Luton Safeguarding Children Board

Annual report

2015 - 2016

Report author: **Fran Pearson**
Independent Chair of the Board

Date: **December 2016 (Final)**

Chair's introduction

The Annual Report of the Luton Safeguarding Children Board is a report on the Board's effectiveness from April 2015 to March 2016. Equally relevant though, is to look forward to the future, and to link the achievements of 2015 to 2016 to the priorities for 2016 to 2017 that the Board is currently implementing. The starting point for the Board's work programme is that as a body, we want to make the children and young people of Luton safer, and that during 2015-2016 the Board had identified the relevant areas, based on local need, to prioritise. During the year the Board was reviewed by the Office for Standards in Education - Ofsted - as part of a wider inspection of children's services in Luton. This annual report makes several references to the findings of the Ofsted inspectors. They judged our Board as one that "requires improvement". I thought this was a fair judgement and it fits with my view that, despite the achievements of the Board during the year (which were recognised by Ofsted and which are covered in this report), there is still considerable work for us to do.

I started as Chair of the half way through the year, at the end of September 2015. I wanted to write the annual report this year in a way that questioned whether or not the Board had a made a difference to children and young people in Luton who needed safeguarding. In my opinion the Annual Report is where the Chair assesses the effectiveness of the Board. I have made it brief and to the point, but also tried to evaluate how effective the Board has been, rather than simply describing our activities. This also answers the criticism of the Ofsted inspectors that:

The Annual Report for 2014-15 requires improvement. Although it provides an overview of key activities and learning and includes information and data on the work of the local designated officer, the CDOP [Child Death Overview Panel] and the multi-agency risk assessment conference, it lacks robust analysis of the effectiveness of local safeguarding practice, processes and procedures. The report does not include any data on, for example private fostering or the take-up of safeguarding training

To do the analysis, I have used a framework from the National Association of Safeguarding Children Board Chairs and commented on how our Board measures up against that framework. There are some really good pieces of work going on in Luton, so it is a pleasure to include examples of good practice as well.

Local context

Turnover and Serious Case Reviews

As the Ofsted inspectors commented, the year for our Board was characterised by being extremely busy. "*The LSCB has maintained a clear focus on serious incidents and on ensuring effective challenge between Board partners. This is in spite of a very busy year, which has included four serious case reviews and a 50% turnover of Board members*".

The voice of young people

Luton's Board was increasingly well served during the year by a group of young people who regularly gave up their time to comment on safeguarding issues, and in addition by the work

of the participation officer at Luton Borough Council who approached particular groups of young people through her extensive knowledge of networks in town, to get their views on the Board's main discussion topics, so that the views of young people could be central to Board meetings.

Working with the other Bedfordshire Safeguarding Children Boards

Luton's needs are different from Central Bedfordshire and Bedford Borough in many ways, with its size, closeness to London, the deprivation in some parts of the town, its ethnic mix with new communities moving in, and the population that is young and changing rapidly, as well as the advantages that its good transport links give to those who want to exploit children, including via Luton airport. However , there are many issues that are common to child safeguarding across the county, such as sexual exploitation, how we respond to child neglect, and Serious Case Reviews for each of the three Boards have examined similar issues in recent years - and certainly issues that we can all learn from. Many families from Luton use services in other parts of Bedfordshire. For example, just over 50% of the students at Central Bedfordshire College in Dunstable, are from Luton. A number of significant organisations cover the whole county or areas that are larger than Luton. The Bedfordshire Police Force, the Probation and Community Rehabilitation Company are county-wide; and East London Foundation Trust and Cambridgeshire Community Services also operate beyond Luton and in other parts of Bedfordshire.

Housing in Luton - pressures that the town has not experienced before, and the implications for families

During 2015-2016, Luton faced a new level of demand for its housing - and from a new direction. London councils, unable to afford to house families at London prices, began to buy and rent as much available property in Luton as they could. Some of these families moved in with child protection histories that it was vital for Luton children's services to know about, and which in turn created a demand for assessment and ongoing support. One London borough rented an entire block of former offices and placed families with young children there temporarily; the Board asked for a paper from the director of Housing at its December 2015 meeting to try and unpick both the causes and likely consequences for safeguarding children of these new stresses on the town. One of the consequences was that families from Luton who needed housing then had to be housed in places such as Milton Keynes and further afield, causing them real difficulties in getting their children to school and in retaining links and support in their community. Stress on families is of natural concern to a Safeguarding Children Board.

External inspection and judgement on our Board - the Office for Standards in Education (Ofsted)

Ofsted inspected Children's Services and our Board in January and February 2015. The judgement on our Board was 'Requires Improvement'. The inspectors' views of where our strengths and weaknesses lay were ones that I had identified on arriving as Board Chair, and ones which
members who were interviewed by the inspectors, set out, along with evidence of what the Board's work had achieved. I would like to thank all the Board members who gave up their time to be interviewed, and who gave a clear account of all the work they had done. More information from the inspection is included throughout this report.

