in her education and career as a young adult. However, she later experienced further abuse within her family and had significant mental-health difficulties resulting in several suicide attempts. The learning from this SAR have supported safeguarding practice around suicide prevention and cultural competence to address any system gaps and improve support for children in care and care leavers like Kiara.

The LSCP contributed to a yet unpublished SAR regarding Adult Y who had ongoing mental health problems and who sadly took their own life in 2025. The review recognised that transition into adulthood can create additional safeguarding vulnerability, particularly for young people with complex needs, disabilities, exploitation concerns or other vulnerabilities who may not meet thresholds for adult services.

The LSCP recognises that effective transition requires more than the transfer of a case between services. It depends on early, coordinated planning, continuity of relationships, effective information sharing and a shared understanding of risk across children's and adults' systems. Learning also reinforced the importance of professionals understanding the different legislative and eligibility frameworks that apply after the age of 18 and avoiding assumptions that another service will automatically take responsibility.

What difference did it make? This learning strengthened the partnership's focus on safeguarding as a continuum across adolescence and into adulthood, encouraging greater consideration of transition at an earlier stage rather than waiting until a young person approaches their 18th birthday. It has supported stronger links between children's and adults' safeguarding arrangements and a greater emphasis on ensuring that risk, vulnerability and protective factors remain visible during transition. The intended difference for young people is improved continuity of safeguarding support, fewer opportunities for them to fall between services and decisions that are better informed by their individual circumstances and ongoing vulnerability.

What challenges remain? Transitions remains an area requiring continued partnership attention. Differences between children's and adults' legislation, thresholds and service eligibility can create gaps for young adults who remain vulnerable but do not meet criteria for statutory adult intervention. Maintaining consistent multi-agency ownership of risk, ensuring timely information sharing and embedding transition planning sufficiently early therefore remain important priorities. The LSCP will continue to work across Pan Beds with partner agencies and LSAB to strengthen the interface between children's and adults' safeguarding and seek assurance that learning about transition is translating into consistent frontline practice. The partnerships will therefore undertake an audit of transitional safeguarding in Q1 2026/27.

The Safeguarding Bedfordshire training offer and local website content has been reviewed and revised to ensure learning from local and national reviews was incorporated.

SECTION 11 SELF ASSESSMENT

Section 11(4) Children Act 2004 requires each person or organisation to which the Section 11 duty applies to have regard to any guidance given to them by the Secretary of State, for more information about this guidance click [here](#). The self-assessment forms part of the independent scrutiny arrangements and feeds into the reporting requirements as set out in [Chapter 4 - Working Together 2023](#). The three Safeguarding Children Partnerships have a statutory duty to assess whether agencies in their areas are fulfilling their statutory obligation to safeguard and promote the welfare of children, as described in Section 11 Children Act 2004.

The three SCPs in Pan Bedfordshire have collaborated for several years and asked all partners to undertake a self-evaluation on specified standards. The self-evaluation has traditionally focussed on two to three of the eight standards. However, the Section 11 self-assessment focus for partners was across all eight Section 11 Standards with an emphasis on neglect. All Partners were asked to consider the following questions:

- *What areas in your Section 11 do you want to highlight as good practice?*
- *What areas in your Section 11 do you need to improve on?*
- *What would be helpful from other agencies to help you meet these standards?*
- *What evidence do you have that there are improved outcomes for children, young people, and their families where neglect is a concern?*

Partners identified that as appropriate, key areas which they may need to further develop. These areas of development have been collated into an action plan which is being monitored through the **Pan Bedfordshire Assurance and Improvement Group**.

IMPACT OF ACTIVITY – SECTION 11

During 2025/26, the partnership undertook a Pan Bedfordshire Section 11 safeguarding self-assessment and scrutiny process to test how effectively partner agencies were meeting their statutory safeguarding responsibilities. The process brought together local authorities, health providers and commissioners, Police, Probation, Youth Justice and other services, providing a system-wide view of safeguarding leadership, governance, workforce development, multi-agency practice and the extent to which children and families influence safeguarding activity. The Pan Bedfordshire Assurance and Improvement Group have also monitored the action plans from the 2024-2025 Section 11 which focussed on safeguarding responses to Neglect.

The tool was used to assess each agency against the eight standards based on the requirements of [Section 11 Children Act 2004' \(pages 13-17\)](#). Throughout the self-assessment, consideration was given to evidence improved outcomes for children young people and their families as a result of the arrangements.

1. Senior management have commitment to the importance of safeguarding and promoting children's welfare
2. There is a clear statement of the agency's responsibility towards children, and this is available to all staff
3. There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare
4. Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children & families
5. There is effective training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children & families
6. Safer recruitment procedures including vetting procedures and those for managing allegations are in place
7. There is effective inter-agency working to safeguard & promote the welfare of children
8. There is effective Information Sharing.

Importantly, the exercise was used as a mechanism for challenge and improvement rather than simply a compliance exercise. The multi-agency scrutiny workshop in May 2026 examined the quality of individual returns, tested evidence of impact and identified common areas requiring further attention. Partners were challenged to move beyond describing activity and demonstrate more clearly how safeguarding arrangements result in improved experiences and outcomes for children.

The scrutiny identified significant strengths across the system, including visible senior leadership, established multi-agency arrangements, strong safeguarding training and supervision, use of audit and quality assurance, children's participation and increasing confidence in professional curiosity and challenge. There were particularly strong examples of child-centred and outcome-focused practice within local authority services, youth services and community health, alongside evidence of improving safeguarding practice in policing, acute health, mental health, Probation and Youth Justice. Independent scrutiny for Luton concluded that the Luton system demonstrated strong statutory compliance alongside increasingly mature, child-focused safeguarding practice.

