Luton Safeguarding Children Board

2012/2013 Annual Report on the effectiveness of Safeguarding in Luton.

www.lutonlscb.org

Preface

The Apprenticeship, Skills, Children & Learning Act 2009 introduced a requirement for LSCBs to produce and publish an annual report on the effectiveness of safeguarding in the local area. The revised Working Together 2013 guidance has provided additional detail and states the annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period. The report should list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

Welcome

The year covered by this annual report has seen the LSCB continue to build on the good rating awarded by OFSTED for safeguarding children in Luton. The Board has kept its governance arrangements under close review and has continued to cultivate a healthy challenge towards those agencies responsible for safeguarding and promoting the welfare of children and young people. It has held its annual business planning and review day, which included engagement with practitioners and managers about their lived experience of prevention, early intervention and child protection provision, and with elected representatives about their perspectives on systems and services. The Board is acting on the feedback received through that engagement and through newsletters, and future business planning and review days will complete the "you said, we did" feedback loops. Additionally, with Lloyd Denny, Vice Chair of the LSCB and one of the Board's two lay members, I have continued to meet with front line practitioners across statutory and voluntary agency services to review their observations and concerns about safeguarding systems and services in Luton. These are crucial opportunities for assessing performance and quality, and will remain a fundamental part of the Board's priorities going forward.

This activity, however, has to be informed by a very clear sense of what good looks like. The aforementioned business planning and review day included the LSCB revisiting and reaffirming its commitments to what good looks like for the child, for the team around the child, for the organisations around the team and for the LSCB around the organisations. This whole system view, with children and young people at the centre, remains the benchmark against which the LSCB evaluates its own performance and those of its statutory and non-statutory partners.

Another key part of the Board's assurance activities has therefore been quality audit. The programme of section 11 (Children Act 2004) audits has continued alongside scrutiny of the outcome of cases and monitoring of the action plan to address the feedback from OFSTED on services for looked after children. At strategic levels multi-agency arrangements appear to be working well and the commitment of senior managers to

ensure closer collaboration and inter-agency working is evident. At operational levels there have been good examples of collaboration between services which have protected children and young people from abuse and/or neglect. As Independent Chair, I know of situations where agencies have worked effectively together to prevent problems from escalating and to protect children and young people from harm. However, budget reductions have impacted seriously, even perhaps detrimentally, on all statutory and non-statutory partners, whilst demands on their services have not diminished. There comes a time when further efficiencies in the way that services are organised, managed and configured cannot be achieved without loss of quality and effectiveness. It is my judgement that such a tipping point has been reached. This is why, going forward into the 2013/2014 business planning year, the LSCB has amongst its priorities to monitor and scrutinise the impact of thresholds, workloads and decisions about which services to maintain on the safety and well-being of children, young people and their families. Children and young people must be at the centre of all decision-making and increasingly protecting the front line of provision for children in need and for children requiring protection is proving challenging. The LSCB and its members must beware the tendency in situations of austerity to retreat into silo working and single agency mentalities. The LSCB and its members must continue to advocate for what good looks like, as outlined above.

The challenges faced by statutory and non-statutory agency partners in Luton are considerable. Levels of poverty and disadvantage, as revealed for example by public health statistics for people in Luton, concerns about child sexual exploitation, and bringing communities and organisations together to tackle organised crime, are just some examples of where the LSCB's focus has fallen and will continue to lie. Besides overseeing how well the various agencies are working together in understanding and responding to these challenges, the Board itself has also directly engaged in developing strategies, facilitating service provision, and raising awareness. Examples include engaging with faith communities and with schools about safeguarding. Drawing on evidence from Luton and elsewhere, the Board has set challenging priorities for 2013/2014, including engaging with children and young people themselves about how safe and secure they feel, and how effective the agencies with which they engage are in promoting their well-being. The Board will continue to promote awareness of, and services to tackle child sexual exploitation and it will support statutory services that have come together to address organised crime and to promote community safety.

The Board recognises the need for agencies to work together effectively and will, therefore, prioritise how adult social care and children's social care work effectively together to support parents and children, where both parties in a family have needs that must be met if young people are to be safe and secure. The Board will prioritise both early intervention and services for looked after children to ensure that assessments are thorough and provision is available to meet identified needs. Moreover, increasingly the Board will locate its work within a learning improvement culture, bringing to the fore evidence and learning from local, regional and national inquiries, reviews of near misses and good practice, and peer challenge.

I commend this annual report to you, the reader, and look forward to presenting its contents and conclusions to leaders in the council, police and health economy. We owe it to children and young people in Luton, and their families, to build and maintain resilient safeguarding systems, for example ensuring that services are underpinned by policies and procedures that reflect the latest statutory guidance and research evidence. We owe it to them, and to the staff on whom we rely to promote children's well-being, to ensure that practitioners and managers are also resilient and looked after. It is far less of a challenge to ensure that policies and procedures are up-to-date than it is to promote the well-being of staff and to retain their experience and expertise. In thanking all those who have safeguarded and promoted the welfare of children and young people, and their families in Luton during 2012/2013, I also recognise that the challenges facing us all to keep children and young people safe and to promote their well-being will increase in the forthcoming year. It is my assessment that the LSCB has the resilience to undertake this task but no-one can afford to be complacent about the determination, resources, courage, challenge, curiosity and care that will be needed.

Professor Michael Preston-Shoot
Independent Chair

Governance and Accountability

The LSCB's current governance arrangements are shown below in Figure 1. There are currently three standing subgroups of the LSCB (Executive, Child Death Overview Panel and the Serious Case Review Panel). Both the LSCB Strategic Board and Serious Case Review group are chaired independently.

In addition, 2 task and finish groups were commissioned by the Executive group to progress specific areas of safeguarding activity:

- Safeguarding children at risk of/experiencing sexual abuse through sexual exploitation; and
- Safeguarding in the private, voluntary and independent sector, including faith communities.

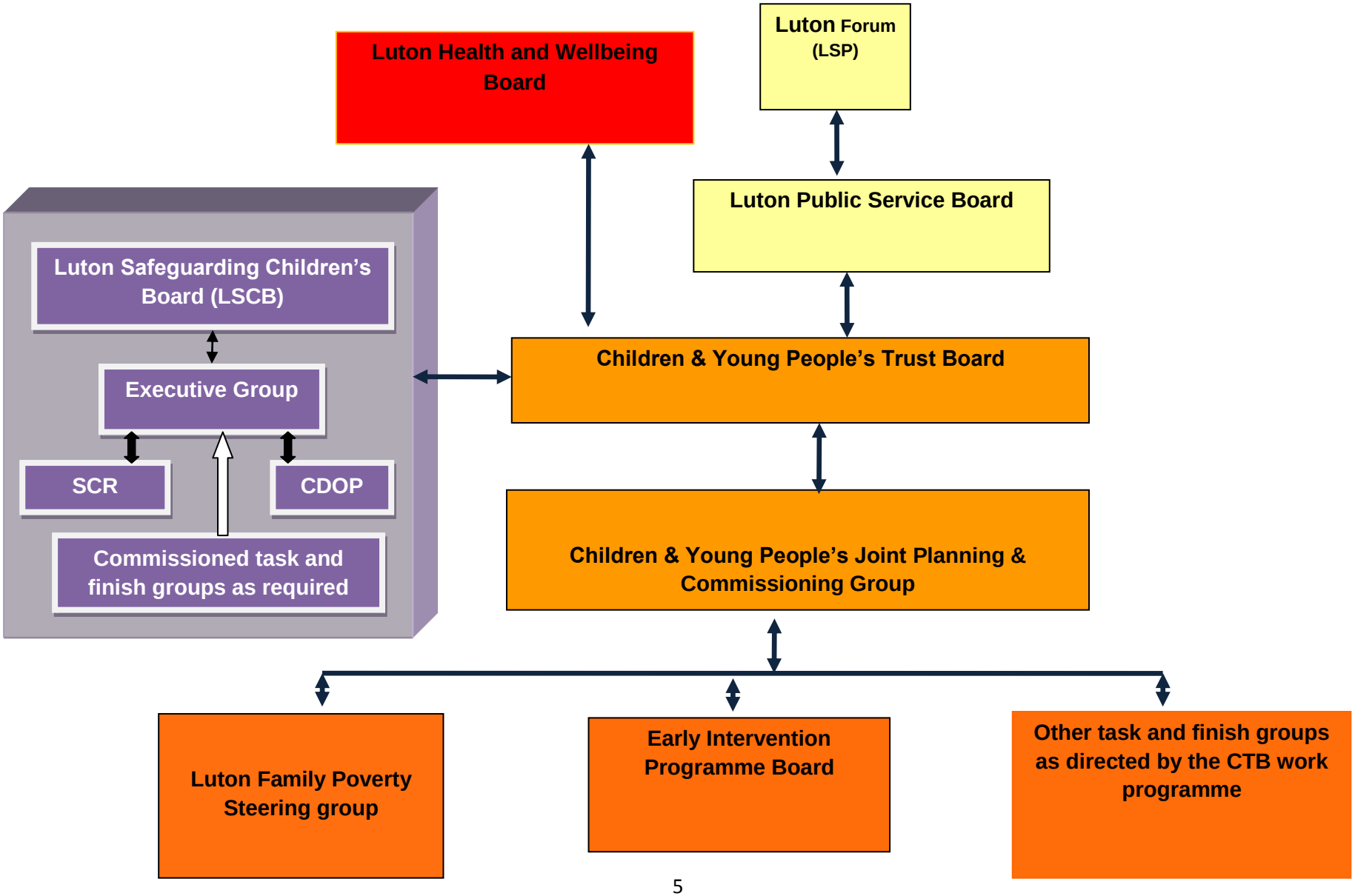
An Annual Business Plan is approved by the LSCB which details key objectives to progress activity against the 2012-2013 identified strategic priorities. Please see Appendix 1.

The LSCB, Children's Trust Board and the Luton Health and Wellbeing Board

The wider partnership and governance arrangements for the LSCB are also set out in Figure 1. The LSCB and the Children's Trust Board (CTB) link through the Independent Chair of the LSCB, who is a standing member of the CTB. The Director of Children's Services 'chairs' the CTB and is a member of the LSCB and provides a quarterly update to the LSCB on the work of the Children's Trust Board. Similarly, the LSCB Independent Chair (representing the LSCB) reports quarterly to the CTB on the work of the LSCB. As a standing member of the CTB, the LSCB Independent Chair can both influence and monitor progress against the priorities of the CTB.

The strategic relationship between the two Boards is in line with national guidance issued at the end of March 2010. In November 2010, the statutory requirements for CTBs were removed, permitting local areas to make arrangements to reflect local needs. In Luton, CTB partners agreed to continue with the current arrangements. The CTB reports to the Luton Health and Wellbeing Board (HWB) through the Director of Children's Services (DCS). Although, the LSCB Independent Chair is not a standing member of the HWB, he attends annually to present the LSCB Annual Report and can be co opted to attend as required.

Figure1 - Governance and Accountability arrangements with local partnerships



An assessment of performance and effectiveness of local help services set in the context of national research

The safeguarding arrangements for teenage parents

A review of the UK government's 1999 report on teenage pregnancy was completed in 2007, with the publication of a report - *Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomised trial of sex education and their implications for policy* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465587/

The aim of the review was to examine the risk factors identified in the original government report on pregnancy at or before age 16 years among young women and partners of young men, using more recent data. The review confirmed the following risk factors: Socioeconomic disadvantage, being born to a teenage mother, expectation of being a teenage parent and low educational expectations as potential risk factors for teenage pregnancy.

The report concluded that many of the original risk factors identified in the 1999 government report remain relevant and the relationships with parents and school, as well as expectations for the future, may have important influences on teenage pregnancy. The report confirms that school is a key source of sexual health information for young people and supports the view that sex education should focus on skills and emotional literacy as well as knowledge.

Local Picture

An assessment of the safeguarding arrangements for teenage parents in Luton in May 2012 provided both local and comparative national statistical data as follows:

- Most recent published data for Under 18 year olds conception rates stands at 33.7% per 1,000 which is an increase on the previous 2009 data of 29.4%;
- From April to December 2011 the Luton Teenage Caseload Midwifery team saw 54 mothers of whom 10 had had a previous pregnancy;
- Of the 54 young mothers seen by the Teenage Caseload Midwives, 7 were 'Looked After Children' and 7 were known to the 16+ Team;
- In a nine month period, there were 36 under 18 year old terminations with 1 repeat, compared with 48 terminations and 4 repeats in 2010/11 The number of terminations performed under 10 weeks exceeds the national target of 70%; and
- The overall proportion of Luton's 16 to 18 years olds who are not in employment, education and training (NEET) is 6.3%, with a higher proportion of these being teenage parents. However the 'Care to Learn' figures for under 19 year olds was 11 in February 2012, a slight increase from 10 in December 2011, this equates to 4.8%, compared to the East of England average of 10.7%.

An evidence based approach has been developed locally to support the reduction of teenage pregnancy which includes two key components:

- Comprehensive education about sex and relationships (SRE); and
- Easy access to effective contraception.

Current activity in Luton includes:

- A workforce development programme to develop the skills of frontline workers including training on safeguarding children, sex and the law, and working with boys and young men;
- Dedicated support for vulnerable young people through a young people's worker providing1:1 and group work;
- Betty McKean I & 2 which provides accommodation and support for vulnerable young women including teenage parents. Betty McKean 1 works with 16 – 25 year old pregnant young women (without children) and Betty McKean 2 with 16 – 25 year olds pregnant with children and other complex needs;
- Three dedicated Teenage Caseload Midwifes to support the needs of young pregnant women for up to 29 days after birth;
- Improved access to contraception though a dedicated young people's sexual health service. (On average Brook are in contact with approx. 2000 young people each quarter through the town centre clinic, satellite clinics and outreach work);
- Condom Card (C:Card) scheme operating from 22 sites; and
- Free Emergency Hormonal Contraception (EHC) with Chlamydia screening is available from 21 pharmacies for women aged 13 and above.