National Context

The Wood Review of Local Safeguarding Children Boards

In December 2015, the Prime Minister announced a large-scale review of safeguarding partnership arrangements, to be led by Alan Wood, a well-known children's services leader. This would include safeguarding children Boards, but also two functions undertaken by Boards - the collection, analysis and response to child deaths by the Child Death Overview Panel that each local area has; and the commissioning of Serious Case Reviews, when a child dies or is seriously harmed and abuse or neglect is known or suspected - which currently sits with safeguarding children Boards. Alan Wood gathered evidence for his review from January to March 2016 and Board members contributed via surveys and face to face events with Alan Wood. The Wood Review was published in June 2016 and legislation, to enable some of the changes it suggested, is currently making its way through Parliament. It suggests substantial changes to some of the functions of LSCBs and allows new local flexibility for the way Boards organise themselves. At the moment, Chairs of Boards, directors of children's services and other national groups who have an interest in the future workings of safeguarding children Boards, are discussing what the Wood Review means. Next year's annual report will cover the conclusions reached in Luton.

Safeguarding in Education - new statutory guidance: as the year began, the government published *Keeping Children Safe in Education* - which sets out what head teachers, teachers and staff, governing bodies, proprietors and management committees are expected to do. Education colleagues are hugely important members of our partnership, and this guidance was a timely reminder of the scale of the safeguarding responsibilities that they hold, but also for the Board in terms of our support to the sector.

The Independent Inquiry into Child Sexual Abuse: after difficulties appointing a Chair, a national enquiry began its work - of investigating "whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales". Awareness of the inquiry and the issues it will raise over what are likely to be many years, will be a task for all local safeguarding partnerships. At time of writing this report, the enquiry has had to appoint its fourth Chair and has had other difficulties.

Thanks to colleagues: During the year Michael Preston-Shoot stood down as Chair of the Board, a role he had carried out for over six years. Michael set the Board up for the future, and there are a number of projects and initiatives to thank him for. In the annual report you will also read about the large number of Serious Case Reviews the Board completed during 2015-2016. During his time as Chair, Michael was supported by another independent person, also very committed to Luton - Keith Ibbetson - who chaired the Serious Case Review group of the Board. The SCR group was well steered by Keith and both he and Michael are due the thanks of all Board members. In addition, during 2015 -2016, the small support team for the Board, funded by all the agencies who are Board members, went through many changes. An interim Board manager was appointed, who was around for much of the year, and thanks are due to also to Christine Bridgett for her management. Finally, the longstanding administrator of the Board left towards the end of the year and the last word of thanks is to Marie Lowe. A new business manager, Vijay Patel, came into post in December 2015, which is a permanent appointment and one that is very welcome.

Holding myself and the Luton Safeguarding Children Board to account

I hope you will look at our plans for 2016-2017 and use these to question me about how effective the Board is in leading and driving improvements in safeguarding children in Luton. I was genuinely delighted to be appointed as independent Chair and I want to bring the annual report to as many organisations and groups in Luton as possible, and use the opportunity to find out more about the current safeguarding issues in Luton and how the Board can support families, community groups, and volunteers, as well as the more obvious professionals, in keeping children safe in Luton.

Fran Pearson
Independent Chair

Table of Contents

Section 1 Luton - our town

1. Children living in this area

Approximately 54,700 children and young people under the age of 18 years live in Luton. This is 26% of the total population in the area.

A significantly higher proportion of the local authority's children are living in poverty, compared with regional and national averages. Luton is in the top quartile of England authorities for child poverty and is the 47th most deprived local authority in the country. One in four (14,769) children in Luton live in poverty, using the national definitions. The levels of deprivation affecting children in Luton are high, with several electoral wards in the top 10% most deprived areas in the country.

The proportion of children entitled to free school meals:

- In primary schools = 18% (the national average is 16%)
- In secondary schools = 20% (the national average is 14%)

Children and young people from minority ethnic groups account for 61% of all children living in the area, compared with 22% in the country as a whole.

- The largest minority ethnic groups of children and young people in the area are Asian and Asian British and Black and Black British.
- More than 120 languages are spoken in Luton. Half of all school children do not speak English as their first language.

The proportion of children and young people with English as an additional language:

- In primary schools = 52% (the national average is 19%)
- In secondary schools = 48% (the national average is 15%)

2. Child protection in this area

- At 30 November 2015, 1,916 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,480 at 31 March 2015.
- At 30 November 2015, 158 children and young people were the subject of a child protection plan. This is a reduction from 241 at 31 March 2015.
- At 30 November 2015, two children lived in a privately arranged fostering placement. This is a reduction from five at 31 March 2015.
- Since the last inspection, nine serious incident notifications have been submitted to Ofsted. Five serious case reviews have been completed or were ongoing at the time of the inspection

Data above taken from Ofsted's inspection report

Section 2 Luton Safeguarding Children Board Priorities for 2015-2016

The Board set the following priorities. They were originally intended to cover the period 2015 - 2017, however, the Board's priorities changed following our development day in March 2016. This was because the person facilitating our development day (Professor Jan Horwath) gave us a good challenge as Board members: was the evidence locally informing our choice about what to prioritise?

Priority 1: Reducing prevalence and impact of ABUSE IN SPECIFIC CIRCUMSTANCES, including CSE, Grooming for violence and extremism, sexually harmful behaviour, Female Genital Mutilation, forced marriage and honour based violence.