What difference did it make?

The Section 11 process provided the partnership with greater assurance about both the strengths and vulnerabilities of the safeguarding system. Rather than accepting agencies' self-assessments at face value, independent scrutiny identified where assurance was robust and where further evidence or action was required. This included challenge to workshop participants around the quality of outcome evidence, consistency of safeguarding practice, participation in multi-agency meetings and the consequences of growing demand and workforce pressures.

There is also evidence that scrutiny led to tangible changes in practice. For example, East London Foundation Trust responded to identified areas for improvement through audit of

safeguarding records, strengthening expectations around recording family relationships and risk alerts; continued safeguarding supervision and training; development of mechanisms to capture service-user feedback; and further embedding routine enquiry about domestic abuse. The Trust also embedded use of the Pan Bedfordshire Effective Support guidance within Level 3 safeguarding training and supervision and introduced routine monitoring and feedback on safeguarding referrals.

More broadly, the process highlighted examples where safeguarding learning was already translating into changed systems and practice, including the development of a neglect pathway, improvements to "*was not brought*" procedures, redesigned safeguarding templates, improvements in thresholds and Section 47 decision-making, strengthened conference attendance, increased Family Group Conferencing and reductions in drift for children subject to child protection plans.

For children and families, this means that the partnership has greater confidence that safeguarding is embedded as a shared responsibility across agencies, rather than residing solely within children's social care. Stronger audit and supervision, more consistent use of safeguarding thresholds, improved information sharing, increased attention to children's voices and stronger professional challenge all create the conditions for earlier identification of risk, better-informed decision-making and more coordinated support around children and their families.

What challenges remain?

The most significant challenge is to demonstrate more consistently the direct difference safeguarding activity makes to children's lived experiences. Independent scrutiny found that many agencies were able to provide strong evidence of governance, training, meetings and processes, but the link between this activity and measurable improvements in children's safety, wellbeing and experience was less consistently evidenced.

There also remains variation between agencies in the quality of recording, analysis, risk articulation and use of children's and families' voices. Multi-agency Section 47 practice, professional escalation, attendance at safeguarding meetings and timely information sharing require continued attention. Workforce capacity and increasing demand were identified across agencies as system-wide pressures, while organisational change within health creates an additional need to maintain visibility and accountability for safeguarding arrangements.

The partnership has therefore agreed that the next Section 11 cycle should have a sharper outcome focus, including revision of the self-assessment template, clearer evidence of the consequences of capacity and resource pressures, improved assurance around participation in safeguarding meetings and stronger measures of impact. The partnership is also considering revising the format of the workshop to a peer panel approach in 2026/27.

Overall, the Section 11 process provided good assurance that safeguarding arrangements across Pan Bedfordshire are effective, improving and increasingly child-focused. Its greatest

value, however, was in highlighting the next stage of the partnerships' development and moving beyond assurance that safeguarding systems are in place to demonstrating consistently that those systems result in children being safer, receiving help earlier and experiencing better, more joined-up responses from the professionals who support them.

LEARNING FROM MULTI AGENCY AUDITS

The **Pan Beds Quality Assurance and Improvement Group** and **LSCP Quality Assurance Learning and scrutiny Group** undertook an established rolling programme of audits and highlight reports throughout 2025/26 which included themes linked to learning from reviews. The audits undertaken in 2025/26 are summarised below, many of the findings in the audits were similar in terms of general practice identified elsewhere that needed to be improved.

Child Sexual Abuse Audit

During December 2025 the partnership completed a significant Pan Bedfordshire multi-agency audit examining nine Child Sexual Abuse cases from across Bedfordshire. The audit reviewed the quality of referrals, assessment and understanding of risk, partnership working, interventions, safety planning and overall case management. The purpose was to understand how effectively agencies were working together to identify, assess and respond to Child Sexual Abuse and if safeguarding arrangements were achieving the desired outcomes for children.

The audit identified a number of strengths within partnership practice. Referrals to Children's Services were appropriate across all audited cases, demonstrating that agencies were generally identifying concerns at the right stage and taking appropriate action. There were examples of effective multi-agency working, good understanding of risk in some cases and evidence that the voice of the child had informed decision-making. Some cases also demonstrated particularly strong safety planning and coordinated professional responses.

Importantly, The audit enabled the partnership to identify recurring themes and areas for improvement. Findings highlighted that assessments did not always fully consider the wider vulnerabilities of children or how these increased their risk of abuse. The audit also identified occasions where cultural factors were insufficiently explored, and opportunities to understand the impact of domestic abuse, coercive control, and parental vulnerabilities had been missed.

The audit also identified an over-reliance on mothers to manage and implement safety plans, particularly in circumstances where they may themselves have experienced abuse or trauma. This highlighted the need for safeguarding plans to be more realistic, better supported by professionals and shared consistently across agencies.

A further learning theme related to children who chose not to disclose abuse. The audit found that follow-up opportunities were not always clearly planned or recorded, increasing the risk that opportunities for disclosure could be missed. Similarly, the reliance on self-reporting by perpetrators regarding behaviour change or treatment engagement was identified as a potential risk within some cases.

The audit findings demonstrated the value of a robust multi-agency review process. Rather than focusing solely on individual practice, the audit explored wider systems issues including communication, recording, understanding of vulnerability, professional curiosity and decision-making. Learning from the audit has been incorporated into the work of the Child Sexual Abuse Steering Group and is informing further workforce development, guidance and practice improvement activity.

However, the audit process also identified the importance of ensuring that multi-agency audit tool work well across all single agencies and not just those that routinely receive referrals, provide assessments and deliver recovery services. This learning has been fed into the Pan Beds Assurance and Improvement Group and utilised in audit planning for 2026/27.