Additional areas identified for local development are as follows:

- The re-alignment of the referral and care pathway for vulnerable young pregnant teenagers and young parents to incorporate clinical into community services;
- The continuation and expansion of the young parent 'Bump to Birth' programmes and supporting parent groups with a particular focus on under 25 year olds;

- The development and implementation of a standardised 'Sex and Relationship Education '(SRE) package to include a workforce training package;
- A targeted education programme for boys and young men within local communities;
- Targeted early intervention - A predictive risk profiling system to be developed which will identify vulnerable young people at an earlier age; and
- Development of a single generic programme to raise the aspirations of vulnerable young people and boost self-esteem.

LSCB Assessment

With the demise of the 'Healthy Schools' scheme, gaining access by sexual health professionals to all Luton schools to provide a standardised and coordinated Sex and Relationship Education (SRE) package is proving problematic. This is of considerable concern, particularly in light of the increased public awareness of Child Sexual Exploitation and the importance of educating children and young people on what a 'healthy relationship' looks like.

The engagement by the current dedicated vulnerable young person's sexual health worker in both the LSCB task and finish group on CSE and the Sexual Exploitation Risk Assessment Conference has been very useful. However, improved links with the Luton Teenage Pregnancy Coordinator should also be established as we are unclear on any links between teenage pregnancy and child sexual exploitation.

Action required

- The LSCB has recently endorsed a training package for use by Luton schools to educate pupils and staff on Child Sexual Exploitation (CSE). This will be piloted in the Autumn term of 2013 and will provide an opportunity for sexual health workers to work in tandem with LSCB trainers to roll out the package to jointly promote awareness of CSE underpinned by important sexual health messages and signposting to local services;
- The LSCB receives and reviews the annual Public Health report and will seek assurance that access to Luton schools to provide Sex and Relationship either as a 'stand alone' package or as part of a broader CSE package is no longer an issue;
- The Luton Teenage Pregnancy Coordinator to be invited to contribute to the CSE task and finish group; and
- Awareness raising of CSE within education settings will be included in the LSCB Safeguarding in Education strategy, due for launch in the Autumn of 2013.

Working with families who choose to Home Educate

When parents opt for Home Education (HE) for their children, it is their right to do so, they can deny both access to the home and the child (ren), if they so wish. The function of the Home Education officer is to monitor the HE provision. Clearly, if over time the parents/carers are not meeting the requirements under the 1996 (previously 1944) Education Act (to ensure children between the ages of 5 and 16 undergo full time education), then the HE officer can interject and take appropriate action.

Local picture

A review of the current safeguarding arrangements and data for children who are **Home Educated** (HE) shows the level of HE in Luton remains fairly constant. At the time of the review (Oct 2012), 75 children were being home educated, however, the number varies over the year and can peak at 100. This increase includes a recurring spike at the start of each Autumn term, when children are not allocated places at preferred schools and parents then opt for home education. The regularity of visits by the HE officer is typically at 6 month intervals. However, for the top 37% of HE providers (see Figure 1 below), this may be extended to annually only, similarly, for the 10% assessed locally as providing poor quality provision, regularity of visits may increase to 3 monthly.

The reasons for Home Education are diverse but typically can be grouped as follows:

School

- bullying 5%;
- not able to obtain required school/distance or access to a local school 5%;
- as a short term intervention for a particular reason (e.g. behaviour, won't attend school) 17%; and
- Dissatisfaction with a particular school(s) provision(s) 11%.

Beliefs

- religious or cultural beliefs 11%;
- philosophical or ideological views including traveller culture 40%;
- dissatisfaction with the UK state system in general 9%.

SEN

- *statemented* special educational needs, (e.g. Asperger's) 2%.

The quality of provision is assessed by the HE officer on a 3 point scale. The home educators who fall into the Grade 3 category tend to be temporary home educators, or home educators who take on home education close to the end of Y11 which leaves little time to address deficiencies.
Figure 1

GRADE	DESCRIPTION	PERCENTAGE
1	Timetable and curriculum effectively implemented. Good evidence	37%
2	Satisfactory – partial evidence, timetable or curriculum	53%
3	Poor – ineffective provision	10%

LSCB Assessment

While local authorities do have powers to intervene where there are grounds for concern about a child's welfare (Children Act 1989), this relies on the Local Authority being aware of safeguarding concerns in the first place. Research suggests that school is an important safety net in identifying the abuse or neglect of a pupil, a safety net that is not available to home educated children. It is imperative, therefore, that the HE officer is appropriately trained in child safeguarding and is as alert to addressing concerns not only in education provision but in identifying and referring any safeguarding concerns appropriately. The Luton HE officer has attended appropriate safeguarding training but has not identified any safeguarding concerns sufficient to warrant a referral to statutory services.

Action required

- An annual assurance report on HE activity will continue to be sought as part of the LSCB Improvement and Learning Framework. The report will be presented to the Executive Group; and
- The HE officer must ensure he continues to develop his knowledge and awareness of safeguarding issues through attendance at appropriate LSCB training workshops. All safeguarding training attended should be detailed in the HE annual assurance report.

Parental Mental Health and Safeguarding Children

Learning from serious case reviews is acknowledged to be important. The sixth two yearly national analysis of serious case reviews: *New learning from serious case reviews a two year report for 2009 to 2011*, (University of East Anglia & University of Warwick) was published in July 2012. **https://www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011**

A particular focus of this biennial review was an examination of serious case reviews for children aged 5-10 years. Parental mental health problems featured in a majority of cases, and suicidal or self harming behaviour was particularly prominent. The report comments that being a

parent is generally perceived to be a protective factor in relation to adult suicide or self harm; however, when a parent is threatening or actually carrying out suicidal or self-harming behaviour, this protective element may have been lost. The 2009-2011 report also provides a clearer understanding of the extent to which domestic violence, misuse of alcohol and/or drugs and parental mental health problems factors were significant for the family involved in each of the serious case review reviewed (139 cases): 63% of cases featured domestic violence and 58% featured mental health problems of one or both parents. Parental substance misuse was mentioned for 42% of families, with a context of drug misuse in 29% of families and alcohol misuse in 27% of the cases. l4% of families didn't feature any of these factors.

Local picture

With **parental mental health** identified as a theme in both local serious case reviews and partnership reviews, the LSCB sought assurance from the South Essex Partnership Trust (SEPT) on local safeguarding arrangements which identifies and supports children of parents who are service users of mental health. The LSCB endorses the view that the vast majority of service users with mental health are well able to provide appropriate care for their children.

A commissioned report was received which confirmed all service users of mental health are subject to a Care Programme Approach (CPA) process which is a continuous assessment and review process, involving an ongoing assessment of risk to others, including children. This includes children living with or known to the family. The welfare of children whose parent(s)/carer(s) have been admitted in an emergency situation is assessed immediately and routine checks/information sharing is made with the LBC Referral and Assessment team. Appropriate information is shared with community services (health visiting and GP) to ensure other NHS professionals working with the family are fully aware of any mental health issues which may impact on a child's needs.

LSCB Assessment

A referral pathway and an ongoing assessment process are in place and appropriate information sharing arrangements within the wider 'health' community have been developed.

All professionals must be alert to the findings in the most recent biennial review on SCRs which confirm that while singly, parental substance misuse, domestic violence and parental mental ill health may pose risks of harm to the child, it is the combination of these factors which is particularly 'toxic'.

Action required

- The findings identified in the latest Biennial Review report on Serious Case Reviews to be incorporated into existing LSCB training workshops.

Supporting parents/carers with learning disabilities

The Social care Institute for Excellence (SCIE) have produced a Research Brief titled: *Helping parents with learning disabilities in their role as parents* **http://www.scie.org.uk/publications/briefings/briefing14/index.asp**

Several factors have been demonstrated to have an adverse effect on parenting: these include low socio-economic status; unemployment; and social isolation or exclusion. All of these factors make parenting difficult, and parents with intellectual or learning disabilities are at greater risk of experiencing one or more of these disadvantages than other groups. Many parents with learning disabilities are unemployed, on low incomes and rely heavily on benefits and statutory services; many are single mothers; and few have the same opportunities for "informal social learning" from friends and extended family as non-disabled parents. The failure to receive sufficient and appropriate support from services can adversely affect both the parent and their children.

Local Picture

A report following a review of the safeguarding arrangements for **children of parents with learning disabilities** was received in March 2013. This area of safeguarding continues to be a focus for the LSCB, particularly in light of the Luton Child B SCR where the young mother involved had a learning disability which did not meet the threshold for adult social care involvement. The report confirms criteria remain in place for referral to the Community Learning Disability Team and recognises that some adults will not meet this criteria. In these circumstances, communication between professionals takes place to determine what support can be offered and where appropriate, the person may be signposted to another agency.

The South Essex Partnership Trust (SEPT) Learning Disabilities Service accepts referrals for cognitive/ adaptive functioning assessments where there is a need to establish if the person is eligible, due to their learning disability, to access services within SPLD/Intensive Support Team/Forensic Community Treatment Team. All social care issues are referred to the Community Learning Disability Team. SEPT will assist in providing information which will support referrals to other services such as education or housing.

Whilst in some cases the parent(s) may not meet the eligibility criteria for referral to the Learning Disability Team, given the wider potential risk to a child and the issues associated with the adult's additional child care responsibilities, an assessment will be completed. With consent, the completed assessment is shared with the referring service, usually children's social care.

LSCB Assessment

National research has focused particularly on learning disabled mothers because typically they are their children's primary or exclusive caregivers. It is of concern that fathers with learning disabilities may not be assessed for support of any kind to help them understand their parenting role, if their partner does not have learning disabilities.

Action required

- The LSCB will seek assurance that fathers in Luton as well as mothers are assessed, and clarity as to lead responsibility to prevent parents/carers falling in a gap between adult and children's services, the availability of effective parent training programmes, particularly, home based programmes, and the specific number of parents/carers with learning disabilities who are supported by adult services.

Arrangements for meeting the needs of deaf children in Luton

National research has provided the following statistical data - *'Deaf children across the UK are known (NDCS, 2010) to be at particular risk of a range of less than optimum outcomes: they are 3.4 times more likely than hearing children to experience abuse; 40% will experience mental health problems in childhood; educational outcomes lag significantly behind national averages. Deaf children, whether using spoken or signed language, face significant challenges in achieving normative linguistic, cognitive and psychosocial development. Around 40% of deaf children will have additional needs, such as ophthalmic problems or developmental delay. Over 90% are born into hearing families with usually no prior experience of raising a deaf child. Over 40% of deaf children will have mental health difficulties in childhood / early adulthood (DH, 2005). They are more likely to experience bullying. Many deaf children live in families on low income, and deaf children are more likely to become unemployed as young adults (Office for Disability Issues,* 2008)'.

Local Picture

The number of deaf children in Luton is not statistically large – 58 children had statements for a hearing impairment in 2010/11 (although the actual number of deaf children may also include those of preschool age and those whose statement might be for profound learning disabilities which includes a hearing impairment). Meeting the complexity of deaf children's needs in Luton within diverse family contexts requires an integrated service approach across audiology, education services and social care. To this end, a 'Pan Bedfordshire' working group has been established, *The Children's Hearing Impairment Strategic Working Group (CHISWG*). However, gaps in service provision and inconsistencies across LA boundaries remain.

The current picture is as follows. Paediatric audiology services refer to an outreach service for deaf children and a home visit is undertaken by a specialist and qualified early years practitioner within 48 hours of the referral. This outreach service is commissioned by Luton Borough Council (LBC) from Icknield Primary School, and provides a pathway from diagnosis to early support and education. In addition, Icknield Primary School provides specialist resourced childcare (for 2-4 year olds). Resourced education placements for deaf and hearing impaired children are provided by both Icknield Primary and High Schools. LBC commissions an outreach support service from the primary and high school to support other deaf and hearing impaired children in mainstream schools in Luton, and some speech and language support in other schools although, worryingly, this is primarily limited to Icknield Primary school due to capacity / limited resources.

LBCs Children's Disability team has designated responsibility for deaf children 'in need' and their families. This team has one worker with basic communication skills for working with deaf children. This is not unusual: 46% of local authorities do not have a qualified social worker with responsibility for working with deaf children and their families; and the average staff complement of qualified social workers working with deaf children and their families across local authorities is 0.25 (NDCS, 2010). However, this limited specialist knowledge and expertise within Luton's Disability team is relevant because it may impact on the ability of the team to recognise the seriousness of a presenting problem involving a deaf child. There is some anecdotal evidence from Teachers of the Deaf (TOD) in Luton to support this, who say that they often feel they are taking on a 'social work' role and dealing with a level of child protection issues without social work intervention. Steps have been taken to start to address this, with regular meetings set up between the TOD at Icknield Primary School and the Disability social work team manager, to discuss concerns regarding individual children / families.

LSCB Assessment

In Luton, there is no systematic arrangement for ensuring deaf children and their families receive a joint assessment involving health, education and social care, nor a defined multi-disciplinary 'pathway' for planning and service provision. This may be in common with half of all local authorities (NDCS, 2010), but is hardly acceptable.

Through the CHISWG, work has been undertaken to clarify with Teachers of Deaf (TOD) and outreach workers for deaf children the formal referral arrangement with children's social care but there still appears to be a significant degree of ad-hoc practice in this area. TOD describe that they "hang on" to deaf children they might be concerned about because they do not feel confident in either the referral arrangement or the likelihood that a child will receive an appropriate assessment and / or service provision.

There is evidence of some gaps in integrated arrangements in response to deaf children which in turn can result in delays in recognition of need and provision of assessment, lack of preventative work, ambiguous pathways of service provision, and responsiveness only in situations of acute need (the escalation of which might be preventable with early support). These challenges, alongside the diverse family contexts of deaf children, indicate the need to consider further how to consolidate an integrated and skilled provision for deaf children and their families in Luton.