Priority 2: Ensuring children and families receive the right service at the right time through EARLY HELP

Priority 3: Reducing the prevalence and impact of NEGLECT

Priority 4: Improve the delivery of the Board's core statutory duties as defined in Working Together 2015 by embedding the new structure and governance within the Luton Safeguarding children Board

Priority 5 Improve communications and recognition locally of the LSCB as a key strategic body responsible for safeguarding children in Luton

A timeline for our year

October 2015	The LSCB Luton Pledge was formally launched at the Luton Town Football Ground.
December 2015	Serious Case Review into "Child D" published
December 2015	Board and rest of Bedfordshire agree a standardised way of responding to Female Genital Mutilation
January 2016	Spotlight event on Missing Children (Pan Beds)
January and February 2016	OfSTED "Single Inspection" of children's services provided by the Council, and of the safeguarding Board - OfSTED award the Board the grading of "Requires Improvement"
January and February 2016	Care Quality Commission Inspects Luton and Dunstable University Hospital - rating = "Good"
February 2016	Independent Chairs of the Safeguarding Children and Safeguarding Adults' Boards in Luton join each other's Boards to improve Think Family Approach to safeguarding

February 2016	Workshops for all of Bedfordshire on Female Genital Mutilation
March 2016	Board members' development day to set priorities for 2016-2017 Training contract with Luton Borough Council ends, to be replaced from 1st April 2016 by a Pan-Bedfordshire training Programme and unit.

What makes an effective safeguarding Board?

Work done by the National Association for Independent LSCB Chairs says that effective Boards:

1. Have an informed understanding of safeguarding arrangements and performance in single agencies
2. Have an authoritative oversight of the quality of front-line multi agency practice
3. Have effective governance arrangements and operating structure
4. Have clear lines of accountability with other strategic partnerships and be able to demonstrate its influence on the work of those partnerships
5. Operate a robust business planning approach to its work and routinely use feedback from children, young people and their families to evaluate its impact as well as service provision
6. Have a strong culture of challenge that is the responsibility of all Board members
7. Have a coherent strategy and deliver an action plan to address CSE and missing
8. Ensure learning from audits, case reviews, Serious Case Reviews and child death reviews reaches frontline practitioners and is used to develop practice and service provision
9. Ensure the provision of high quality multi agency safeguarding training and evaluate the impact on practice of such training
10. Set out the expectations of safeguarding training for all through its training strategy
11. Be able to evidence the impact of its work on improving practice and outcomes
12. Be visible to all stakeholders; including by publishing an evaluative and analytical annual report.

At the end of this annual report is a conclusion on how well the Luton Safeguarding Children Board did in 2015-2016 in each of these areas. Below is a summary of the Board's progress in meeting its priorities.

Priority 1

Reducing prevalence and impact of ABUSE IN SPECIFIC CIRCUMSTANCES, including CSE, Grooming for violence and extremism, sexually harmful behaviour, Female Genital Mutilation, forced marriage and honour based violence.

This was a wide-ranging priority area, where the Board focused on **Child Sexual Exploitation** and Children who go **missing**. In addition, the Ofsted inspection rightly recognised work to develop a pathway for reporting and responding to the risk of **Female Genital Mutilation.**

Another significant area of progress was the signing of a Memorandum of Understanding with Luton Airport to tackle the risk of children being trafficked.

Due to the breadth of this priority, it was not possible for the Board to give them all the elements listed in it equal attention. Grooming for violence and extremism, forced marriage, and honour based violence were not given as much attention by the Board as the priority suggested. In addition the Ofsted inspectors noted that the Board's sub group on bullying, sexting and online issues was not yet fully operational.

The Board was influential in:

- Commissioning with the other Bedfordshire safeguarding Boards a report into how effectively they work in the county on Child Sexual Exploitation was progressing;
- Suggesting ways in which the Child Sexual Exploitation Panel for Bedfordshire could be more effective - and these changes were adopted. The Board's November 2015 audit around sexual exploitation cases was the mechanism for doing this, backing up and testing out findings from the earlier report;
- Commissioning the play "Chelsea's choice" for all Year 8 pupils in Luton's educational establishments, to highlight the dilemmas around sexual exploitation. The play was shown in March 2016.
- Signing a Memorandum of Understanding with Luton Airport to build on work there tackling the risk of children being trafficked
- Developing a Female Genital Mutilation pathway and holding Pan Beds workshops on FGM in February 2016
- Holding a spotlight event in January 2015 which used the latest data about children and young people who go missing in order to get a wide range of around 100 professionals thinking about the implications for their practice.

Where the Board has more to do

- Developing a clear picture of what front-line professional practice is like for children who have been or are at risk of being sexually exploited, and who are missing from home, care, school or education. The Board's priority area of Missing Children for the current year, 2016-2017, responds to this.
- Engaging with children, young people, parents and other community members about bullying, sexting and online issues - a working group will be taking these forward in the second half of 2016-2017.

Priority 2

Ensuring children and families receive the right service at the right time through EARLY HELP

During 2015-2016, early help services began to have an impact for children and families in Luton - this was recognised in the Ofsted inspection of children's services.

"Early help services have been restructured to strengthen the interface with children's social care. The number of early help assessments has increased significantly...

- *Well-developed early help services ensure that children, young people and families are able to get the help and support that they need to tackle problems as soon as possible.*
- *The Flying Start programme, which is part of the early help strategy, is bringing together children's centres, health visitors and school nurses alongside other early help services, including the early help hub.*
- *Schools recognise the importance and significance of early help. They provide effective early support to families when need is first identified and/or direct them to other early help services as appropriate. With family support workers funded by, and based in, schools, the number of early help assessments (EHAs) has more than doubled, from 525 in 2014–15 to 1,191 in the first nine months of 2015–16 "*

What was less clear was the **Board's role** in monitoring and testing out the effectiveness of these services. Luton has another longstanding and effective forum for doing some of this - the Children's Trust Board. In addition, the safeguarding Board now has a focus on Neglect as one of its two major areas of work for 2016-2017. Because Early Help is so critical to tackling neglect, this offers an opportunity for the Board members to agree and put into action the boundaries and focus of the Board's Early Help work.