Child to Parent Violence and Abuse (CAPVA) Audit

During 2025/26 the partnership sought assurance regarding the findings, themes and action plan arising from the Pan Bedfordshire Child to Parent Violence and Abuse (CAPVA) audit. CAPVA presented as an area of practice that continued to present significant challenges across children's and adults' services.

The audit highlighted numerous examples of effective intervention and partnership working. In several cases, intensive support provided by professionals resulted in reduced conflict, improved family relationships and successful step-down from statutory services. These examples demonstrated the positive impact that coordinated and persistent intervention can have when families receive the right support at the right time.

However, a recurring theme across the audit was children and young people with SEND and neurodiversity needs. While these vulnerabilities were often recorded, there was not always sufficient exploration of how they may contribute to behaviours, family dynamics and support needs. This highlighted the importance of ensuring safeguarding responses are informed by a full understanding of the child and their circumstances.

The audit identified several questions for consideration and discussion by Pan Bedfordshire Assurance and Improvement Childrens Sub-Group:

- How do the partnerships and their partners improve the knowledge and understanding of Parent Carer Assessments in CAPVA?
- What are the partnerships and their partners response to Harmful Sexual Behaviours?
- What are the partnership and their partners response to children and adults with ADHD within CAPVA assessments?
- How do the partnerships and Partners address an apparent lack of reflection or self-criticism by some agencies completing the audits?
- How do the partnerships and their partners improve case recording and their interpretation of information shared?
- How can communication between agencies and internal departments be improved?
- What more does the partnerships and their partners need to do to promote and support use and embedding of the Think Family Approach?

- How do the better address Cultural issues in cases of CAPVA?
- How do the partnerships and their partners better promote the role of lead practitioner and use of multi-agency chronologies?

The audit generated significant partnership discussion and prompted several practical improvements. These included the development of a CAPVA Toolkit, integration of CAPVA learning into multi-agency safeguarding training, development of awareness resources and discussions around specialist training relating to Harmful Sexual Behaviour and ADHD. The audit also supported wider work on multi-agency chronologies, demographic recording and information sharing. The following are examples of activity undertaken:

- Development of a CAPVA Toolkit across the three SCPS and two SABs
- Harmful Sexual Behaviours Training being considered with Forensic CAMHS
- ADHD webinars undertaken, other training being considered with Forensic CAMHS and useful resources on working with ADHD have also been added to the website
- Continued work with partners across Pan Bedfordshire to standardise the language used for CAPVA demographics
- Domestic Abuse 'Power Hours' including a session on CAPVA
- *Domestic Abuse and CAPVA* is included with our Multi-Agency Safeguarding Bedfordshire Training
- *Domestic Abuse and CAPVA* is also included within Single Agency Training
- An AI Video and awareness briefing around the different assessments for CAPVA has been produced for the Safeguarding Bedfordshire Website

Perhaps most importantly, the audit reinforced the value of system-wide learning. Rather than focusing solely on individual case practice, the review considered how services interact, communicate and share responsibility. This enabled the partnership to identify improvements that could strengthen safeguarding responses not only for families affected by CAPVA, but across wider safeguarding practice.

The audit findings continue to inform quality assurance activity and provide a valuable foundation for future improvements in how partners work together to support children, young people and families experiencing violence and abuse within the home. However, the partnership has more to do in the coming year with a formal launch of the CAPVA practice guidance and toolkit and 'power hour' sessions to support embedding learning into practice.

WHAT ELSE DID WE DO TO MAKE A DIFFERENCE?

OUR GOLDEN THREADS

VOICE AND LIVED EXPERIENCE OF CHILDREN AND YOUNG PEOPLE

One of the clearest strengths and development themes was the increasing influence of children's voices. The participation of two young people from the Children in Care Youth Council

brought direct challenge to professional discussions, including around safeguarding training, appointments, mental health support, Return to Home interviews, language and what professionals mean when they describe a child as being “safe at home”.

The annual Voice of the Child Conference took place in November 2025 and provided one of the partnership's most significant opportunities to engage directly with children and young people from across Bedfordshire. The theme of the conference, ‘Feeling Safe in Our Community and Feeling Safe in Our Lives’, reflected issues that had been emerging through participation activity, safeguarding reviews and strategic discussions during the year.

The event was particularly notable because it was opened and led by young people through the Big Beds United programme, demonstrating the partnership's commitment to meaningful participation and co-production rather than consultation alone. Young people shared candid feedback about the challenges they experience in their daily lives. Common themes included concerns regarding online safety, experiences within educational settings, bullying, peer relationships, exploitation and gangs.

Feedback from educational settings highlighted concerns about inconsistency in how bullying incidents are managed and reported. Young people described situations where behaviours perceived as banter could become harmful and where responses from adults were not always consistent. The conference also provided valuable insight into children's perceptions of safety and risk within their communities. Concerns relating to gangs, exploitation and online harms featured strongly throughout discussions and reinforced wider safeguarding themes being identified through audits, reviews and community safety activity.

The partnership viewed the conference as more than a standalone event. Findings were translated into a formal action plan and incorporated into the work of partnership groups. This ensured that children's voices influenced future safeguarding priorities rather than simply being recorded. The conference successfully demonstrated that when children are provided with meaningful opportunities to participate, they contribute valuable insight into safeguarding risks, service effectiveness and areas requiring improvement.

During the year, the partnership further strengthened its commitment to participation through the development of the dedicated young people's pages on the [Safeguarding Bedfordshire website](#). Importantly, these pages were co-produced with children and young people to ensure that information was accessible, relevant and user-friendly. The collaborative approach ensured that content reflected the issues that matter most to young people and was presented in ways that they felt were engaging and understandable.