Action required

- The LSCB will seek assurance that the gaps identified are/being addressed.

Sexual Assault Referral Centre (SARC) arrangements

The **Peterborough Sexual Assault Referral Service** (SARC) provision was initially jointly commissioned by NHS Bedford and NHS Luton(1st Jan 2012 – 31st March 2013) to provide the three local authority areas across Bedfordshire with a paediatric examination service for forensically acute cases of sexual assault involving children under 13 years. The service provided for a forensically secure environment at the Peterborough SARC with both a Community Paediatrician and Forensic Medical Examiner (FME) in attendance. The purpose of the forensic examination is to gather evidence which may assist in a subsequent criminal prosecution.

Sexual assault cases involving children over 13 years of age are managed by a FME at the Bedfordshire and Luton SARC (The Emerald Centre) situated in Bedford.

In October 2012, the Peterborough provider gave notice on the current contract, although agreement was reached to provide cover on a case by case until March 31st 2013. The LSCB acknowledges the challenge faced by commissioners in identifying providers compliant with the national standards when such small numbers are involved. From April 1st 2013, a contractual agreement has been reached with a provider, the Havens, in London.

Fortunately, the number of children requiring such examinations in Luton remains low (3 children) and is broken down in age range as follows:

1 x 4-5 years

1 x 8-9 years and

1 x 12 - 13 years

LSCB Assessment

The LSCB continues to raise concerns regarding the distance Luton children are expected to travel (be it Peterborough, Bedford or London) when they have experienced such a traumatic assault.

Where a sexual examination of a child under 13 years is required but the alleged sexual assault is reported outside of the forensic window (roughly 3 days), such cases should be referred to the Edwin Lobo Child Development Centre, in Luton. Findings from audit have identified a lack of clarity around referral pathways to medical examination provision and concerns regarding report sharing pathways for monitoring and reviews.

Action required

- The LSCB will re issue guidance on Child Sexual Assault Medicals to provide further clarity on which cases should be referred via the acute pathway; and
- The LSCB will seek further assurance on current arrangements during the 13/14 Business year.

The implementation of the Common Assessment Framework (CAF) arrangements

The revised **Working Together 2013** (WT) guidance places a focus on effective assessment of the need for early help but makes a fleeting reference only to CAF, instead referring to 'early help assessments'. The statutory guidance stipulates that where a child or family may need support from more than one agency (e.g. education, health, housing, police), there should be an interagency assessment undertaken by a lead professional.

Local picture

A report on the **implementation of the Common Assessment Framework (CAF) arrangements** identified a welcome increase in staffing resource to the local team from 2 to 5 posts. This has enabled significant development of local processes including case logging on CareFirst (social care database), case allocation, case tracking to monitor progress/identify outcomes and awareness raising road shows. Of particular note is the ability to identify CAF cases which may require early escalation to social care (Step up) via a red/amber/green (RAG) rating system. Where a case is identified by the CAF team to be of significant risk and requires immediate escalation to the Referral and Assessment (RAT), a documented process has been established which includes a process to challenge decision making in the event of disagreement regarding thresholds.

Table 1 – **Number of CAFs completed**

Area	2011/12 Q1	2011/12/Q2	2011/12 Q3	2011/12 Q4	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
Central	15	8	14	6	11	22	18	
East	6	5	7	7	16	13	9	10
North	12	13	10	10	28	5	5	14
South	5	13	10	13	30	15	9	18
West	15	11	22	5	25	34	16	14
Total	**53**	**50**	**63**	**41**	**110**	**89**	**57**	**56**
Table 2 CAFs completed by referring agency								
Area	**2011/12 Q1**	**2011/12/Q2**	**2011/12 Q3**	**2011/12 Q4**	**2012/13 Q1**	**2012/13 Q2**	**2012/13 Q3**	**2012/13 Q4**
Schools	35	27	28	30	32	24	28	29
Health	7	11	16	5	12	5	10	10
RAT					58	52	10	6
LBC	11	11	17	6	7	7	9	6
YOS							13	7
Other	0	1	2	0	0	0	0	0

GCP						10	0	

LSCB Assessment

Practitioner feedback (LSCB Open Day 2012 & Practitioner Discussion Forums) identified a number of key issues relating to the current CAF process in Luton including:

- Practitioner perception that the CAF process is extremely slow;
- Information sharing arrangements are not effective;
- Repeated requests for CAFs to be completed rather than a referral to Children's Social Care; and
- Cuts to early intervention and prevention services.

Action required

- In 2013, the LSCB will consult with the LBC CAF team and publish a threshold document, detailing the process for the early help assessment and the type and level of early help services to be provided; including the level of need for when a case should be referred to children's social care for assessment and statutory services;
- As an interim measure, the existing CAF team should reassess its procedures to ensure they reflect the revised Working Together 2013 guidance, particularly with regard to raising awareness with those professionals identified in the guidance as appropriate lead professionals; General Practitioner (GP), family support worker, teacher, health visitor and/or special educational needs coordinator. In addition, contact should be made with all statutory partners to address issues identified with CAF process during the Section 11 compliance audit (Most agencies struggle with the Common Assessment Framework (CAF) and the challenge for those agencies working across 3 local authorities is managing 3 processes, how to use CAF and what is its function. Links between the CAF and early help/intervention need to be strengthened);

- The LSCB has identified early help and prevention as a key area of focus in its 13/14 Business Plan and will coordinate audit activity to consider what difference has been made to a child or young person subject to this process.

The welfare and well being of children using or affected by alcohol or drugs

The Advisory Council for the Misuse of Drugs (ACMD) 'Hidden Harm' report (2003) noted that parental drug use can compromise a child's health and development from conception onwards. Parental substance misuse has been associated with genetic, developmental, psychological, physical, environmental and social harms to children. Social deprivation and the financing of drug or alcohol consumption may

restrict money allocated to meet basic needs for the child and being under the influence of substances may affect parental responsiveness to the physical or emotional needs of a child.

Research confirms, in complex families, professionals must guard against the tolerance of unacceptable levels of care, particularly where this is seen as normal for the family or community and be mindful of the differing priorities between child protection and substance misuse systems (statutory and voluntary sector) which may impact on positive collaboration between services/agencies.

Local picture

Services to support children using or affected by alcohol or drugs are commissioned by the Luton Drug and Alcohol Partnership (LDAP). An audit to identify new service users (with children) ran between April and September 2012. The audit identified 143 adults assessed for structured drug treatment and 255 adults for alcohol treatment. 26 drug clients had children living with them and 42 alcohol clients had children living with them. Please note, these figures reflect new service users (with children) accessing services in the 6 month audit period only and not the total number of adults with children regularly accessing drug and alcohol services in Luton. Following the assessment, 16 families were referred to children's social care.

During the audit period, sixteen young people accessed structured interventions for drug and alcohol problems. This reflects a reduction on the previous year and is in line with the national trend which is seeing a decline in the use of Class A drugs by young people who are tending to experiment with alcohol and/or cannabis instead. In addition to offering structured interventions, PUKE, the young people's alcohol service and Underground, the young people's drug service provide one to one support to young people who are concerned about their parents' alcohol or drug use. Seventy young people accessed these services from April 2012 – September 2012.

Between midnight and 4.00am each Friday and Saturday night, a young people's alcohol worker is available in the Accident & Emergency Unit at the Luton & Dunstable Hospital. On average, 5 young people attend the A&E Dept each weekend as a result of their alcohol consumption, two thirds arriving by ambulance. Around half of all young people seen by the A&E alcohol worker are female. The role of the alcohol worker is to provide information and advice to the young person and their parent or carer. Very few young people are assessed as needing further intervention and are able to return home without being admitted.

LSCB Assessment

Effective working arrangements are in place to support both young people and parents/carers misusing drugs and/or alcohol with drug and alcohol services making appropriate referrals to CSC where safeguarding concerns are identified.

The Head of the Luton Drug and Alcohol Partnership is a member of the LSCB Executive group and pro actively supports the work of the LSCB through her chairing of the CSE task and finish group. Representatives from the Underground (Young people's drug and alcohol service) are standing members of the Sexual Exploitation Risk Assessment Conference and the CSE task and finish group.

A local protocol – 'Guidelines for working relationships between child social care and drug and alcohol agencies to safeguard the children of drug and alcohol using parents/carers' has been developed and disseminated. This protocol provides clear pathways for professionals to refer drug or alcohol using parents to appropriate provision and to Children's Social care and details information sharing and data collection arrangements.

Action required

- The LSCB to review the two existing local protocols with a view to combining all relevant guidance into a single document.

Managing allegations of abuse against adults who work with children

This is a function of the local authority and is managed in Luton by the local authority designated officer (LADO). In preparing this report, the LSCB has considered data relating to allegations made in the period from April 2011 to March 2012. The number of referrals reported to the LADO in the period totalled 172, an increase of 16% on the 10/11 year period. The picture regarding referrals by sector remains fairly static with schools being the largest individual sector. However, the overall picture continues to show most allegations fall outside the education sector (see Figure 2).

Significantly, the data shows an increase in referrals under the category of sexual abuse (13 in 2010/11 to 30 in 2011/12). However, please note, the 'sexual abuse' category is an overarching category with 5 sub categories:

- sexual assault,
- grooming;
- inappropriate behaviour;
- abuse of a position of trust; and
- other.

Figure 1: Allegations by Sector

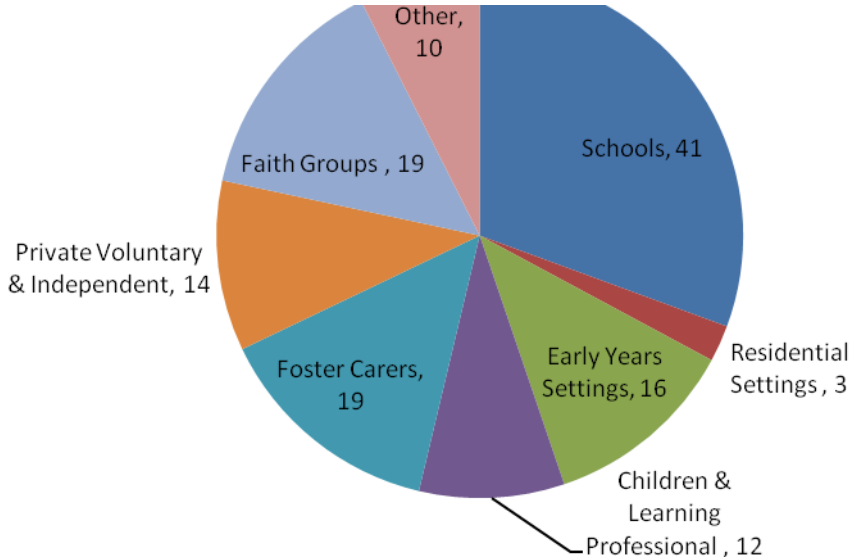
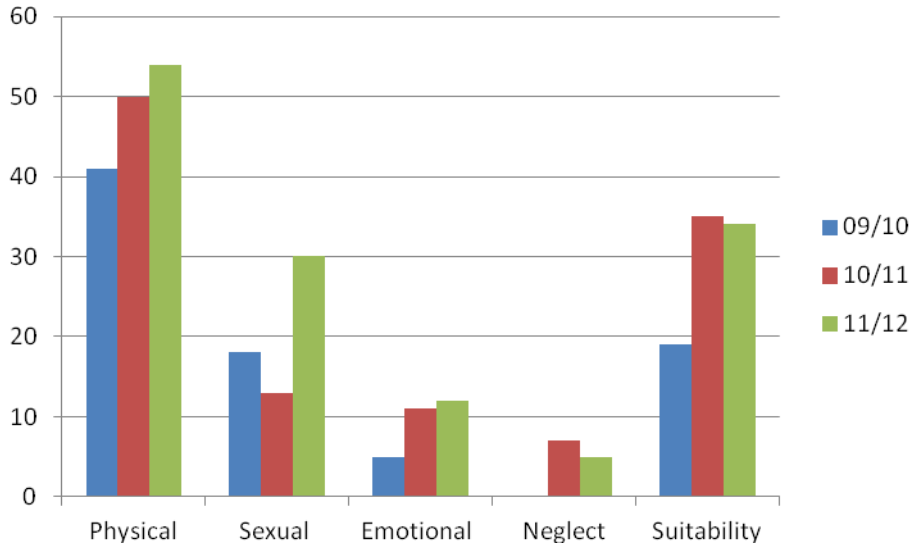


Figure 2: Allegations by Category

'Suitability' is the second largest referral category. The type of referrals made under this category are wide ranging and to date have included allegations of abuse or neglect regarding a professional's own children or against professionals who perpetrate violence, including domestic abuse.



LSCB Assessment

The revised Working Together 2013 guidance has extended the reporting requirements to all organisations to report allegations of abuse against adults who work with children to the local authority designated officer (LADO) within 1 working day. This includes both paid employees and volunteers. Commendably, Luton has already undertaken some awareness raising activity with the private, voluntary and independent sector and has already seen an increase in referrals from this sector.

Children and young people have been protected as a result of 9 unsuitable adults being removed from the children's workforce in Luton. This is a total of 22 adults since the first report in 2009/10.

There has been a further increase in allegations in Mosques and Madrassahs during the reporting period (16 cases in 2011/12 compared with 12 cases in 2010/11). Work to engage with faith organisations, including Mosques and Madrassahs has been a priority during this Business year (please see page 36 for further details).

New statutory guidance for schools has been issued by the DfE to address concerns within the teaching profession about a perceived high level of false allegations. As a result schools can no longer share unsubstantiated allegations on a teacher reference. The guidance also states that adults who have had multiple unsubstantiated allegations made against them should not have this information shared on a reference. The guidance introduces a fifth conclusion term for school staff only, that of 'False'. NB. An unsubstantiated allegation means 'there is insufficient evidence to prove or disprove the allegation; it does not imply guilt or innocence'.