Priority 3

Reducing the prevalence and impact of NEGLECT

Neglect affects the lives of too many children in Luton. It was a theme of the Serious Case Reviews commissioned by the Board in 2015-2016, Child D, Child E and Child F, all of which were about neglect of babies or very young children in the town. Child D was published in the year this report covers, and Child E and Child F have both been published since.

Where the Board was influential /had impact

Luton's Board made a decision to use a tool developed by a national body to help professionals in Luton work with families to assess how much of an effect neglectful parenting might be having on a child's life. This is the Graded Care Profile, and the Ofsted inspection commented that:

The need to improve the professional response to neglect is a key learning outcome from a number of SCRs. Having identified the lack of progress in this area, the new chair of the LSCB has taken swift action to address the deficit by appointing a part-time development officer to focus on this issue. The new chair has also secured the services of a leading national

expert on neglect to facilitate the Board's development and business planning day in March 2016.

The development officer was crucial, as were the Board members who supported the work, in beginning to pilot the use of the Graded Care Profile. At time of writing, Luton's way of implementing this tool has been commented on in the context of other places where the tool is being introduced - in Luton the piloting and the roll out of Graded Care Profile has been led and passed on by a genuinely multi-agency group, which is apparently not the case in other parts of the country, meaning that we already appear to have greater professional buy-in and good will as a result. The Board's development day in March 2016 did indeed result in challenge to Board members to define what it was about neglect that we wanted to tackle in Luton, and it was of great benefit to have Professor Jan Horwath, who is very well known and regarded in the field of child neglect, facilitating that day for us.

Another aspect of work around neglect that the inspectors commented on was the messages from young people, gathered and written up by the Participation Officer, that gave some powerful insights into what teenagers think about, and have experienced in relation to, neglect. These are the responses to the question: **What thoughts or recommendations do you have regarding this topic/your circumstance to improve the outcomes for families?**

- Make sure professionals recognise things early enough
- Teachers play a big part in recognising issues, teachers who manage/run the exclusion units for those who are classed as naughty; they should receive good training in recognising signs of abuse/neglect
- Teach school children from young about abuse/neglect and help friends understand what to do if they notice things in their friends, or their friends tell them stuff. Teach them young enough so it stays with them as they get older
- When social workers get involved with families they can cause panic, so it would be good to have professionals who know how to explain things better, like advocates, youth workers, family workers etc along with the Social worker
- Professionals need to make sure they don't speak down to people, this often makes things worse. Approach is everything
- Parents and a house do not change over a week or short term its small steps
- Rather than just do stuff to try to 'fix' a family. Do stuff that bonds them and builds relationships, interactive stuff, not therapy. Things like nice sessions, cooking, art etc, sessions that help parents and children have fun
- Support groups for parents not just the formal support/parenting classes you put them on
- Make sure you help to maintain good relationships with children & parents
- Kids love their parents to bits so remember that
- When you take a child into care make sure you 'Listen' to very young children, they may not be able to say it in ways you understand, but if they are telling you something is wrong – believe them until you have proved otherwise. Don't just think they are acting up cos they want to move placement or go home
- Despite being neglected children still love their parents and most parents love their children they just have issues
- Even if you have been neglected you really miss your parents

- Social workers should try to put themselves in the parents shoes and understand them not just view them as 'bad parents'
- Make sure you listen to the views and feelings of the children in the family about what they want and how they feel
- Perhaps you could have carers (peer parents) who spend time in the home with families to help teach the parents how to be parents in the home rather than classes
- If a family are on child protection and you go and visit them and have bad news to share, make sure you **always** leave the house on a positive note, make sure the children feel reassured and are ok

Where the Board has more to do

The views of the young people were a timely reminder of something that surfaced again at the Board development day - we have not had enough focus on adolescents and understanding the impact of neglect on this group of Luton's children. At time of writing, because adolescents have become a clear part of the Board's priority work on neglect for 2016-2017, this is being addressed.

The Ofsted inspectors commented that the Board had been strong in responding to lessons from the Serious Case Reviews about neglect in some ways, but not in others. So for example the Designated Nurse for Safeguarding from the NHS worked with other professionals, mainly from the range of NHS organisations that cover Luton, to develop a bruising protocol. This was to make sure there was a clear process laid out for professionals so that bruises to non-mobile babies were all followed up consistently, and this came out of the Child D Serious Case Review. However, some of the other messages from Serious Case Reviews were not being shared with professionals. This has been addressed at time of writing in a number of ways including the Serious Case Review Sub Group organising the huge and very wide ranging number of SCR recommendations around neglect into a thematic framework so that it's possible to see what progress is needed and what improvements are taking place in the really crucial areas. In addition, messages to practitioners have been put out consistently since those comments by the Ofsted inspectors. In September 2016, the training unit ran two half day sessions on adolescent neglect, which were fully booked. The LSCB conference in October 2017 included sections on neglect and reached a wide range of professionals, and a Child and Adolescent Neglect Conference for all of Bedfordshire is taking place in March 2017. Additionally the Board went on to commission a report specifically about adolescent neglect to inform its work and pull together the issues that came out of specific sessions.