What difference did this make? The development of the website represents an important example of participation influencing service design rather than simply informing consultation activity. It also supports the partnership's aim of ensuring children and young people know where to access advice, support and safeguarding information if required. The next step is to move from consultation towards co-production, ensuring children are routinely involved in

shaping priorities, services, training and evaluation, including children with SEND and children whose voices may be less frequently heard.

There is also evidence that participation is becoming more embedded within individual partner organisations. Community health services use co-production within service design, recruitment and quality improvement, supported by a People Participation and Involvement Strategy, co-production toolkit and mechanisms for gathering service-user feedback. During Q4, work also commenced to increase the direct collection of feedback from children and young people rather than relying predominantly upon the views of parents and carers.

This development complements the partnerships' Pan Beds Voice of the Child Conference, Development Day participation and young people's safeguarding webpages. It demonstrates a developing shift from seeking children's views through individual participation events towards embedding children's experiences within the design and evaluation of services. The next stage is to ensure that participation is systematic and inclusive, particularly for children with SEND, children experiencing exploitation or neglect and those whose voices are less frequently heard.

Challenges that remain:

The partnership's challenge for the coming year is therefore not just to demonstrate what has been delivered, but to establish what has changed for children because of collective action. Strengthening the use of multi-agency intelligence, systematically testing the impact of learning, improving early intervention, embedding meaningful participation and further developing responses to contextual harm will be central to achieving this.

PAN BEDFORDSHIRE POLICY AND PRACTICE GROUP

During 2025/26, the partnership continued to work through the Pan Bedfordshire Policy and Procedures Group to review and develop safeguarding policies and procedures across Luton, Bedford Borough and Central Bedfordshire. The Pan Bedfordshire approach is particularly important because many partner organisations, including police and health services, operate across local authority boundaries. Having common procedures therefore reduces the risk of practitioners being expected to work to different safeguarding processes depending on where a child lives and provides a more consistent framework for multi-agency practice.

The Policy and Practice Group meets twice a year and has a rolling programme of work that continues throughout the year linked to the updates required in May and November. The procedures have been updated, linked to learning from reviews from Luton, across Bedfordshire and Nationally. [Amendments to procedures](#) can be found here and are linked to learning from reviews and audit within Luton.

This has been another busy year with the group providing **93** new and/or revised procedures and guidance which can be accessed at this [link](#). There has been a number of one-page briefing documents developed on issues arising from Reviews that practitioners have given feedback have been helpful in raising awareness of safeguarding issues.

A significant focus during the year was ensuring that procedures reflected changes in national guidance, learning from local and national safeguarding reviews, emerging safeguarding risks and changes arising from Families First for Children. This also enabled learning identified elsewhere in the partnership to be translated into operational expectations for practitioners rather than remaining solely within review reports or strategic discussions.

What has the impact been?

There is evidence of impact in the way policy development has increasingly been connected to identified practice issues. For example, recurring learning about thresholds, information sharing, professional disagreement and escalation, cumulative harm and the visibility of children across services informed wider procedural development and the move towards the Pan Bedfordshire Effective Support: Meeting the Needs of Children Guidance. The common guidance provides practitioners working across Bedfordshire with a more consistent framework for understanding levels of need, the relationship between Family Help and statutory intervention and when concerns require escalation.

Policy and procedure work has also provided an important mechanism for translating case review learning into system change. The learning concerning children placed across local authority boundaries resulted in scrutiny of out-of-area notification arrangements and action to strengthen the route through which notifications are received and children identified on systems. This is an important example of the partnership going beyond disseminating learning and changing an operational process to reduce the risk of vulnerable children becoming less visible when they move between areas.

Similarly, learning concerning neglect has reinforced expectations around professional curiosity, cumulative harm, use of family history, escalation and GCP2, while review activity concerning children who may be hidden from universal services has strengthened attention to information sharing and the interfaces between health, education and children's social care. In addition:

- The development of a suite of briefings has provided practitioners with quick, concise, awareness raising opportunities on a number of subjects for example see above with positive feedback from Partners that practitioners are using the documents in daily practice and finding them user friendly.
- The Pan Bedfordshire [Injuries and Bruising Protocol for Immobile Children 0-18 years](#) pathway/protocol has supported a more combined and collective approach to guidance.
- The Pan Bedfordshire [Child sexual abuse in the family environment](#) has clarified practice guidance and linked to other CSA training delivery.

What difference did this make?

The principal evidence of impact is therefore at system and practice-framework level. The wider effectiveness of the safeguarding framework received positive independent assurance through the January 2026 Ofsted inspection. Inspectors found that children referred to MASH received timely and appropriate responses; relevant partners shared information effectively in strategy

discussions; risks were identified and responded to promptly; and decision-making was informed and proportionate. This provides important evidence that the wider multi-agency framework within which Pan Bedfordshire procedures operate is supporting effective safeguarding practice.

Challenges that remain

The principal challenge is that having an effective policy or procedure does not demonstrate that it is consistently understood or applied in practice. Learning from reviews during 2025/26 continued to identify recurring issues involving professional curiosity, cumulative neglect, information sharing, thresholds, escalation and the use of safeguarding tools. This demonstrates a potential gap between the existence of procedures and their consistent application at the frontline.

The partnership therefore needs to develop stronger assurance about implementation and impact. For significant new or revised procedures, this should include baseline information where possible, implementation and communication activity, subsequent audit or dip-sampling and practitioner feedback. This would enable QALS to assess whether a procedural change has resulted in observable changes in professional behaviour.