These changes are controversial and concerns have been raised about the possibility that patterns of unsubstantiated allegations against an individual could be 'hidden' by staff who change schools regularly or move in to supply teaching. There is also a concern that separate standards have been developed for one sector of the workforce.

Action required

- The LSCB will continue to monitor activity in this area via an annual assurance report to the LSCB and prioritise work with the Faith sector.

Supporting individuals vulnerable to radicalisation via the Channel process

Channel is a multi agency approach to identify and provide support to individuals who are at risk of being drawn into terrorist-related activity. The Channel process forms a key part of the Government's *Prevent* strategy. Channel provides a mechanism for safeguarding vulnerable individuals (both adults and children) by assessing the nature and extent of the potential risk they face before they become involved in criminal activity and where necessary, provide a support package tailored to an individual's needs.

Local picture

The Channel process in Luton is managed via the Channel Panel, a multi agency forum which meets on a 6 weekly basis. The panel is chaired by Martin Pratt, the Director of Children's Services for Luton Borough Council. In the period reviewed (October 2011 to March 2012), 9 individual cases were referred to the Channel Panel. Of the 9 individuals, 7 were adults (2 female and 5 male) and 2 were young people, both male. Both young people were already known to statutory services and therefore guidance and support was provided by the Channel Coordinator to the professionals already working with them.

LSCB Assessment

The Luton Channel model of working is recognised nationally as good practice. The process is well embedded in Luton and actively supported by partner agencies and benefits significantly from the Director of Children's Services being its standing Chair.

Action required

- An area already identified for immediate development is to raise awareness generally to the process to encourage referrals from professionals (other than the police) and the wider community and to promote the referral process. To this end from April 2013, WRAP training (Working towards raising awareness to Prevent) will be promoted and managed within the Luton Safeguarding Children Board training programme.

Families with No Recourse to Public Funds

Local authorities have a statutory duty to provide accommodation, subsistence, and social care to people who are subject to immigration control and have no access to state benefits but have assessed care needs under social care legislation. However, there is no mechanism for reimbursement of costs by the UK government. There is no statutory guidance for local authorities on their duties to people with NRPF and this will inevitably result in inconsistency of practice across the country.

A report published by the NRPF (no recourse to public funds) Network found that social services departments in 51 local authorities supported 6,500 people with 'no recourse to public funds' in 2009/10 at a cost of £46.5m. The report found that there has been a dramatic increase in the numbers of supported children & family cases in recent years and a decline in the number of single adults who are supported for health reasons. The financial burden of providing support for this group lies disproportionately with local authorities, who have little control over the immigration decision-making process.

Local picture

This issue remains a complex and challenging area for local services and has been highlighted by the LSCB because of concerns regarding the number of Roma woman and children reportedly 'begging' in Luton. No Recourse to Public Funds' (NRFP) applies to a person who has no legal entitlement to welfare benefits, housing support or to UKBA (UK Border Agency) asylum support. In general terms individuals affected have arrived from abroad or are the children of people who have arrived from abroad, even if the child was born in the UK, and are:

- refused asylum seekers;
- visa over stayers (commonly visitor visa holders or student visa holders);
- post-18 years and former unaccompanied asylum seeking children with failed applications; and
- people illegally arrived in UK without making themselves known to UKBA.

An issue identified locally is the difficulty by some NRPF families in registering with a local GP surgery because of an inability to provide proof of an address of at least 6 months. In the UK, there is no law excluding anyone from primary care, and therefore immigration status and 'ordinary residence' are irrelevant when registering with a GP. Neither is there legislation, statutory guidance, or case law suggesting that people must be 'resident' for any length of time, or have a visa etc.

LSCB Assessment

All children living in the UK of statutory school age are eligible for and must attend educational provision. However, because of the illegal status of the parents (usually working for 'cash in hand' type work), these children may not be known to services and fall beneath the radar of statutory universal provision.

No child of a parent who falls within the NRPF criteria is eligible for Free School Meals, Uniform Vouchers or Pupil Premium Payments to schools, even if the child was born in the UK. This can result in the very poorest children receiving the least financial support.

The inability to register with a GP locally has reportedly resulted in some NRPF families attending the A&E Dept for minor illnesses.

Action required

- Clearly, any barrier to registering children with a GP is a safeguarding risk and the Luton Clinical Commissioning Group (CCG) must ensure all Luton GPs are aware of the correct legislation with regard to this particularly vulnerable group.

Multi Agency Risk Assessment Conference (MARAC)

Multi-Agency Risk Assessment Conferences (MARACs) are regular multi agency meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by an Independent Domestic Violence Adviser (IDVA) a risk focused, co-ordinated safety plan can be drawn up to support the victim. An IDVA is a named professional case worker for domestic abuse victims whose primary purpose is to address the safety of 'high risk' victims and their children. IDVAs are a victim's main point of contact. They normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop coordinated safety plans. Co-ordinated Action Against Domestic Abuse (CAADA) is a national charity which provides practical help to support professionals and organisations working with domestic abuse victims.

Local picture

MARAC referrals in Luton continue to increase. There were a total of 363 referrals in 12/13 compared to 244 referrals in 2011/12, an increase of almost 50%. This level of referrals is now significantly in excess of the recommended number of cases (290) which (CAADA) have proposed should be identified annually within Luton. 47% of cases (170) were referred by non police agencies in 2012/13. This also exceeds the CAADA recommended ratio between police and non police referrals which is set at 60/40. In line with the increase in volume of referrals the number of children identified in high risk households is also increasing with a total of 525 children identified in 12/13.

While the increase can in part be attributed to targeted training (particularly in relation to referrals from non-police agencies) and is therefore indicative of improved awareness and identification of cases by professionals in Luton, this significant increase in volume is not without its challenges.

Table1: MARAC Performance Data April 2012- March 2013

Date Held	Number of Cases Discussed	Number of Repeat cases	Number of children in the household	Referring Agency												
				Police	IDVA	Children's Social Care	Community Services	trust/ L&D	School	Housing	SEPT Mental Health	Probation	(Women's Aid, LAWC)	Substance Abuse	Adult Social Care	MARAC
03/04/2012	23	7	31	10	6	0	1	0	1	0	0	0	5	0	0	0
01/05/2012	20	7	31	12	4	0	0	0	1	0	1	0	0	1	0	1
12/06/2012	30	12	24	9	10	1	0	1	0	3	1	2	1	0	0	2
03/07/2012	28	7	35	15	5	3	0	0	2	0	0	0	1	0	0	2
07&21/08/12	49	11	76	36	7	2	0	1	1	0	0	0	1	1	0	0
11/09/2012	24	5	39	16	3	2	0	0	1	0	0	0	0	0	0	2
02/10/2012	27	9	32	11	5	3	0	0	0	2	0	0	2	1	1	2
06/11/2012	26	8	39	13	9	2	0	0	1	0	0	1	0	0	0	0

04&18/12/12	47	16	78	29	15	1	0	0	1	0	0	0	1	0	0	0
08&29/01/13	**40**	**13**	**78**	**20**	**9**	**3**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**1**	**0**	**3**
19/02/2013	**24**	**8**	**38**	**12**	**8**	**1**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**
12/03/2013	**25**	**6**	**24**	**10**	**7**	**1**	**1**	**0**	**2**	**1**	**0**	**1**	**0**	**0**	**0**	**2**
TOTAL	363	109	525	193	88	19	2	2	16	6	2	5	11	4	1	14

To address the increased referral rates, MARAC meetings have increased in frequency from monthly to a three weekly cycle. However, agencies have reported that the increased frequency has impacted on the quality of their research and consequently limits the availability of information available at the MARAC meetings.

Local agencies are not adequately resourcing the MARAC and attendance by core partners has averaged at only 86% during the 12/13 business year. Core partners are those agencies identified by CAADA to consistently attend all meetings, namely; Bedfordshire Police, Bedfordshire Probation Trust, Community Health Services (CCS), Children's Social Care, Specialist Domestic Violence Service (IDVA), Housing Services (LBC), Mental Health Services (SEPT) and Drug and Alcohol Services.

Action required

- Core agencies must identify a named MARAC officer to attend each MARAC and ensure sufficient capacity for the officer to undertake checks in advance of each MARAC;
- If the named MARAC officer isn't available, a sufficiently knowledgeable deputy should attend; and
- The LSCB will continue to monitor MARAC arrangements on a quarterly basis.

Safeguarding arrangements for trafficked children

Child trafficking involves moving children (up to the age of 18) across or within national borders for purposes including sexual exploitation, forced labour and domestic servitude. Whilst it is unknown exactly how many children are trafficked to the UK each year, research indicates that most victims will be aged 12 or older, and from one of up to 40 countries. Both girls and boys are trafficked (CEOP, 2011). Internal trafficking describes British children who are moved and sexually exploited within the UK; the majority of these victims are girls.

Research confirms that there are many obstacles to identifying trafficked children (Pearce, et al., 2009). Practitioners may not recognise the signs or disbelieve what children say because it sounds so extraordinary. In addition, because they have been groomed to keep silent, and threatened with violence to themselves and family members, children rarely make disclosures. Much of the evidence that points to trafficking will be circumstantial, such as where the child was found.

Local picture

In Luton there are a number of smuggled children arriving via the Airport. They generally claim asylum on arrival, are age assessed and if considered under 18 years are deemed to be children in care and are supported accordingly. These children and young people have usually been sent to the United Kingdom as economic migrants, wishing to access education and other opportunities. They rarely go missing from their placements. Within the Children and Learning Department 16+ team, there are 29 current and former Unaccompanied Asylum Seeking

Children. (UASC). Eleven of these are aged between 16/17 years and in the care of the Local Authority. The remainder are aged up to 22 years and are classed as care leavers. Each has an allocated Personal Advisor and their needs are addressed via a Pathway Plan. One of these young people has just successfully obtained a degree at university and is now studying for a Masters degree.

The pan Bedfordshire missing children group reviews children entering the UK from overseas who go missing. No Luton asylum seeking child has gone missing for any significant time during 12/13.

LSCB Assessment

From the data received from LBC, it doesn't appear that Luton Airport is being used as a regular port of entry for trafficked children into the UK.

However, when children are identified as 'trafficked', national research suggests that as up to 50% of trafficked children go missing, Children's services must act speedily to support and protect them. If a child disappears, the case should remain open until they have been located.

The memorandum of understanding in response to the trafficking of children through Luton Airport: practice guidance is a useful tool to outline agency roles and responsibilities in relation to trafficked children.

Action Required

- The LSCB will continue to monitor activity in relation to Trafficked children via an annual assurance report to the LSCB Executive.

Safeguarding Children who are living away from home

Research suggests that children in care who are in homes are more at risk of going missing than those in foster care and significantly higher than the general population. The Missing Children and Adults cross government strategy identifies children in care are three times more likely to run away than other children. The consequences of going missing for children in care include the risk of abuse, sexual assault and sexual exploitation.

An accelerated report by the Children's Commissioner on Child Sexual Exploitation in Gangs and Groups with a special focus on children in care was published in July 2012 - http://www.childrenscommissioner.gov.uk/content/publications/content_580

The report identifies that the current body of literature on child sexual exploitation consistently cites children in care as being particularly vulnerable to child sexual exploitation (Pearce and Pitts, 2011, Pearce 2009, Creegan 2005, Scott and Skidmore 2006, Coy 2008, Brodie et al,

2011). The report states children in care are inherently vulnerable and therefore require greater vigilance in terms of their protection. Most of those in residential care are aged 12 and over with the peak age range being 14 to 16 years old. Abuse or neglect remains the key primary reason for placement (45%) and almost half (49%) of children are placed in a care home for a duration of less than three months. Of those children placed in a home, the data indicates that 29% have had at least five previous placements with only 24% being on their first placement. Residential children's homes may be perceived as a placement of last resort, rather than as the most appropriate placement for a child. The report appropriately comments, 'if a child is placed in an inappropriate setting without an accurate assessment of their needs, the staff in any children's home could struggle to keep them safe'.

In July 2012, the government published their response to the All Party Parliamentary Group (APPG) report into children missing from care and the accelerated report from the Office of the Children's Commissioner (OCC) Government response to the APPG inquiry and OCC report

The following actions have been identified:

- Immediate action to make sure Ofsted can share the names and addresses of children's homes with local police and other agencies;
- An expert working group to develop a data collection system which gives a much clearer picture of the numbers of children who go missing from care;
- An expert working group to develop better risk assessments for children placed out of borough; and
- An expert working group into the quality of care in children's homes, including the qualifications and skills of the workforce and the management and ownership.

Local picture

Identifying appropriate placements to safeguard children living away from home is managed by the LBC Integrated Commissioning Manager Tier 4 services. Appropriate placements may include:

- independent fostering placements with fostering agencies (including short term respite provision and emergency/short term placements);
- residential units with providers (either with their own educational provision or a mainstream provision) – this also includes children and young people with disabilities and additional needs;
- residential/special schools (for 38 or 52 week placements);
- secure/emergency accommodation (for children meeting age/service thresholds such as 16+); and
- secure units (on rare occasions when such provision is authorised by a Corporate Director).

LBC Commissioners are required to satisfy themselves that services commissioned are safe for children and young people, that the local authority's expectations of its providers are clearly stated, and that effective monitoring takes place to ensure that these expectations are met. The section 11 audit tool is used by commissioners to monitor compliance by providers.

All Luton's 'Looked After Children' (LAC) and their carers are advised of an LBC commissioned independent Advocacy and Mentoring provider (Reconstruct) available to support and represent Luton LAC. The Reconstruct contract is appropriately monitored by the Commissioning team.