Priority 4

Improve the delivery of the Board's core statutory duties as defined in Working Together 2015 by embedding the new structure and governance within the Luton Safeguarding Children Board

The Board Chair and members completed a review of the structure of sub groups around the Board and began to implement the resulting changes during 2015-2016. They also commissioned a review by someone independent of any organisations in Luton of the training support that the Board commissioned. This report amongst other things noted the

lack of a training sub group where the discussions that were needed to set the direction for multiagency safeguarding training could happen.

Where the Board was influential /had impact

The new arrangements were gradually set up during 2015-2016 with the following sub groups all in place for Luton, and then other arrangements strengthening the way that Luton Safeguarding Children Board works with the other two LSCBs in Bedfordshire.

- Scrutiny Assurance (Chair = Service Director for Quality Assurance, Luton Borough Council)
- Learning and Improvement (Chair = Designated Nurse, Luton Clinical Commissioning Group)
- Serious Case Review (Chair = Independent Chair of the Safeguarding Board)
- Multi Agency Audit (Chair = one of the Board's Lay Members)
- Child Death Overview Panel (Pan Bedfordshire, Chair = Director of Public Health for Luton)
- Training (new Pan Bedfordshire Group)
- Child Sexual Exploitation (Bedfordshire governance arrangements)

And to steer all of this, an Executive Group of senior leaders from member groups, attended by young people to give their direct messages about safeguarding issues in Luton.

The Board also agreed during the year, after commissioning an independent review, to move into training arrangements with the other two LSCBs in Bedfordshire. Combined, these steps meant that the Board moved into 2016-2017 with mechanisms for:

- looking in appropriate detail at the performance of individual organisations as well as the way they work together to keep children safe, through the newly set up Scrutiny and Assurance Group
- commissioning, and assessing the quality of training that has relevance both for Luton specific issues, but also with all the benefits of doing things the same way across Bedfordshire
- continuing the governance around Child Sexual Exploitation that had been assessed in an independent review as having strengths
- quickly resolving attendance and membership issues, as well as any emerging multi-agency tensions via the Executive group
- making the best use of the Board's constructive lay members, especially by inviting one of them to chair a sub group of the Board

One aim that I had when starting as Chair halfway through the 2015-2016 year, was to make sure that the Board was led by the data that we have about safeguarding in Luton. Ofsted inspectors commented positively about the format in which the Board has put that data together - its scorecard - but also said that the scorecard needed to expand to include measures of effectiveness around child sexual exploitation. To model this intention of making the Board's prioritisation explicitly led by data, the December 2015 Board meeting started by looking at some of our performance data, as did the spotlight event on Missing Children in January 2016. Data was at the centre of the Board's development day where Professor Jan Horwath repeatedly challenged us about what we thought our priorities should be - and data helped lead us to a clear focus for the 2016-2017 year.

Where the Board has more to do

A positive additional step that was agreed at the very end of the year was that the two safeguarding Boards - the children's one and the Board for adults - should develop their ways of working together. Although this is not formal governance, but is rather led through the two independent chairs, it has already at the time of writing, led to some more joined up thinking around areas where both Boards have a common interest - domestic violence; and thinking through the consequences of abuse in childhood and what this means in terms of adults who go on to have needs for support in later life.

Priority 5

Improve communications and recognition locally of the LSCB as a key strategic body responsible for safeguarding children in Luton

The Board was influential in

As the OfSTED inspectors recognised, a major achievement of the year was the launch of the Luton Pledge. Substantial work by the Board team and Board members went into achieving buy-in for the pledge from faith and community groups in Luton. The pledge united many different groups in being able to sign up to protecting children and young people in Luton. The press release for the Pledge said:

Luton Safeguarding Children Board (LSCB) has brought community groups together to commit to a shared responsibility to protect children and young people from abuse and harm.

The LSCB officially launched its safeguarding pledge at Luton Town Football Club (LTFC) yesterday (12 October) at Kenilworth Road stadium.

*Luton Town First Team manager, **John Still**, signed the pledge together with **Kevin Thoburn**, LTFC Community Trust, acknowledging the club's and trust's commitment to protecting children and young people.*
In consultation with different communities the LSCB developed a pledge which organisations sign up to, promising to protect children and young people from:

- *being groomed and sexually exploited and abused in our community and online*
- *physical abuse, female genital mutilation, bullying and cyber bullying*
- *being drawn into violent and extreme behaviour both in our community and abroad*

Communities who sign the pledge will also agree to promote the emotional wellbeing of children so that they can achieve and do well and enjoy a healthy way of life.

Where the Board has more to do

Ofsted inspectors also commented on the Board's influence on other strategic groups and partnerships as being limited. The one exception though was the very consistent attendance from the Board's previous chair at the Children's Trust Board, "*which helped to shape the development of the Flying Start strategy for Luton, not least by emphasising the critical importance of partnership working*". At time of writing, and as mentioned earlier in the

report, there is increasingly joined up working and mutual influence between the adults' and children's safeguarding Boards, and the next aim is to extend that to the community safety partnership for Luton in terms of how we define each Board's role in relation to domestic violence.

Also mentioned earlier, and now a part of the Board's work in 2016-2017, is the development of a community engagement strategy for the Board. Already the Board is establishing stronger links with faith and community groups around safeguarding and acting upon the Ofsted recommendation that the LSCB
"Increase the level of engagement with faith groups and voluntary sector organisations in order to ensure that they, and the LSCB, are confident that they are responding effectively to safeguarding issues".