The implementation of the Effective Support guidance provides an important opportunity to apply this approach. Rather than measuring success through publication or attendance at launch events, the partnership intends to assess whether implementation is associated with better-quality referrals, improved understanding and application of thresholds, fewer inappropriate referrals or disputes and, ultimately, children receiving the right support at the right time.

During 2026/27, assurance will increasingly need to demonstrate not simply that procedures have been reviewed and published, but that practitioners understand and use them consistently and that changes to procedures result in earlier identification of risk, improved multi-agency decision-making and better safeguarding outcomes for children.

CHILD DEATH OVERVIEW PANEL:

The Child Death Overview Panel covers Bedford Borough, Central Bedfordshire, and Luton Borough councils alongside the BLMK Integrated Care Board (ICB) and conducts statutory reviews of all child deaths (under 18) to learn lessons, identify local trends, and propose preventative multi-agency actions. The [Bedfordshire and Luton CDOP Annual Report 2024-25](#) outlines multi-agency child death reviews and local data trends.

Overview and Key Statistics (2024–2025)

- **Notifications:** The Child Death Overview Panel (CDOP) was notified of **49 deaths** of children living in Bedfordshire and Luton (compared to 48 in 2023/24). [\[1\]](#)
- **Age Breakdown:** **43%** of all children who passed away were babies under 28 days old. [\[1\]](#)
- **Location of Death:** **80%** occurred in a hospital, **16%** at home, and **4%** in another setting. [\[1\]](#)

- **Main Categories of Death:**
 - Perinatal/neonatal event: **43%** (vs. 34% nationally across England)
 - Acute medical or surgical condition: **18%**
 - Chromosomal, congenital, and genetic anomalies: **17%** [\[1\]](#)
- **Modifiable Factors:** The panel identified potentially modifiable factors in **24 cases (37%)**, meaning changes or local/national interventions might lower future risks. [\[1\]](#)
- **Demographics:** Some overrepresentation was noted for Asian, Black, and "White Other" ethnic groups relative to their overall population size. [\[1\]](#)

While the Child Death Partners are responsible for the child death overview process the LSCP receives key learning and uses it to consider any changes needed to improve child safeguarding practice. More information can be found here: [CDOP](#)

PRIVATE FOSTERING

The LSCP Strategic Board has remained concerned that the reported numbers of children within private fostering arrangements remained low with **three** children under the age of sixteen at the end of 2025/26. Private fostering continued to be a focus with an annual assurance report being provided to the Strategic Board in November 2025.

Whilst there is always more to do to increase awareness in Luton we are happy to report that:

- Partners promoted the CORAM BAAF Private Fostering awareness day
- The Fostering Team run monthly paid adverts in E-Luton throughout 2025/26. These are changed monthly to promote different areas of fostering. August focused solely on private fostering. 33,000 residents are signed up to receive E-Luton this should increase reach.
- Luton Council Communications Team post regularly to social media, Facebook and Instagram. Private fostering is regularly featured.
- Attendance at events and information stands to promote all areas of fostering, including private fostering.
- Events attended have included:
 - Christmas Markets
 - Community Awards
 - Eid Festival
 - Picnic in the Park
 - St Patricks Day parade
 - St Georges Day
 - Pride
 - International Women's Day event

The LSCP is aware private fostering numbers remain low, however, they are committed to continue to promote awareness and also to seek assurance and challenge partners as needed.



Training has been commissioned in collaboration with the other two safeguarding partnerships in Bedfordshire for the last seven years under the banner of [Safeguarding Bedfordshire Training](#). It provides a multi-agency programme to meet the priorities of the three local safeguarding partnerships (Bedford, Central Bedfordshire, and Luton).

IMPACT OF ACTIVITY - TRAINING AND DEVELOPMENT

Luton SCP received quarterly reports throughout 2025/2026 to its Quality Assurance Learning Scrutiny Group which demonstrated impact set out below and in the detailed training report here: [Appendix A Data Snapshot](#).

Headlines and data

- Safeguarding Bedfordshire delivered **87 learning events** in 2025/26 with **2582 practitioners attending**; a **30% increase** on last year. This increase is attributed to our growing programme of free events. (*Appendix 1: Attendance by agency*). **Overall satisfaction rate remains at 99%**.
- **eLearning completion rate remains at 89%**, with 11,190 users completing a course. These figures are in line with 2024/25. eLearning **satisfaction rose to 94%**.
- Late **cancellations/ non-attendance remains a challenge**; 10% rate on paid learning events and 21% on free sessions. Reasons for non-attendance include staff shortages/ capacity issues, health reasons and attendance of safeguarding meetings/ court. These rates are in line with 2024/25 levels.
- New learning events for 2025/ 26 included;
 - Developing an Understanding of Child Sexual Abuse
 - Designated Safeguarding Leads – Childminders
 - Working within Child Protection (S47)
 - Learning from CSPR's sessions to cover local and national learning (multiple sessions)
 - Neglect bite size sessions
 - MAPPA webinar
 - Professional Curiosity workshop
 - Sexual Assault Referral Centre webinar
 - Technology Assisted Child Sexual Abuse
- Our training programme continues to benefit from our **Partners supporting delivery through training pools** alongside a small number of externally commissioned trainers.
- The Pan Bedfordshire **Safeguarding Partnership website had 454,241 visits**, an increase of 58% on last year.
- **Satisfaction rates increased** year on year, to **99%** for paid learning content, **99%** for free CPD events and **94%** for eLearning.