LSCB Assessment

A review of the safeguarding arrangements of all Luton LAC in residential provision was undertaken. The subsequent report identified eight Luton children who are placed in six residential homes outside of Luton. Visits to the homes identified clear policies and procedures on children going missing and robust recovery plans in place with very good relationships with the local police force. All the homes reportedly had a good understanding of the risk of sexual exploitation, particularly in relation to LAC.

Robust arrangements are in place to monitor the progress of a child or young person in an Independent Fostering Agency placement.

Residential Units (also secure units and safe/emergency accommodation) are monitored by commissioners via monthly reports or updates (including any therapeutic reports etc). Potential providers receive visits from commissioners as part of the evidence-gathering procedure, and on occasions commissioners will visit the establishment after a young person has been there for a few weeks. Residential Units are also monitored via the Children's Cross Regional Arrangements Group (CCRAG), which is chaired by Hertfordshire County Council.

An 'Other Arrangements' and 'Suitable Accommodation' framework policy has been introduced within the councils 16+ Team, in relation to Semi Independent living providers for young people aged 16+.

This document sets out the framework and requirements to be taken into consideration when placing children Looked After and Care Leavers aged 16 & 17 (and in certain circumstances care leavers aged 18 and over, i.e. where Children's Services is commissioning and paying for the accommodation), in accommodation and/or placements that are not registered under the Care Standards Act 2000 and are therefore not inspected by Ofsted. The Care Planning process for the individual child must conclude that the child's needs are best met by a placement in 'Other Arrangements', that is, they are deemed sufficiently able and competent to benefit from a semi-independent type of placement due to their abilities and needs.

This policy was developed in conjunction with the Childrens Cross Regional Arrangements Group (CCRAG), ensuring that providers are either licensed or registered as Houses of Multiple Occupancy (HMO's) via LBC's Environmental Health Team, The Fire and Rescue Service and the Integrated Commissioning Team Children and Families. This policy covers procedures, including the safeguarding of young people in their

care and notification protocols (such as missing etc.). This should ensure that accommodation is safe, suitable and meets best value and quality standards.

Action Required

- The LSCB will monitor compliance with recommendations arising from the Government response to the APPG inquiry and OCC report

Private Fostering

Private Fostering Research Report https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/189386/DCSF-RR229.pdf.pdf

The Children Act 1989 defines private fostering as occurring when a child under 16 (or under 18 if disabled) is cared for, and provided with accommodation, for 28 days or more by someone other than a close relative, guardian or someone with parental responsibility.

The government report published in March 2010 confirms the circumstances surrounding private fostering arrangements are diverse as are the characteristics and needs of the children in them. Examples given include African and Caribbean children with parents abroad, children attending language schools or other UK educational establishments, children living away from home because of parental problems, 'sofa-surfing' adolescents and unaccompanied immigrant children.

Local picture

In Luton, the Referral and Assessment Team (RAT) receives all enquiries and referrals regarding proposed or existing private fostering arrangements. All publicity states the RAT as the single point of contact. Once it has been confirmed that a child's circumstances fit the criteria for private fostering, the case is transferred to the designated worker for private fostering in the Referral and Assessment Team. The designated worker undertakes all suitability assessments and subsequent welfare visits and is supported by a named Senior Social Worker colleague from the Fostering Team who will visit jointly as necessary.

The Referral and Assessment Team Manager signs off decisions made at the assessment stage relating to the overall suitability of private fostering arrangements.

In Luton, 4 new notifications of 'privately fostered' children were received during 2012/13. As of 31st March 2013, 5 'privately fostered' are being monitored by the Children and Learning Department at LBC.

LSCB Assessment

Despite the legal duty on parents and carers to notify local authorities in advance about private fostering arrangements, this rarely happens in practice. This may be partly through ignorance or reluctance on the part of carers or parents to bring such arrangements to the attention of the authorities. Without notification, local authorities are not able to check whether the carers may be disqualified persons who may have committed offences against children or whether they are suitable carers (Holman 2003).

Private Fostering was identified as an area for development during the Ofsted inspection in March 2012. The Children & Learning Department has devised an action plan (see Appendix 3) which includes awareness raising activity with the residents of Luton as well as professionals. This has had little impact on the reported number of private fostering arrangements which stands at 3, a reduction of 2 since March 2012.

Action Required

- LBC must continue to take all steps, particularly within school communities, to promote the legal duty on parents/carers to notify them of all private fostering arrangements.

Safeguarding issues arising from Guns and Gangs in Luton

The LSCB has reviewed the safeguarding arrangements in place to manage and monitor the rise in firearms related crime, since September 2012.

The LSCB is assured that effective arrangements are in place across a range of partners including Bedfordshire Police, Youth Offending Service, Bedfordshire & Luton Probation Trust and Luton Borough Council to identify young people involved and to mitigate risks posed by and to the young people identified.

Action required:

- The LSCB will receive regular updates on partnership activity

Child Sexual Exploitation

The sexual exploitation of children was brought sharply to public notice by the recent court cases in Rochdale, Derby and Oxford. Each case has exposed the appalling violations to which some children are being subjected but significantly, has supported professionals to be better able to identify this insidious crime. Conversely, a continuing challenge for professionals is supporting a young person who is unwilling or unable to recognise that they are being 'groomed' and are victims of child sexual exploitation.

The work of the Pan Bedfordshire task and finish group has made steady progress in coordinating safeguarding arrangements around incidences of CSE, culminating in the pilot Sexual Exploitation Risk Assessment Conference (SERAC) Project. The SERAC pilot will run from April to Sept 2012 and therefore falls outside the reporting year for this annual report. An information sharing pathway to enable professionals to share intelligence around CSE with Bedfordshire Police has been established but is not currently being well used.

The LSCB, in collaboration with Bedford Borough and Central Bedfordshire Safeguarding Children Boards established a task and finish group, chaired by Glynis Allen, Head of the Luton Drug and Alcohol partnership. The terms of reference established for the group included developing a 'Pan Bedfordshire' strategy to support the national action plan for tackling child sexual exploitation, published on 23 November 2011.

Progress against the strategy includes:

- Activity to better understand the scope & scale of CSE in Luton;
- Delivery of a range of Professional raising awareness seminars;
- Revision of the Pan Bedfordshire CSE Protocol;
- Development of a Professionals information leaflet;
- Development of a CSE page on the LSCB website;
- Communication with all Luton hotels and guest houses to raise awareness/ how to report CSE concerns;
- Information article for parents & carers published in Luton Line;
- Piloting of Sexual Exploitation Risk Assessment Conference (SERAC); and
- Development of a 'centralised' CSE Intelligence sharing process with Bedfordshire Police.

A report from the University of Bedfordshire on research to explore the sexual exploitation of children and young people in Luton is due for publication in the Autumn 2012. This research report together with the SERAC evaluation report will inform the LSCB and shape future recommendations on the development and delivery of local arrangements to identify and support victims of CSE and prosecute perpetrators.

Safeguarding in the Independent, Voluntary and Community sector, particularly faith communities in Luton

The project to support third sector organisations, including faith organisations to develop effective safeguarding standards is positive. However, the challenge for most settings is that they are 'staffed' by volunteers with little or no knowledge of safeguarding and very little spare time. The Safe Network resources are free, easily accessible and developed specifically for this sector but settings still require enormous support to translate model policies into effective practice. Without a dedicated resource to co ordinate activity, maintain momentum and act as a single point of contact for settings, slow progress will continue to be made in this area.

Supporting smaller faith groups and non maintained early years settings with the development of safeguarding standards continued to be a focus for the LSCB in 2011/2012. The project is being delivered in partnership with the SAFE Network, a national organisation jointly managed by the NSPCC, Children England and Child Accident Prevention Trust. Organisations are invited to access free on line resources available on the Safe Network web site to develop safeguarding policies and best practice for their own settings/groups. **http://www.safenetwork.org.uk/Pages/default.aspx** . Additional network meetings and training sessions are run as forums for support.

An LSCB 'participation' logo has been developed to award to groups/settings who have successfully evidenced compliance against the LSCB/Safe Network Quality Assurance (QA) framework.

Safeguarding in Education settings

There continues to be significant changes in the way schools in England are funded, governed and managed with substantial delegation of control from local authorities (LAs) to individual schools. However, regardless of this, section 175 of the Education Act 2002 places a duty on local authorities in relation to their education functions and governing bodies (of maintained schools and FE institutions) to exercise their functions with a view to safeguarding and promoting the welfare of children who attend. The same duty applies (section 157) to independent schools, which includes academies and free schools. It is welcome therefore, that as a direct outcome of learning from local partnership reviews, a Safeguarding in Education strategy has been developed which will provide a framework for all Luton schools to develop and embed sound safeguarding principles. It is anticipated that the strategy will be supported by the appointment of a dedicated post.

A best practice safeguarding strategy for Early Years, Schools and FE settings has been developed. The decision to commission this work arose from learning indentified in a number of partnership reviews (see Learning and Improvement section).The strategy was launched on May 8th at the Head Teachers forum and was subsequently circulated widely for a period of consultation. The time line for implementation of the strategy is 1st October 2013.

Compliance with Section 11 of the Children Act 2004

Section 11 places duties on a range of organisations and individuals to ensure their functions, and any services they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

The 2012/13 s11 audit was once again undertaken in partnership with Central Bedfordshire and Bedford Borough Safeguarding Children Boards and followed a 'Peer Review' format. Statutory partners were invited to self assess their agencies against the following two s11 standards:

1. **Senior management commitment to the importance of safeguarding and promoting children's welfare.**
2. **Effective inter-agency working to safeguard and promote the welfare of children.**

Cross border agencies presented their self assessments to a joint meeting with representation from Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards. Luton only partners presented their self assessments to the LSCB on Dec 19th 2012.

All agencies are able to evidence strong commitment and understanding of the importance of safeguarding at a senior management level. Agencies are willing to be open and transparent in their self assessments. There is evidence that a number of informal forums within agencies have been established to address safeguarding policy, practice and concerns. In addition it is evident that:

- There is an increased understanding about what needs to done, including awareness and anticipation of safeguarding issues and activity to address the issues;
- Agencies are responding very positively to inspections and audits;
- There is greater integration between children/young people and adult services;
- The learning from local and national Serious Case Reviews is routinely embedded into training;
- Progress is being made around participation activity and engagement with children and young people;
- Agencies internal training spans a broader safeguarding agenda; and
- Internal safeguarding audits are being undertaken.

However, areas for development are identified as follows:

- Most agencies struggle with the Common Assessment Framework (CAF) and the challenge for those agencies working across 3 local authorities is managing 3 processes, how to use CAF and what is its function. Links between the CAF and early help/intervention need to be strengthened; and
- Dissemination of learning from SCR's and case file audits needs to be embedded into practice and as part of reflective supervision. There is a need for agencies to agree how to evidence that the dissemination of learning is done and the impact it has on outcomes for children.

All actions identified have been captured in an action plan which is monitored by the LSCB Executive Group.

The Child Death Overview Panel (CDOP)

Invariably it is child deaths that have elements of abuse and neglect which attract the most publicity. However, each year thousands of children also die from causes ranging from sudden unexpected infant death to suicide. The remit of the CDOP is to analyse information gathered about the child (all children up to 18 years) from before and immediately after their death and identify any modifiable factors which may have contributed to their death.

In nearly 1:4 of Luton cases reviewed, consanguinity (blood relation) was identified as a modifiable factor. Unsafe sleeping practices were identified in all of the sudden unexpected deaths in infancy. Smoking and maternal obesity were also noted. Public Health are aware of the modifiable factors and meetings have been held with key leads at the Luton and Dunstable Hospital together with an action plan to ensure work is co-ordinated around issues of smoking and obesity for maternity services. Public Health is working with the NE Thames Genetics Service to deliver a plan to reduce genetic related deaths in Luton.

In Luton during the period April 2012 - March 2013 there were 31 child deaths reported to the Child Death Overview Panel. This is in line with the average of number of deaths reported in the previous 4 years, 6 (19%) of the deaths were unexpected and information sharing meetings were held within 48 hours of the death being reported. 74% of the children who died were under 1 year of age with just over two thirds of these deaths being in the first month of life.

Within the population of Luton, the 2011 Census showed that 14% of the population of Luton were of Pakistani ethnicity; however, of the 31 deaths reported, 52% were of Pakistani ethnicity. Similarly the 2011 census showed that 44% of the population were White British but only 22% of the children who died in 2012-2013 were White British.

20% of the deaths were in the Dallow Ward which has a higher population of children aged 0-18 and is one of the Luton Wards amongst the top10% most deprived areas in England.

During this reporting period, the CDOP panel met on 9 occasions and a total of 35 Luton cases were reviewed and closed. 17 of these deaths occurred in the period 2010-2011 with the remaining occurring during the current reporting year. Of the 35 cases reviewed and closed, 40% of the child deaths were categorised as death from chromosomal, genetic or congenital anomalies and 23% as death from a perinatal or neonatal event. 4 (11%) of the deaths reviewed were sudden unexpected and unexplained deaths.

Trends in Safeguarding (LSCB Year End Performance data 2012-2013)

Child Protection

The number of children subject to a child protection (CP) plan continues to decrease and is lower than at any point in the last 2 years. The number at Quarter 4 stands at 194 and of those, 78.9% are subject to a CP Plan for the first time. Of the 194 children, 79% are registered under the abuse categories of 'emotional' or 'neglect', the remaining 21% being covered by a combination of multiple categories. The average age of a child subject to a plan is 6 years. However, the age group with the highest prevalence of children is the 'Under 1 year' category with 29 children registered.

The number of child protection cases reviewed to timescales remains consistently high and indeed, all those children at year end, who should have received a timely review, did so.

The number of section 47's taking place this year is just over half the number of last year, and more in line with 2010-11. Interestingly, the conversion rate from s47 to Initial Child Protection Conference (ICPC) also remains constant at around 55% (52% in 10-11).