Section 3 Reports to the Board and what they tell us about impact

Training Report

The Board made a substantial change to training arrangements in 2015-2016. Following an independent report, a decision was made to change training providers, moving from Luton Borough Council's provision, to a new arrangement with the two other Safeguarding Boards in Bedfordshire - Central Beds and Bedford Borough, who already had a joint training unit. This arrangement began on 1st April 2016 and will be evaluated in the next annual report. The new arrangement has been widely welcomed by the agencies that deliver services across the whole county.

Meanwhile the following courses were provided in 2015-2016:

- Keeping Children and Young People Safe Online
- Child Sexual Exploitation Panel (CSEP)
- Safeguarding Children: A Shared Responsibility
- Working with Difficult, Evasive and Dangerous Families
- Protecting Disabled Children
- Child Sexual Exploitation - Are you Colluding with Silence?
- In Our Shoes - Evidencing the Child's Journey and Experiences
- Safeguarding Children: A Shared Responsibility
- Self Harm in Children & Young People
- Thinking the Unthinkable - Nature & Impact of Sexual Abuse
- Introduction to Safeguarding Children (PVI - Level 1)
- WRAP - Safeguarding Children from Radicalisation and Extremism
- Identifying Neglect and Graded Care Profile

Just under 2000 places were taken up on courses during the year with a spread of attendees from across statutory services, including from schools, and from the private and voluntary sector. The new training arrangements mean that in 2016-2017 it should be possible to begin to measure what impact the multi-agency training programme is having on safeguarding practice.

Private Fostering

The Annual Report on private fostering came to the Board in September 2016. Private fostering refers to an arrangement involving children or young people, aged under 16 years (18 if they have a disability) living with a person who is not a close relative.

Impact

The number of known privately fostered children in Luton is currently low. Attempts are in progress to increase the number of new notifications through the targeting of services where it is felt there are areas of potential risk, need and vulnerability (such as schools, GPs, adult safeguarding services and other specialist groups). At the Board meeting in September 2016, LSCB members noted that although other areas of the country were experiencing similarly low levels of notification, this was an issue that the Board would champion, and agreed the following actions:

- Scrutiny and Assurance Subgroup of the Board to identify a champion for this.
- Staff would be reminded to ask and forward information to social care if applicable.
- Even colleagues on Board sub groups were unaware of the definition of "privately fostered" - so a "Frequently Asked Questions" about private fostering has been placed on the Luton Borough Council website

http://www.luton.gov.uk/news/Pages/Are-you-looking-after-someone-elses-child.aspx

- The Board noted and welcomed a communication strategy around private fostering.

It is too early to assess the impact of these actions, so the 2016-2017 Annual Report will do this.

Child Death Overview Panel Annual Report 2015-2016

Child Death Overview Panels were set up following a 2004 report: *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation.* From 2008 CDOPs took on responsibility to review all child deaths in an area. In relation to safeguarding, the Wood Review of Local Safeguarding Children Boards states that: 'Over 80% of child deaths have medical or public health causation', and includes the estimate that 'only 4% of child deaths relate to safeguarding or require [a Serious Case Review] to be carried out'. It is likely that as a result of the Wood Review, Child Death Overview Panels will move out of local safeguarding structures, but for the time being, the CDOP, which covers not only Luton but also Central Bedfordshire and Bedford Borough, remains a sub group of the three safeguarding Boards in Bedfordshire. The primary function (as required by the Local Safeguarding Boards Regulations 2006) is to undertake a comprehensive and multiagency review of all deaths of children normally resident in Bedford Borough, Central Bedfordshire and Luton aged 0-18 years of age, in order to better understand how and why they die and to use the findings to take action to prevent other deaths and to improve the health, wellbeing and safety of children and young people.

The principles underlying the overview of all child deaths are:

- Every child's death is a tragedy.
- Learning lessons including referring cases for in depth review/scrutiny such as Serious Case Review
- Joint agency working and informing service provision
- Positive action to safeguard and promote the welfare of children

There are two interrelated processes for reviewing child deaths:

1) A rapid response service, which is used to investigate unexpected deaths
2) A paper based review of the deaths of all children under the age of 18

During the period 1st April 2015 to 31st March 2016 the panel met on eight occasions and completed full reviews on 40 children residing in Bedford Borough, Central Bedfordshire and Luton. These cases were from 2013-2014, 2014-2015 and 2015-2016.

Modifiable Factors

One role of a Child Death Overview Panel is to comment on whether with any changes ("modifiable factors"), a similar case could be prevented in the future.

In 2015-2016 modifiable factors were identified in 52.5% of cases reviewed which is significantly higher than the national picture of 24%. The modifiable factors identified included: consanguinity, smoking of one or both parents, co-sleeping, obesity and factors relating to service provision.

Consanguinity is a major risk factor for inherited disorders and CDOP panels nationally continue to be concerned that inter-family couples do not have sufficient understanding of the increased risks of having a child with a disability or of having a child die under the age of five. Within Luton, targeted action has been taken to improve awareness in high risk communities, and this work needs to be ongoing as this year there was a three year high in the percentage of cases reviewed that were closed under the category of Congenital Anomalies or Chromosomal Defects, however, not all of these will have been as a result of consanguinity.

All numbers from Child Death Overview Panels are small, and five-year-trends can be relied on far more than one year's data. However, targeted action needs to continue in Luton in relation to consanguinity, and the Safeguarding Children Board needs to take time during 2016-2017 to understand what this actions consists of and how the Safeguarding Children Board can support this work.