- **Impact of training:** Each learning event is **evaluated** to evidence impact and inform future learning opportunities. **1425 (55%)** evaluations were returned to show how attendance at Safeguarding Bedfordshire training has had a consistently positive impact on participants' knowledge, confidence, and practice. **Feedback** highlights a strengthened understanding of multi-agency working, including greater clarity on roles, responsibilities, thresholds for intervention, and the processes leading to Child in Need and Child Protection. Participants report **increased confidence** in recognising concerns, making effective referrals, and engaging with other professionals to ensure timely and appropriate support for children and families.

FINAL EVALUATION: IMPACT, ACHIEVEMENTS AND FUTURE PLANS

The partnership's core objective is to coordinate and hold partners to account to make sure they are protecting children and young people in Luton who might be or are at risk, and to ensure that timely learning from serious child safeguarding incidents is identified and implemented. The LSCP has continued to work collaboratively with our two neighbouring Safeguarding Children Partnerships in Central Bedfordshire and Bedford to ensure there is a more joined up approach to safeguarding.

This is particularly important where agencies deliver services across and are represented on several partnerships. In agreeing a common approach and response to specific safeguarding and child protection issues such as child exploitation, neglect for example Pan Bedfordshire groups operate across the three partnerships.

The three statutory partners of the three safeguarding children partnerships meet via a **Pan Bedfordshire Strategic Leadership Children Group** that meets bi-monthly to discuss key issues, demands and to prioritise areas of work to be taken in regard to the safeguarding and promoting the welfare of all children. The LSCP Strategic Business Plan 2025-27 sets out the partnership priorities and how it measures impact through audit, performance data and the voice of the child. This model has worked well with actions delegated to the appropriate lead safeguarding partnership or subgroup and monitored via action plans held by the **Pan Beds Assurance and Improvement Group** with regular highlight reports from the sub-groups, and progress reported back to the **LSCP Strategic Board**.

In order to reduce pressures and demand in the system, Pan Bedfordshire activity especially around audits is coordinated by the **Pan Beds Assurance and Improvement Group**, which means that the partners were able to participate in the wider audit programme. It was also able to gather evidence of good practice in the system and benchmark against the neighbouring SCPs.

LSCP is unique in the county in that it also has joint arrangements with the Luton Safeguarding Adults Board and their joint work is overseen by **Statutory Partners Chairs Safeguarding Assurance Group** who act as executive for each Strategic Board and ensure that their vision

and strategic direction takes account of cross cutting priorities and a shared Risk Register ensures that each Board is alert to system risks.

There has been significant joint work including via a cross cutting section on development day and examples within operational practice where the relationships established at strategic level have supported innovative practice. An example of this has been input into the On Street Sexual Exploitation Strategy and action plan. The LBC contextual safeguarding strategic lead and Strategic Business Manager have contributed to Operational Delivery Groups on early intervention and prevention, as well as input into an action plan on international recruitment irregularities operation due safeguarding concerns for both adults and children.

The partnership has established strong leadership and constructive, critical challenge of practice with the three statutory partners meeting monthly to provide greater oversight, drive on priorities and to evaluate risk, resource and capacity in the system. The wider partnership meetings have good representation from both statutory and voluntary organisations, including schools and have retained lay membership. Relevant agencies have demonstrated their commitment to safeguarding by contributing across a range of meetings and subgroups many of which are across Pan Bedfordshire.

Key assurance has been sought and evidenced around the priorities and how they have made a difference to outcomes for children and young people. As highlighted in the partnership safeguarding snapshot and through the report there has been scrutiny of both single and multi-agency performance and assurance information. Audits presented to the LSCP provide a window into the multiagency safeguarding system. The LSCP has also participated in the Pan Bedfordshire section 11 self-assessment and provided challenge to partners and relevant agencies regarding their evidence against the safeguarding standards.

Assurance around systems, structures, processes and governance was collated with oversight by the Pan Beds Strategic Leaders Group. The LSCP has reviewed its funding for partnership activities and has undertaken an Organisational Change Assessment of its business support this financial year. This was in the light of additional pressures in the system such as evaluation and evidence of impact under *Families First for Children Pathfinder Programme* delivery.

Funding contribution levels from partners have remained static with the Local Authority remaining the largest financial and in kind contributor to the arrangements. This remains a priority for the LSCP to review, not least to comply with the Working Together 2026 funding requirements for equitable and proportionate funding from the three statutory partners and to ensure the LSCP has sufficient funding to function and be effective.

PARTNERSHIP SELF EVALUATION: IMPACT

The report considers what the LSCP set out to achieve in its previous Yearly Report and what evidence there is of whether it achieved its objectives and made a difference to the lives of children, young people and their families living in Luton. *Working Together to Safeguarding Children 2023* was the relevant statutory guidance applicable throughout the reporting period.

In preparing this report, the partnership has also considered the strengthened expectations subsequently set out in *Working Together 2026* (18 March 2026) as an additional framework against which to test the maturity and future development of its arrangements.

An important feature of the partnership's approach during 2025/26 was its commitment to reflection and challenge. The annual LSCP Development Day 2025 brought together approximately forty multi-agency representatives, including care experienced young people, to review safeguarding priorities, examine emerging themes and assessing progress against the Strategic Business Plan.

Partners focused on LSCP priorities including neglect, child exploitation, domestic abuse, safeguarding in education, training impact, lived experience and participation of children and young people. Children and young people present directly challenged the partnership on issues including communication, language, what safety means to them, engagement and prevention, reinforcing the importance of maintaining a child-centred approach to all safeguarding activity.

Throughout 2025/26, Luton Safeguarding Children Partnership continued to strengthen the effectiveness of its multi-agency safeguarding arrangements while operating within a period of substantial national and local change. The partnership implemented revised governance and scrutiny arrangements, supported the development of Families First for Children, strengthened its use of safeguarding intelligence and quality assurance, responded to learning from local and national reviews, and placed greater emphasis on understanding what difference collective safeguarding activity makes to children and families.