The rate of children ceasing to be the subject of a child protection plan who had been the subject of a CP plan continuously for two years or longer, increased to 9.2% in the year, higher than both the two previous years (6.8% in 2012). As a result , LBC Children & Learning Department are currently undertaking audits of these cases to understand the reasons why, and formulate actions to reduce the numbers. The rate of children who became subject to a child protection plan in the year, but for a second or subsequent time, rose to 17.6% - from 11.8% last year and 10.5% in 2011.

The number of private fostering arrangements recorded, showed a small increase against 2011/12 and 2010/11 figures, with a total of 5 for the year.

Responding to Children in Need

The year-end position for the number of children in care rose to 388 but has remained relatively constant throughout the year, and indeed over the last several years. The rate per 10,000 under 18 population (79.1) is marginally higher than our latest statistical neighbours figure (74.8).

Outturn figures in respect of the timeliness of children's initial and core assessments show that performance against both measures came in below target. The rate of initial assessments completed to timescale was 73.4% against a target of 78.0% and the rate of cores assessments to

timescale was 74.9% against a target of 80.0%. A report into the apparent 'poor' performance against these measures has been written and processes are currently being put in place to help eradicate the issues encountered this year.

The number of children and young people referred to Children's Social Care has significantly reduced in 2012/13 after 4 years of continual rises. At the end of Quarter 4 a total of 3,003 referrals had been made, a 48% reduction on the previous year.

Referral rates regarding concerns for child protection and homeless young people remained constant, accounting for 16.8% and 2.68% of all referrals received, domestic violence referrals fell from 32% in 2011 to 20.3% in 2012. The area of concern showing the biggest increase in referrals was that of general childcare, the proportion of all referrals of which was 33.6% in 2011, and 52.1% in 2012. Overall, these four areas of concern combined, accounted for 89.2% of all referrals received.

The rate of children being referred to the service for a subsequent time, but within 12 months of the original referral stands at 28.2% for the year. This represents a minimal decrease from the previous year's rate of 28.5%. The rate of referrals that went onto an Initial Assessment stands at 69.3%, a reduction on last year's figure of 86.2%.

Youth offending, homelessness and substance misuse

Outcome figures for the rate of new convictions or disposals imposed in 2012/13, amongst children 'looked after' by the authority for over 12 months (8.7%), show a rise in offending rates compared to 2011/12 (5.5%) and this is expected to be above national average. However, it should be noted that this rise would remain inside outcomes recorded in 2010 and 2011 reporting years.

In respect of new entrants to the Youth Justice System, Luton has recorded a 3rd consecutive annual reduction, albeit at reduced rate; there are now just 151 new entrants compared to 326 recorded in 2009/10. Despite this reduction, Luton still has a higher rate of new entrants than comparative neighbours and national figures.

Similarly, in considering re offending rates, Luton's latest reported performance (2011/12) is relatively positive and has a lower (but marginally rising) level of re-offending. Standing at 32%, the local, proven rate of re offending amongst those already in the system compares favourably to national and statistical neighbours whose figures were 35% and 36% respectively. Data collection for this year's indicator commences following the completion of the 2012/13 reporting year, completed in September 2013 as per national indicator methodology.

The percentage rate for young victims of crime, i.e. those aged under 18 years, for 2012/13 stands at 6.4%, this is lower than has been recorded in either of the two previous years.

The number of under 18's presenting themselves to the LBC 16+ team as homeless in the final quarter remains relatively high (32), and whilst the annual outturn is almost identical to last year, the number has increased over 4 fold since 2011.

The number of young people receiving harm and reduction support for alcohol abuse in Quarter 4 was higher than in any other period of the year. In total, 3,938 young people received such support in the Quarter, bringing the total for the year to 12,944. This figure represents a 41.2% increase on 2011/12 and almost a doubling of the 2010/11 outturn.

Conversely, the number of new presentations to structured alcohol and drug services is low (a 50% reduction on last year) and reflects the wide range of preventative work taking place in schools and community groups.

Health Indicators

Collaborative work has been ongoing throughout 2012-13 to strengthen the collation and reporting mechanisms around LAC 'health' related safeguarding data. Subsequently, the outturn figures for Annual Health Assessments of looked after children show that 91.8% had their assessment during the period. This represents an improvement on the previous year whereby only 55.0% were subject to their annual assessment. Conversely, outturn figures relating to annual dental checks and immunisations both showed that the percentage of looked after children receiving their checks had fallen in comparison with the previous year.

Of the year end cohort, 71.3% had their annual dental check (against 87.6% in 2011-12) and the rate of up to date immunisations fell to 88.2% (from 93.8% in 2011-12).

Cambridgeshire Community Services (Provider of adult and children community health services in Luton)

Of the 279 'Looked after Children' in care for 12 months or more , 91.8% (256) had completed their annual health assessment, 71.3% (199) their annual dental check and 88.2% (246) were up to date with their immunisations.

Luton and Dunstable Hospital

Data provided indicate the number of under 18's presenting with self harm and mental health issues during 11/12 totalled 129. Of these, 92 were female and 37 male.

NB. Due to the classification of patient illness it is only possible to search under specific presenting complaints including: deliberate overdose and poisoning, mental illness, deliberate self harm or behaving strangely. Therefore some attendances may have been omitted if classified under any other presenting complaint.

South Essex Partnership Trust (SEPT) (Provider of Mental Health services)

The number of referrals into the Core Team (including LAC) for the year ending March 2013 stood at 640, and the number of referrals into the Early Intervention Services, which also includes LAC, stood at 222. The number of Children within the CAHMS SCRIPT service was 184 (Oct, Nov, Dec and March only).

Monitoring progress against recommendations identified in the 2012 Ofsted Inspection of Safeguarding and Looked After Children (SLAC)

The LSCB monitors progress against the recommendations identified in the Ofsted Inspection report with updates provided at each Strategic Board meeting.

See **Appendix 3** for SLAC Action Plan

The Learning & Improvement Framework

Statutory functions of the LSCB in relation to Serious Case Reviews

The LSCB Regulations (2006) require the LSCB to undertake reviews of serious cases and to advise the local authority and other LSCB members on lessons to be learned. This forms part of the wider responsibility of the LSCB to monitor and evaluate the effectiveness of what is done by LSCB members to safeguard and promote the welfare of children, and to advise on ways to improve outcomes for children and services for children and their families.

Published information about the work of the LSCB in relation to Serious Case Reviews (SCRs) can be accessed on the LSCB website http://www.lutonlscb.org/index.php?option=com_content&view=article&id=139&Itemid=29

Luton LSCB reviews serious cases through the work of the LSCB SCR group. The functions of the group are as follows:

1. To consider child deaths and other serious incidents notified to the LSCB;
2. To advise the LSCB Chair if a SCR or another form of review should be conducted;
3. To maintain the capacity to conduct SCRs and other reviews when required;
4. To oversee the conduct of SCRs and other forms of review;

5. To monitor the implementation of the action plan agreed by the LSCB following SCRs and other reviews and to report progress to the LSCB executive; and
6. To identify lessons that can be learnt from SCRs conducted by other LSCBs and national research summaries of SCRs.

The remit of the SCR group is to consider children and young people where abuse or neglect are suspected to have occurred. Review of other child deaths is the responsibility of the Child Death Overview Panel (See page 32).

The policy of Luton LSCB has been to review cases in a way which enables senior staff and managers to engage directly with front line operational staff in order to gain a more detailed understanding of how and why actions have been taken, what aspects of local systems and arrangements have supported good practice and where services and arrangements for inter-agency work need to be improved.

Arrangements for reviewing cases and accountability for the work undertaken

Since 2009 the Luton SCR group has been independently chaired by an external consultant. He is a qualified and registered social worker with a background in local authority child protection service management. He has substantial experience of conducting SCRs and other methods of reviewing and improving services for children and was part of an expert group which advised the Department of Education during 2012 on the revision of the Working Together guidance on SCRs and learning and improvement.

The SCR group chair operates independently of member agencies; however, the work of the group's chair is subject to annual appraisal and review by the Director of Children's Services and the LSCB Independent Chair. The group reports on its activities to the LSCB Executive.

The standing membership of the SCR group is as follows:

- Designated Doctor NHS Luton Clinical Commissioning Group (CCG)
- Designated Nurse NHS Luton CCG
- Detective Superintendent Bedfordshire Police
- Service Manager Quality Assurance and Safeguarding Luton Borough Council
- LSCB Legal Advisor
- Luton LSCB Business Manager
- Assistant Chief Probation Officer, Bedfordshire Probation Trust

When conducting SCRs and local partnership reviews (described below) members of the SCR group have been joined by managers and named professionals from all LSCB member agencies.

The SCR group meets every three months to conduct its normal business. Additional meetings are held as required to consider individual cases. The LSCB Business Manager and LSCB Administrator maintain systems which enable LSCB member agencies to alert the LSCB to potentially concerning cases. The business unit then gathers briefings about cases which the SCR group may wish to review. The SCR group

chair, the LSCB Business Manager and the LSCB Independent Chair also hold regular discussions on referred cases in order to inform decision making. The LSCB Business Manager and the CDOP Manager also regularly discuss cases to ensure that the Child Death Review arrangements and SCR arrangements are effectively coordinated.

Resources and expenditure

The expenditure on the work of the SCR group (including funding or work commissioned from external reviewers) during 2012 – 2013 was £5,662.23. In the main this was funded from the LSCB budget with some additional funding from the local authority drawn from the Munro funding.

In addition LSCB member agencies make a substantial additional contribution in kind to the work of the SCR group through the following:

- Attendance of SCR group members at meetings;
- Preparation of briefings and reports about serious incidents;
- Conducting SCRs; and
- Conducting and evaluating reviews on cases which do not meet the criteria for SCR.

The group recognises in addition the substantial commitment of front line practitioners and managers who have contributed to reviews by preparing chronologies and reports and attending events arranged to discuss and learn from individual cases.

Context

During 2012 – 2013 as a result of Professor Eileen Munro's review of children's safeguarding there has been a substantial professional debate as to how LSCBs could learn more effectively from practice and particularly from serious cases when children had died or been seriously harmed. These discussions have focused on the revision of the statutory guidance on Learning and Improvement, the methodology for conducting SCRs, how best to communicate SCR findings to the public so that there is greater transparency about the quality of services and – most importantly – how to ensure that services make lasting improvements as a result of the learning from child deaths and other serious incidents.

As well as carrying out its normal responsibilities the SCR group has contributed to these discussions, locally, at the regional level and nationally. The LSCB's work on SCRs contributed to Luton's activities as a 'demonstrator' site under the government initiative to implement the findings of the Munro review. As part of this activity the SCR group chair led a workshop for other LSCBs in the Eastern Region and other demonstrator sites.

The SCR group has also taken steps to ensure that members are equipped to implement revised approaches to learning from serious incidents by attendance at training events (including events on the SCIE 'Learning Together' methodology and Root Cause Analysis) and by circulating and discussing papers on different methods of reviewing and learning from cases.

Activity in relation to Serious Case Reviews

During 2012, Luton LSCB contributed to a SCR carried out by an authority in London, triggered by the death of a young person who had previously lived in Luton. Luton agencies contributed individual management reviews on social care and school involvement with the family and also provided information to the SCR about the involvement of local health services.

Because of the potential serious risk to other family members the LSCB which carried out the SCR has decided not to publish the SCR overview report. Luton LSCB supports this decision and therefore is not reporting the detail of the case. However, the learning from this case contributed in a substantial way to the decision to commission a Luton LSCB 'Safeguarding in Schools' strategy (described below).

In March 2013 the LSCB initiated a SCR in relation to the death of an infant from Luton. The SCR is still in progress and will report its findings and recommendations to the LSCB in the Autumn of 2013. The case is also the subject of a criminal investigation and proceedings in the family court. The findings of the review will be reported in the 2014 LSCB Annual Report.

As reported in previous LSCB Annual Reports the SCR group has closely monitored the implementation of the action plans resulting from SCRs and other reviews conducted by the LSCB. The SCR group and the LSCB Business Unit take a very challenging approach to this task by requiring member agencies to audit the implementation of recommendations in order to demonstrate that learning from reviews is having a positive impact on service delivery and outcomes for children. Information from agencies demonstrating the impact of learning has been published on the Luton LSCB website.

Partnership reviews commissioned in relation to 'near misses' and other serious cases

Since April 2012 the SCR group has commissioned or conducted reviews on serious incidents which did not meet the threshold for a SCR on the following cases.

Case 1 – a primary school aged girl who had been seriously sexually abused by a number of men, including members of her extended family.

The SCR group commissioned a joint report from local education and health services in order to establish whether opportunities for the earlier identification of risk had been missed. It also commissioned a joint report from police and social care to review the conduct of the investigation into the allegations of abuse and the subsequent assessment of risk.

The review found that:

- The child had moved between several Luton nurseries and schools which had disrupted attempts to identify risk;
- School staff had found it difficult to confront and challenge the child's mother who had been uncooperative;
- There had been little involvement from health professionals with the child;
- There had been shortcomings in the collaborative working between police and social care; and
- There had been delays in identifying the high level of risk to the child and in initiating statutory measures to protect her.

Case 2 – a child of nursery age who alleged abuse by a professional.

The SCR group commissioned an independent external reviewer (who is also the Independent Chair of another LSCB) to review the involvement of the child's nursery, the local authority and the police in the case. This case is still the subject of criminal proceedings and the findings will be reported in the 2014 LSCB Annual Report. There was significant learning for the police and the local authority.

The findings of these reviews were reported to the LSCB Executive with recommendations for action to improve services and action plans. Both significantly influenced the LSCB decision to develop a safeguarding strategy for schools, due for implementation Autumn 2013.

Partnership reviews commissioned in order to support the strategic objectives and work plan of the LSCB and member agencies

The LSCB commissioned two partnership reviews, facilitated by the SCR group chair. These were conducted by agencies preparing chronologies of key events and inviting staff who had worked with the child and their managers to attend a review meeting.