The Local Authority Designated Officer's Report

The "LADO" follows up referrals and contacts where there are concerns, or allegations made, about professionals working with children. The LADO Report came to the Board in September 2016.

The focus of the report was to:

- Share learning identified during 2015-2016 about the safe management of children's behaviour in organisations
- Consider how the Safeguarding Board and the LADO can engage more effectively with 'unregulated' organisations that provide services for children
- Update the Board on actions to further develop the performance management system for the LADO service (which had been a recommendation of the Ofsted inspectors)

During the year, there was a slight reduction in overall contacts to the service, but the number of 'active' referrals that come out of these contacts is very similar to 2014-2015. One theory is that the session "In Safe Hands" (see the section below) has helped reduce the number of contacts from people seeking advice about situations that do not fit with the remit of the LADO.

The greatest proportion of referrals were about professionals in schools. As the schools' workforce is the biggest group (approx. 7000 members of staff) working with children in Luton, this was consistent with local authorities in the region and elsewhere. The shift for the first time in 2015-2016 was that there were slightly more referrals about secondary schools than primary schools. Nearly half of referrals fell under the category 'May pose a

risk to children', which refers to information, often from an adult's private life, that indicates they may be an unsafe person to work with children.

Impact

16% of LADO referrals during 2015-2016 came from private, voluntary, independent or faith based organisations, many of which are unregulated. In response, the LADO service delivered *In Safe Hands* to approximately 570 delegates across 14 settings in the town. The session focuses on what research says about settings where abuse has taken place and the features of organisations considered to be safer.

As a next step, the two LADOs will undertake another review of this training material to keep it current and based on learning from national and local cases. The LADOs and the safeguarding Board are going to work together to look at ways in which *In Safe Hands* can be further accessed by unregulated organisations in the town.

Section 4 Conclusions: how effective is our Board?

1. Have an informed understanding of safeguarding arrangements and performance in single agencies
2. Have an authoritative oversight of the quality of front-line multi agency practice
3. Have effective governance arrangements and operating structure
4. Have clear lines of accountability with other strategic partnerships and be able to demonstrate its influence on the work of those partnerships
5. Operate a robust business planning approach to its work and routinely use feedback from children, young people and their families to evaluate its impact as well as service provision
6. Have a strong culture of challenge that is the responsibility of all Board members
7. Have a coherent strategy and deliver an action plan to address CSE and missing
8. Ensure learning from audits, case reviews, Serious Case Reviews and child death reviews reaches frontline practitioners and is used to develop practice and service provision
9. Ensure the provision of high quality multi agency safeguarding training and evaluate the impact on practice of such training
10. Set out the expectations of safeguarding training for all through its training strategy
11. Be able to evidence the impact of its work on improving practice and outcomes
12. Be visible to all stakeholders; including by publishing an evaluative and analytical annual report

In summary, the Board has made progress in all areas during 2015-2016.

Where progress is least solid is in areas 2 (Have an authoritative oversight of the quality of front-line multi agency practice); 4 (Have clear lines of accountability with other strategic partnerships and be able to demonstrate its influence on the work of those partnerships) and 8 in respect of audits (Ensure learning from audits, case reviews, Serious Case Reviews and child death reviews reaches frontline practitioners and is used to develop practice and service provision).

Where the Board has made the greatest improvements is in areas 7 (Have a coherent strategy and deliver an action plan to address CSE and missing), area 1 (Have an informed understanding of safeguarding arrangements and performance in single agencies) thanks to the work of its scrutiny and assurance and SCR subgroups; and in area 9 (Ensure the provision of high quality multi agency safeguarding training, and evaluate the impact on practice of such training) due to its new training commissioning and delivery arrangements.

In terms of a framework to help with measuring the Board's progress in 2016-2017, the measures above from the LSCB chairs' association are one option, but another way to look at the Board's functioning is via the elements that Alan Wood set out in his Review of LSCBs, published in March 2016 - he thinks the issues that strategic Boards should focus on are:

- Determining the physical area of operation covered by multi-agency arrangements
- The authorising vision for multi-agency arrangements, the partnership commitment
- The resource framework, e.g. the cost of multi-agency strategic decision making body, the cost of agreed initiatives, e.g. joint training, agreed local research, innovation in service design

- The method to assess outcomes of multi-agency practice, including how intervention happens if performance falters, and how 'independent' external assurance/scrutiny will be utilised
- The strategy for information and data sharing, including to allow for identification of vulnerable children in need of early help
- High-level oversight of workforce planning, e.g. gaps in skilled areas
- A multi-agency communication strategy on protecting children
- Risk strategy, identifying and adapting to challenges including new events, and establishing a core intelligence capacity

If after reading this report, you have any views on how we can better set out our performance next year and whether one of the two frameworks above is helpful, it would be good to have some feedback on this.