The strongest independent validation of progress came from the Ofsted ILACS Inspection of Luton Children's Social Care published in March 2026, which judged services Good overall. Ofsted described strategic partnerships as "*strong and mature*", found effective governance through the Safeguarding Children Partnership Board, and identified good multi-agency information sharing and timely, proportionate safeguarding decision-making. The inspection also found that the developing Family Help model was resulting in more seamless and timely support, with children and families benefiting from greater continuity of relationships and receiving the right help at the right time.

This positive external assessment is supported by evidence from across the safeguarding system. During 2025/26, **13,006** contacts and **4,108** referrals were received through MASH; education remained the largest source of referrals; **96.8%** of Initial Child Protection Conferences were held within 15 working days; and the Return Home Interview offer rate reached **97.4%** in Q4. Early evaluation of Family Network Support Packages found that **87.5%** of children remained living within their family networks, providing encouraging evidence of the potential of earlier family-led intervention.

The partnership also strengthened its ability to understand the safeguarding system rather than relying solely upon activity measures. Recruitment of a Pan Bedfordshire Senior Safeguarding Data Analyst, continued development of the LSCP Safeguarding Scorecard and introduction of the new Quality Assurance, Learning and Scrutiny arrangements have improved the

partnership's capability to triangulate performance data, audit, review findings, inspection evidence and practitioner intelligence. This is supporting a shift from asking whether an action has been completed towards asking whether it has resulted in measurable improvement for children.

AT A GLANCE

CHILDREN IN LUTON

- **Good** overall ILACS outcome, with **15 references** to partnership and partnership working.
- **13,006 MASH** contacts April 2025 to March 2026, which is 8.5% higher than the equivalent period in 2024/25.
- Contact-to-referral conversion increased from **28% to 43%** indicating referrals are being made appropriately
- **96.8%** of ICPCs held within 15 working days
- Return home interview offer rate reached **97.4% in Q4** and **96% across 2025/26**
- Care leavers with an up-to-date pathway plan increased from **44.5% to 99.4%** between Q2 and Q3, with data cleansing contributing to that change.
- **87.5%** of children in one early Family Network Support Package evaluation remained living within their families. [\[](#)
- Self-rated good knowledge following training increased from **55% before to 97% after** sessions.
- GCP2 completions increased **during 2025/26** but consistent frontline application remains an area requiring assurance.
- Repeat MARAC referrals reached **39%**, giving the partnership a clear area for further scrutiny and action.

KEY ACHIEVEMENTS

The partnership has demonstrated evidence of key progress across its strategic priorities, statutory objectives and golden threads.

1. **Safe at Home:** Neglect received substantially greater strategic and workforce attention through the Pan Bedfordshire Stop: Think Neglect campaign, dedicated online resources, learning activity and increased use and scrutiny of GCP2. Child sexual abuse received renewed strategic attention through specialist training, audit and workforce development. 328 GPs and primary-care staff received specific CSA and sexual assault pathway training, after which the SARC reported increased referrals from GPs, providing emerging evidence of changed professional behaviour.
2. **Safe in the Community:** Multi-agency contextual safeguarding arrangements continued to identify and respond to children at risk from exploitation, missing episodes and serious youth violence. The Return Home Interview offer rate averaged 96% during 2025/26, compared with 76% in 2022/23. The police MACPT model also showed encouraging emerging impact: 37.5% of children receiving a MACPT police-led intervention following a

missing episode went missing again within three months, compared with 57.6% in a comparator cohort. The partnership appropriately treats this as emerging rather than definitive evidence, but it provides an important indication of the potential impact of integrated intervention.

3. **Safe Governance, Structures and Processes:** The separation of the LSCP and LSAB Business Units established dedicated capacity and clearer accountability for children's safeguarding while retaining joint arrangements where whole-family learning adds value. The new QALS structure reduced duplication and provides a stronger mechanism for bringing together safeguarding performance, audit, reviews, workforce learning and professional challenge. A Pan Bedfordshire review of the Multi-Agency Safeguarding Arrangements also independently identified strong relationships, established governance and shared learning while identifying opportunities to reduce duplication and strengthen scrutiny.
4. **Learning** has become increasingly central to improvement. Five Rapid Reviews, one CSPR, two other referrals and two scoping exercises were undertaken during the year. Importantly, the partnership increasingly triangulated findings across cases rather than treating each review as an isolated event. This identified recurring themes around cumulative neglect, professional curiosity, children's lived experience, family history, information sharing, escalation and consistent use of safeguarding tools, leading to changes in procedures, training, quality assurance and operational pathways.
5. **Children's voices** have also become increasingly visible within partnership activity. Young people participated directly in the LSCP Development Day, the Voice of the Child Conference was led by young people, and dedicated young people's safeguarding webpages were co-produced. Within policing, recorded Voice of the Child entries increased from 91 to 407 within six months, indicating significantly greater attention to recording children's experiences within safeguarding practice.

There is further evidence of the approach to safeguarding and evidence of impact throughout the report drawn from partner assurance reports and scrutiny of the Section 11 responses.

KEY CHALLENGES

1. **Neglect and cumulative harm:** Repeated findings across Family T, Family Smith and Family Hamza show that cumulative neglect, family history, professional curiosity and escalation are still not consistently reflected in frontline practice. GCP2 activity increased, reaching 61 completed assessments by the end of Q4, but uncertainty remains about multi-agency ownership, repeat assessment and how the tool informs Child in Need and Child Protection planning.
2. **Domestic abuse and repeat harm:** Domestic abuse remained the most common reason for referral and repeat MARAC referrals reached 39% in Q3, with average repeat referrals across the first three quarters at 37% compared with 27% during 2024/25. The partnership does not yet have sufficient evidence to explain this pattern or establish whether interventions are sustainably reducing risk to children.