Case 3 – a child who had been referred on a number of occasions to the Children and Learning Department by pre-school services and a nursery.

The review was conducted in order to help the LSCB better understand how effectively these services worked together with the social care referral and assessment service.

The review found that:

- There were discrepancies in the understanding that different agencies had about thresholds for referral to the local authority;
- Staff in a nursery had felt unable to challenge the decisions made by the local authority about whether to investigate concerns;
- The local authority responded to referrals as 'one-offs' rather than recognising repeated and accumulating concerns; and
- Safeguarding arrangements in a school had been weakened as a result of substantial organisational changes (including the merger of schools and the loss of key staff).

Case 4 – a young person who had run away from home on several occasions and was believed to have been at risk of sexual exploitation as a result

The review was conducted in order to help the LSCB better understand of the effectiveness of local services in relation to children who repeatedly go missing and child sexual exploitation. This review is still in progress and the findings will be reported in the 2014 LSCB annual report.

Action on learning from reviews of serious cases

The LSCB aims to use the findings from its review work to inform its wider safeguarding strategy. For example the reviews of Cases 1, 2, and 3 outlined above all highlighted shortcomings in the safeguarding work of schools and preschool settings in Luton. Taken together with other information they influenced the decision of the LSCB to review local safeguarding arrangements in schools and to develop a strategy which set out clearly the responsibilities of schools, the local authority and the LSCB.

Cross border working and links with neighbouring LSCBs

The partnership reviews described above have been conducted as part of a wider project involving the LSCB for Central Bedfordshire and Bedford Borough. The findings of these reviews will be shared across both LSCBs and Luton LSCB will continue to collaborate with its close neighbours to develop ways of learning from practice.

Dissemination and learning from SCRs nationally

The Luton LSCB website contains links to copies of significant SCR reports and summaries of research. Learning from local SCRs and Partnership Reviews have been integrated into all LSCB training packages. SCR or Partnership reports are shared with professionals who are members of the LSCB Training Pool to ensure a common understanding prior to delivering LSCB safeguarding workshops.

Objectives and priorities for 2013 – 2014

The recent revised statutory guidance on learning and improvement (Working Together to Safeguard Children 2013) requires the LSCB to develop an overall framework for learning and improvement, including the conduct of SCRs. The guidance promotes the development of a systems approach which takes proper account of the context within which professionals were working in shaping their actions and decisions. The LSCB supports these changes in the belief that they recognise that it is only by creating a climate in which it is safe for staff to openly discuss and learn from experience that services will improve.

During 2013-2014 the LSCB will ensure that it has a coherent and effective learning and improvement framework in place which:

- complies with regulations and statutory guidance;
- enables the LSCB to review serious incidents and other cases in a way which allows it to understand why there have been poor outcomes for children;
- makes the best use of the experience of front line staff;
- makes better use of information from quality assurance activities that already take place (such as existing audits and reflective discussions);

- enables the LSCB to implement long term improvements in services; and
- contributes to the overall performance management and service improvement framework of the LSCB.

In order to do this the SCR group will ensure that members of the group and other key managers and senior professionals in Luton are equipped with the skills and knowledge necessary to conduct SCRs and other reviews of cases in a way which best suits the circumstances.

Workforce Learning & Development

Introduction

The LSCB continues to provide a comprehensive multi agency training programme through a Service Level Agreement with Luton Borough Council and contributes to staffing resources within the Learning & Development team of 1.6 fte posts. Delivery of the programme is facilitated by a pool of approved LSCB trainers who maintain their continuing professional development, by accessing courses/conferences and attending LSCB trainers forums on a quarterly basis, which focus on issues relating to safeguarding children and dissemination of key messages from Serious Case Reviews (SCR's) which are embedded within the training programme .

The annual training programme, agreed with LSCB Executive, is based on identified priority needs, and incorporates key messages from national and local serious case reviews. Delivery of the programme within the available budgets is monitored and risk-assessed on a quarterly basis and an annual quality assurance performance report for both multi and single agency safeguarding training is produced for the LSCB Board.

Single Agency Training

During 2012-13 statutory single agency training has been monitored by the LSCB Executive, with agencies reporting their organisations' training activities and reflecting their level of workforce compliance. Individual agency audit reports were submitted either bi monthly or on a quarterly basis. The lead contact in each case would present their report and respond to constructive challenge, questions or concerns from Executive members, as appropriate. If the Executive required additional assurances, the organisation was asked to report back to Executive with updates within a given timescale.

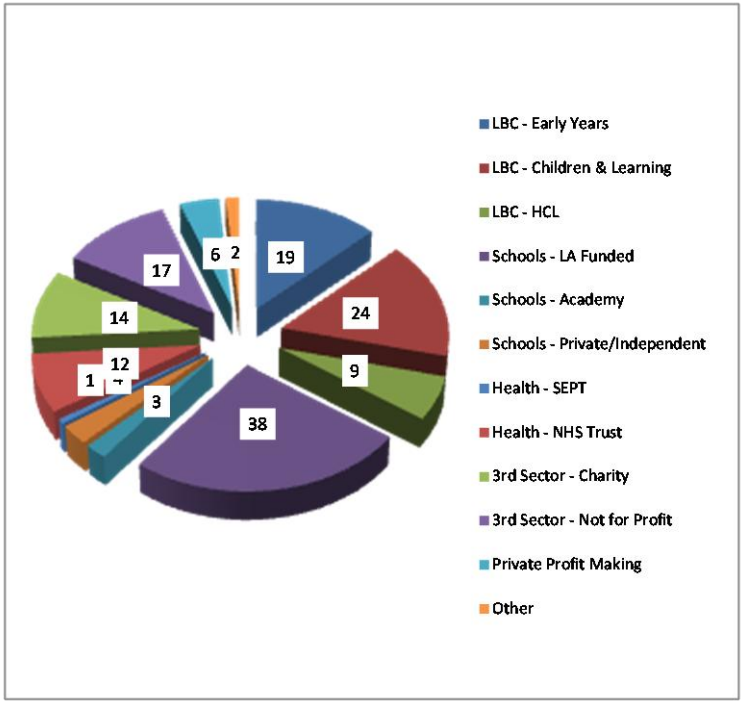
Luton Clinical Commissioning Group (LCCG) became a statutory body on 1st April 2013; previous records showed that 80% of PCT were trained. Within Luton 80%+ of GPs are trained to level 3 (ICD 2010). LCCG has requested an up to date GP Performers list to be able to give an accurate picture of the workforce of safeguarding children training.

LSCB Multi Agency Training Programme

The LSCB multi agency training programme scheduled 46 training events from April 2012 to end March 2013. This included 'Lite Bite' events, which were piloted during the year; seminars on child sexual exploitation and events jointly hosted with Bedfordshire Safeguarding Children Board. Lite Bite events were introduced in response to an identified need for concise, targeted training on specific topics to equip staff with the knowledge to enhance practice.

70% of the scheduled training events ran; the remaining 30% did not go ahead due to: a) the limited number of applications received, requiring decisions about whether it was cost effective to run the training, and b) the loss of some trainers from the training pool, which impacted on capacity to run some events. Applications for training events reached 1,101 during the year with 902 (82%) of employees being allocated a place.

Multi Agency Level 2 Training



Level 2 'A Shared Responsibility' events were oversubscribed during 2011/12, with 130 staff still requiring training into 2012/13. To meet the level of demand, 10 events were scheduled during 2012/13, and capacity was increased on some of the later scheduled events. The number of applications submitted during the year reached 316, of which 190 (60%) were offered places. The take-up of these places reduced to 149 (47%), due to a combination of cancellations with notice, or non-attendance on the day.

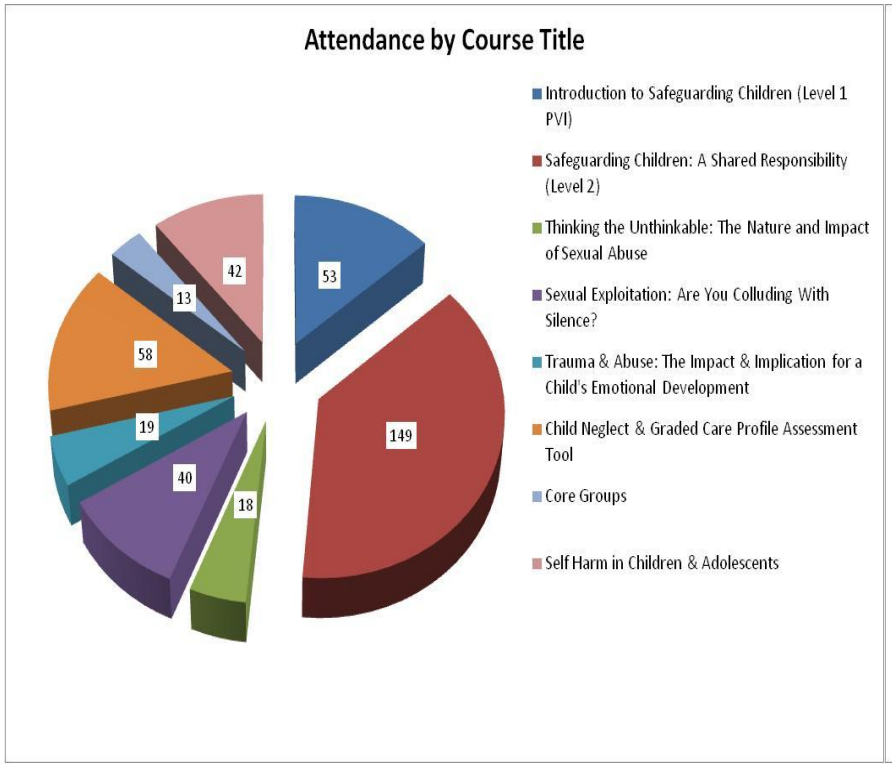
There are several challenges for the Learning & Development team to address in the coming year, to improve accessibility and cost-effective provision:

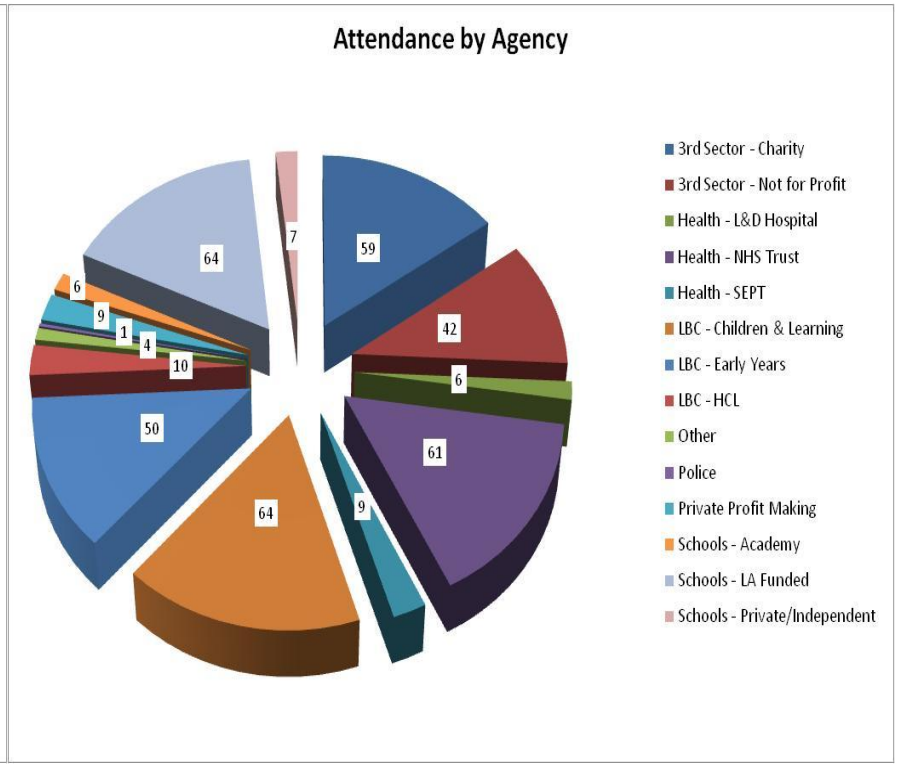
- Ensure the training pathway is being followed within organisations to reduce the need to repeat level 1 and level 2 training every 3 years.
- Develop a 'blended learning' approach by offering e-learning training modules alongside face to face training, reducing the amount of time in a 'classroom environment' without compromising quality of training.
- During the past 2 years the number of applications from social workers within the local authority has decreased, the reasons for which need to be better understood, and no applications have been made by the Police since 2011-12, due to their internal priority to train their workforce to level 1. During 13/14 the Learning & Development team will need to ensure that the needs of these workforce groups are reflected in the training available.
- The loss of internal experts who can deliver this level of training, due to lack of capacity/time, is starting to impact on level 2 delivery, and the Learning & Development team will need to explore viable options to address this, including the prospect of commissioning external providers.

Specialist/Tailored training events

In addition to Level 2 multi agency training, the LSCB scheduled 22 tailored events within the annual training programme. These events were promoted across statutory organisations and private voluntary and independent sector agencies to build knowledge and develop skills within the workforce. Of the scheduled events, 15 were delivered across the 6 specialist areas. Applications exceeded the number of places available, and the response has been to increase maximum capacity for each course. It is anticipated that the introduction of e-learning will assist employees to have some choice over how their learning needs can be met.

The range of training events held and attendance levels by organisation/sector are reflected below.





Serious Case Reviews

The annual training programme incorporates key messages from national and local serious case reviews, which this year required the LSCB to source an additional training package, in relation to Self Harm in Children and Young Adolescents. The LSCB commissioned 2 courses and achieved maximum attendance. LSCB trainers received updates at trainers' forums and access to information from reports for learning purposes were disseminated. Revision of safeguarding training packages commenced from January 2013 to ensure training was reflective of research findings and recommendations from SCRs both locally and nationally which have been highlighted during 12/13. During the forthcoming year a revision of the Domestic Abuse training programme will be taking place and again will reflect any key messages deriving from SCR's.