Section 5 Our plans for 2016 - 2017

The Board's priorities for the next year, based on what we learnt as a Board during 2015-2016, are:

Priority One: Tackling Child Neglect in Luton and as a Board:

- Understanding the impact of the decision to use the Graded Care Profile to assess neglect
- Understanding and responding to the neglect of adolescents in Luton, when many tools and approaches are focused on young children

Priority Two: Children who are missing from:

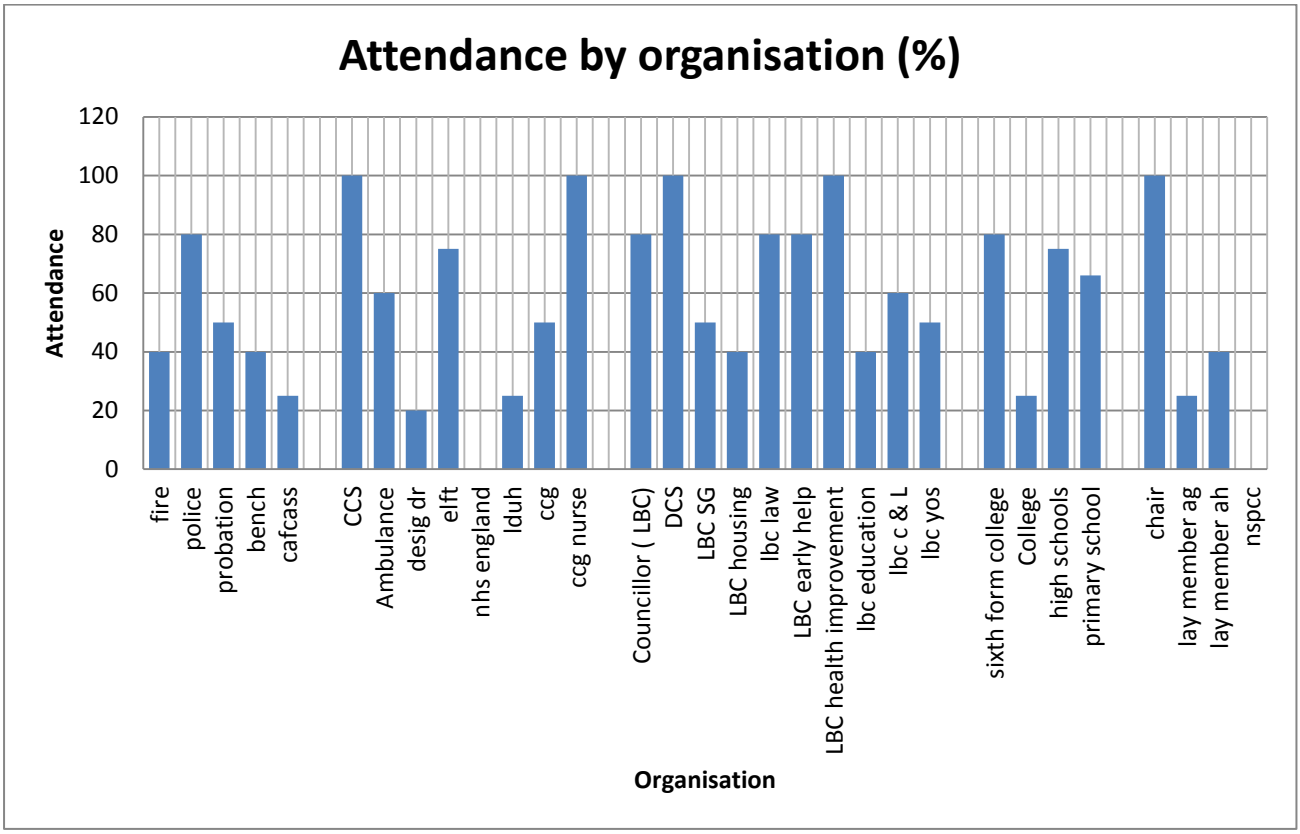
- Education
- Trafficked children
- Looked After Children
- Children at risk of or experiencing Child Sexual Exploitation
- Children in private fostering arrangements

Priority Three: Developing an effective Board where:

- New Board members are clear about their role, the priorities of LSCB and are actively engaged
- Practitioners know about the LSCB, are able to identify how to find information and training
- Board finances support the focus on priority themes

Section 6 Board administration

Agency attendance at Board 2015-2016.There were four meetings during the year.



The Board's budget

The budget was agreed before this year and all agencies are signed up to it for a longer period. It is of note that some national research about police force funding to LSCBs showed that Bedfordshire Police are, based on population size, the most generous police force funders of safeguarding children Boards in the country. (Miller 2015/16).

Although the financial contribution from the Probation Service was relatively small, this is set to go down to about 1/10 of its 2015-2016 size as the service has become the Community Rehabilitation Company and the National Probation Service.

Contribution by agency	Contribution
Luton Borough Council	£121,677.00
CAFCASS	£550.00
Luton and Dunstable University Hospital	£21,767.02
Luton Clinical Commissioning Group	£21,767.02
East London Foundation Trust	£21,767.02
Cambridge Community Services	£21,767.02
Bedfordshire Police	£23,359.60
Probation	£4, 565.44

The Independent Chair and accountability

As Independent Chair of the Luton Safeguarding Children Board, I am, like all independent chairs, accountable to the local authority chief executive. In Luton, this is Trevor Holden. I told the Ofsted inspectors what a good start Trevor and I had made to meeting and holding each other to account, with our first formal meeting in January 2016 having taken place shortly before the inspection started. Since I took up my post in September 2015, my relationship with the Director of Children's Services, Sally Rowe, has been an absolutely essential one, and we meet monthly.

Section 7 Having your say on this report

We know as a Board that we are not as good as we want to be at using the voices of local children and residents to influence our work. This particularly applies to community groups and other local organisations. If you are part of a community group or organisation and would like me to come and talk about this report and the work of the Board, then please do invite me - I want to make better links between the Board and local organisations in Luton. If you would like to comment on any of the issues in this report, your views are important to us. You can contact the Board via our website - it's been rebuilt just as we go to publication so we'd like your views on the site as well as any comments about this Report.