3. **Exploitation and contextual safeguarding:** The partnership recognises that strategic grip was insufficient during part of 2025/26. Falling exploitation flags and recorded CSE assessments cannot yet confidently be interpreted as falling risk, particularly when only 0.9% of assessments recorded CSE as a presenting factor in Q3. Return Home Interview offers are high, but acceptance averaged only 61%, meaning the partnership needs to understand and address why some children do not engage.
4. **Translating learning into consistent practice:** Professional curiosity, information sharing, escalation, children's lived experience and recognition of cumulative harm continue to recur in reviews despite previous training, policies and guidance. This is a crucial finding. The challenge is no longer primarily whether learning has been disseminated, but whether it is embedded sufficiently to change professional behaviour consistently.
5. **Children who are less visible:** Learning from Child Tahmina and education assurance demonstrates continuing vulnerability amongst children who are missing education, electively home educated, newly arrived, frequently mobile or otherwise outside universal-service networks. Health, education and social-care information needs to be connected so that absence from one universal service does not result in absence from safeguarding oversight.
6. **Transitional safeguarding:** Learning from audits and adult safeguarding reviews reinforces the risk of young people falling between children's and adults' services because of differences in legislation, eligibility and service thresholds. Earlier planning, continuity of relationships and shared ownership of risk need further assurance in 2026/27.
7. **Evidence of impact and equity:** Across training, policy, Section 11 and review activity, there is evidence of outputs and intermediate outcomes, but direct evidence of improved lived experience is less consistent. The partnership acknowledges some gaps in EDI information and the need for stronger analysis of whether safeguarding intervention and outcomes are equitable across Luton's highly diverse population.
8. **Partnership capacity and sustainability:** The LSCP Business Unit is operating with reduced resource at the same time as expectations around reviews, scrutiny, data, quality assurance, engagement and statutory reporting are increasing. Funding also remains unequal, with the local authority contributing approximately 49%, health partners 39% and police 11% of the partnership budget. Sustainability and equitable contribution therefore require continued leadership attention.

PRIORITIES FOR NEXT YEAR

The evidence suggests that the Luton Safeguarding Children Partnership functioned effectively during 2025/26 and strengthened its capacity to identify, understand and respond to safeguarding risk. Its principal achievement has been the development of a more mature

safeguarding system in which partnership activity is increasingly evaluated through evidence, scrutiny and the lived experiences of children rather than through completion of actions alone.

However, it is clear that several challenges remain for the partnership to consistently evidence the impact of its work on outcomes for children and families. The partnership will therefore focus its priorities on key elements that contribute to the wider safeguarding system. Its priorities for 2026/27 will retain the same overarching framework, with a renewed focus on ensuring that partnership activity is concentrated on the areas of practice, governance and impact where the evidence demonstrates further improvement is required.

Priority One: Safe at Home

Earlier identification and response to harm at home:

- The partnership should demonstrate that cumulative neglect is recognised earlier, GCP2 is consistently used as a multi-agency tool, repeat domestic abuse is understood and reduced.
- Learning from Protecting all Vulnerable Babies Better, Baby Milo and other local reviews should be embedded in frontline assessment and intervention.

Focus: Earlier identification and response to harm at home, neglect, domestic abuse, child sexual abuse, vulnerable babies and hidden children

Priority Two: Safe in the Community

- The partnership should strengthen the response to harm outside the home.
- This should include renewed strategic oversight of contextual safeguarding including review of Luton MACE.
- Improved identification and recording of exploitation, stronger cross-boundary arrangements and deeper analysis of children's experiences of missing episodes and Return Home Interviews.

Focus: child exploitation, group-based child sexual abuse, missing children and serious youth violence. The role of education settings in safeguarding and promoting welfare

Priority Three: Safe Governance, Structures and Processes

- The LSCP will ensure that its governance, structure, and processes focus on creating better outcomes and demonstratable change.
- Building on the work of the Senior Safeguarding Data Analyst and LSCP Safeguarding Scorecard, the partnership should develop a smaller set of meaningful outcome measures that combine quantitative performance with audit, practitioner intelligence and children's experiences, with stronger analysis of inequalities and disproportionality.
- The partnership should evidencing learning demonstrably changes practice QALS Group should provide the principal mechanism for testing whether learning from CSPRs, Rapid Reviews, SARs, audits, Section 11 and national reviews has resulted in observable and sustained changes in frontline practice.

Focus: governance, data, outcomes, EDI, participation, independent scrutiny, review learning, effective support, escalation, cultural competence and the lived experience of children.

Our overall evaluation is that safeguarding arrangements in Luton were effective during 2025/26 and continued to mature. There is independent and local evidence of stronger partnership working, earlier and more joined-up help, improved multi-agency decision-making, greater use of safeguarding intelligence and a more rigorous approach to learning and scrutiny. Importantly, there are areas where this is beginning to translate into demonstrable improvements in children's experiences and outcomes.

We are also clear that progress is not yet consistently experienced by every child. Recurring learning concerning neglect, professional curiosity, information sharing, escalation and children's lived experience demonstrates that the partnership must continue to test the gap between policy and practice, prevention and safeguarding outcomes.

Our focus for 2026/27 will therefore move further from measuring activity towards demonstrating sustained impact and whether harm is recognised earlier, whether help changes children's circumstances, whether risk reduces, whether improvements are sustained, and whether all children, whatever their background, circumstances or location, experience an effective and consistent safeguarding response.