Safeguarding training within schools

During 12/13 the LSCB introduced a charging policy for schools accessing multi agency safeguarding training. This was implemented with no adverse effect on the number of schools applying for places or on the number of school based staff attending the training.

In consultation with Luton Borough Council's Head of Support, Challenge & Intervention, a standardised level 1 training package was developed for schools.

The aim of the project was to provide a self-contained programme to deliver level 1 safeguarding training for school based staff. Schools participate in a Train the Trainer programme, which has enabled them to elect a member of their staff to become an approved LSCB Trainer and take responsibility for training within their school. A school based trainer pool of 35 people from various settings such as nursery, primary and secondary schools, academies and Barnfield College, has been established as a result. Trainers are encouraged to maintain their professional development by attending Trainer Forums, accessing support from the LSCB, and feedback from direct observations of training delivery under a new quality assurance process being implemented from 1st April 2013.

Faith Communities

Since October 2011, the LSCB has supported a pilot project between Voluntary Action Luton, Prevent and the Safe Network to promote and support safeguarding standards in Faith Communities in Luton. The pilot project sought 30 nominees from a range of faith settings to be enabled to develop safeguarding standards, (using nationally available and free resources) within their faith settings. An evaluation of the pilot project identified that 14 of the 30 original nominees have gone on to become 'Safeguarding Champions'. As the pilot had some success in raising the profile of safeguarding amongst faith communities, one of the priorities for 12/13 for LSCB has been to continue to support faith groups/communities engagement with Safe Network to achieve the recognised standards and demonstrate safer working practices in terms of participating in the quality assurance process and being awarded a kite mark as recognition.

In November 2012, the LSCB held a one-day seminar for faith groups/communities and extended invites to organisations from the Early Years Sector, who were interested in developing safeguarding champions within their organisation. The event was well attended by both sectors with 6 organisations progressing to submit their portfolio to Quality Assurance Panel for consideration of achieving the required standards. This work is a continuing priority in 2013-14.

Child Sexual Exploitation

The LSCB jointly delivered a series of three seminars on raising awareness and other related issues of child sexual exploitation with Bedford Safeguarding Children Board (BSCB). Each seminar focused on a specific theme to assist frontline practitioners and managers within organisations to increase their knowledge, improve their practice and to support the ethos of working more collaboratively within the multi

agency partnership. All professionals were challenged to consider strategies that assist in disrupting perpetrators of exploitative, abusive activity and the protection of children and young people who are at risk of or are being abused through exploitation. The final seminar enabled front line practitioners and managers to consolidate knowledge gained, to embed the new local risk assessment protocol and toolkit into their working practices and identify risks and appropriate action to support children/young people within Luton.

The annual training programme delivered 3 Sexual Exploitation: 'Are You Colluding With Silence?' events and 1 ‘Thinking the Unthinkable' - The Nature and Impact of Sexual Abuse in addition to the Pan Bedfordshire seminars.

A new initiative for 13/14 is working directly with young people in secondary schools within Luton, to raise awareness and understanding of sexually exploitative behaviour/situations, grooming, how to protect themselves and how to report concerns and seek support. This initiative will be piloted by working with the portfolio holder for child sexual exploitation within the Prevention and Early Intervention service and jointly delivering the training during PSHE lessons. Engagement will also be sought to encourage other agencies to support this programme to reach parents and carers.

Quality Assurance

All training events throughout the year have been evaluated on the day using post course evaluation forms. All evaluators are reviewed by the Senior Learning & Development Officer for Safeguarding Training to ensure any issues, queries etc were addressed in contact with both the delegate and where appropriate their line manager.

An impact evaluation has been undertaken for a specific training event arising out of an SCR, and the analysis of findings will be reported to LSCB Executive in September 2013.

As from 1st April 2013 all LSCB courses will be evaluated using a new quality assurance model, based on Kirkpatrick’s model of evaluation. The post course and impact evaluators will assess trainer performance; the impact of training on delegate knowledge and application in practice.

Priorities Areas for 13/14

Over the forthcoming year the priority areas for LSCB multi agency training will include:

- Continuing engagement with faith communities and Early Years sector to achieve safer working practices and support them to achieve the participation kite mark;
- Launch of e-learning modules to improve flexible delivery and accessibility to knowledge-based learning for front line practitioners;

- Direct delivery of sexual exploitation training to young people within secondary schools in conjunction with the Prevention & Early Intervention service and to raise awareness to parents and carers;
- Continued delivery of Child Sexual Exploitation module within the multi-agency programme;
- Ensuring the multi-agency programme continues to deliver training that reflects safeguarding related priorities identified in this report, e.g. parental mental health; learning disability; hate crime; WRAP; and
- Reviewing all LSCB training in response to Working Together 2013, to ensure operational requirements arising from the guidance are reflected in training modules, as appropriate.

LSCB Spend and Budget

The public sector continues to experience unprecedented pressure on budgets. However, in the 12/13 financial year, the LSCB budget benefitted from a strong commitment by each of its partners with no reduction in partner contributions.

Table A - LSCB Income, 2012/13		
LSCB Partner Agency	**% contribution**	**Total**
Children & Learning	47%	**£117,630.00**
Health agencies: PCT	40%	£49,837.00
Luton/L&D Hospital & SEPT		£24,552.00
		£24,552.00
		£98,941.00

Probation	2%	**£5,188.00**
Police	11%	**£26,545.00**
CAFCASS	Nationally set contribution	**£550.00**
Course Charges	N/A	**£13,125.00**
CDOP	N/A	**£43,459.00**
Total		**£305,438.00**
Table B - LSCB Expenditure, EOY 2012/13		
Description		
	Total cost across LSCB Business & Training units	
Salaries	132,640.49	
Premises (rents/rates/insurance)	3,933.04	
Transport (travel to conferences/meetings)	335.70	
Supplies & Services (includes external trainers, venues, refreshments, launch event, stationary, printing & Child B SCR)	62,383.55	
Support Services(HR/accountancy/payroll)	8,072.75	
Capital Financing Costs (covers asset register charges for pc and laptops)	0.00	

Total expenditure	**207,365.53**	
CDOP Underspend from 11/12	**43,464.00**	
Underspend from 11/12	**£72,542.57**	
Underspend from 12/13	**£98,072.47**	
12/13 EOY net position	**£214,079.04**	

Appendix 1

The LSCB Annual Business Plan 2012-2013

The LSCB will provide strong and effective leadership to fulfil its statutory functions to co-ordinate and ensure the effectiveness of work done by agencies for the purposes of safeguarding and promoting the welfare of children and young people. The LSCB has identified the following 7 priorities for its 2012/2013 Business Plan:

- To maintain robust governance arrangements ensuring the independent authority of the LSCB as a statutory body is recognized;
- To continue to promote participation, communication and consultation with children and young people, parents and carers;
- To continue to ensure effective safeguarding policies and procedures are in place to support the work of professionals and review existing policies and procedures (in line with Munro) to enable professional judgement;
- To further improve the quality and effectiveness of safeguarding practice through effective oversight, challenge and measuring of impact;

- To ensure the Children's workforce is supported by the provision of relevant and high quality single agency and multi agency Safeguarding training;
- To learn from child deaths and other serious incidents;
- To co- ordinate safeguarding arrangement in three specific areas;
- Faith Communities;
- Children at risk of/involved in Sexual Exploitation;
- Managing cases of neglect through effective use of the Graded Care Profile (GCP) tool.

Please Note: RAG rating description
Red: Priority
Amber: Extend Current activity
Green: Maintain Current performance

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
• 1. To establish robust governance arrangements, ensuring the independent authority of the LSCB as a statutory body is recognized •					•

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
Undertake an annual review of LSCB governance arrangements (using national assessment tools)	The LSCB Governance Arrangements are collectively negotiated and understood by all LSCB Members.	LSCB Chair/LSCB	The LSCB, Executive and sub-groups have a stable and committed membership.	Annually - Business Planning Meeting Feb 6th 2013 This has not been fully completed as awaiting revision of WT 2013 now available, the LSCB Governance Arrangements should be formally reviewed. This should be carried over to 13/14 Business Plan.	
	The LSCB Governance Arrangements are taken back to Member agencies to promote organisational understanding				
	Board Members, including Lay Members, are properly inducted and supported in their role. LSCB Members re sign their Welcome Pack on an annual basis.				
	To Review Membership annually ensuring board members are sufficiently senior to hold others to account and effect change. Where the LSCB Member is unable to attend, their named representative must be able to commit to decisions made by the LSCB.		The LSCB has clearly understood communication,		

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
	Specify the communication, reporting and accountability relationships with the Children's Trust Board, Shadow Health & Wellbeing Board and LBC Health & Social Care Review group to ensure the LSCB is kept informed of any restructuring/integration /downsizing or alignment by partners		reporting and accountability relationships with key strategic planning partnerships.		
	Monitor and report on attendance at LSCB and sub group meetings	LSCB Business Manager	The LSCB, Executive and sub-groups have a stable and committed membership.	**Completed –** this will be included in 12/13 Annual report	
Develop a clear business plan which reflects LSCB Priorities	Draft and agree the LSCB Business Plan 2012-2013	LSCB Chair and Business Planning T&F group	The LSCB has a business planning, reviewing and improvement system linked to achieving its specific objectives and improving co-operation and effectiveness of the Board.	**Completed**	
Review the implementation of the business plan for the previous year	Carry out an annual review of progress in meeting the business plan objectives and include analysis in the 2011/2012 Annual Report.	LSCB Business Manager/ LSCB Independent chair	The LSCB business plan is a working document that is evaluated on an annual basis.	**Completed**	
Agree a clear budget plan	Calculate the costs of	LSCB Business Manager	The LSCB is clear		

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
for the LSCB.	implementing the LSCB business plan for 2012 - 13		about the resources required to implement its business plan.	**Completed**	
Cooperate with other LSCBs and LSAB	Identify opportunities for partnership working with other LSCBs including joint protocols and shared task and finish groups	Executive Group/LSCB Business Manager	The LSCB benefits from the economies of scale resulting from shared activity with other LSCBs.	**Completed (Joint CSE task and finish group and joint Interagency safeguarding procedures)**	
The independent identity of the LSCB as a statutory body is recognised	The LSCB is working with all relevant local partnerships to address its specific priorities	LSCB Independent chair	The LSCB is recognized as an Independent body clear about its priorities & functions.	Feedback from 12/13 Open Day indicates that role and function of LSCB is understood	
	The LSCB has agreed both reporting arrangements and the exchange of data with partner agencies				
	To promote a high level of professional challenge across and within agencies			The Resolution and Escalation of Professional protocol concerns requires local promotion	
The Board has effective governance arrangements in place to monitor the performance of its	The Independent Chair will meet with the DCS on a quarterly basis. One of these meetings will include an appraisal of the Chair's	Martin Pratt - DCS	Independent Chairs have the relevant skills, can think and act strategically, are willing to challenge	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
Independent Chairs.	performance, reported to the LSCB annually.		and encourage others to do so and are linked into		
	The SCR Independent Chair is accountable to the LSCB Independent Chair and will meet with him quarterly. One such meeting will involve the Director of Children Services and include an appraisal of the Chair's performance. This will be reported to the LSCB annually.	Martin Pratt – DCS/LSCB Independent Chair			
• To promote participation, communication and consultation with professionals, children, young people, parents and carers					•
Raise awareness of the need to safeguard and promote the welfare of children	Develop & distribute LSCB Information leaflets for professionals & wider community ○ Information on CP Conferences ○ The function of the LSCB ○ Role of professionals in safeguarding children	LSCB Business Manager	Accessible information on safeguarding children is available professionals and members of the public.	**Completed**	
	Publicise safeguarding information on the LSCB website including local and national policies, procedures and protocols.	LSCB Business Manager/Communication Lead Officer	Accessible and up to date information on safeguarding issues are available to	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
			professionals and members of the public.		
	To plan & deliver three seminars on the12/13 priority safeguarding themes: ○ Faith Communities ○ Neglect & the GCP ○ Sexual Exploitation to include current research and national developments.	LSCB Training Manager, Business Manager & Training Officer	Our priority themes are given a high profile and agencies are kept up-to-date with national developments on safeguarding.	Specific GCP Training delivered Faith communities & Early years Launch- Completed Nov 12 . Sexual Exploitation – Completed June, Oct 2012 & March 2013 **Completed**	
	Review the 11/12 LSCB Communication Strategy and include an assessment against progress in the 11/12 Annual Report.	LSCB Business Manager/Communication Lead Officer	The LSCB can demonstrate progress against its Communication strategy	**Completed**	
	Review and update the LSCB Communication Strategy to outline activity in the 12/13 Business year		The LSCB is clear on its Communication priorities for the 12/13 Business Year.	**Completed**	
Develop systems and processes for service user participation and consultation	LSCB Member agencies report on their consultation/participation activity with service users.	LSCB Executive	The operation of child protection processes and the	This should be carried into 13/14 Business plan	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
			delivery of CP services are informed by service users.		
	LSCB take a more active role in the annual young people 'Takeover Day' – participate/more involvement			Takeover Day – 23.11.12 Focus on CSE **Completed**	
Ensure that children and young people have a voice within the Child Protection Conference system and that their wishes and feelings are taken into account when child Protection Plans are developed.	Monitoring the work being undertaken within the Safeguarding & Quality Assurance team to ensure the voice of the child is always considered Survey a child at end of CP Plan to see if it has made a difference.	Monitor inclusion of CP data, including child attendance in the LSCB Quarterly Performance Report	The voice of the child is always included in CP Conference decision making whether they are present or not.	**Complete** New model of CP Conferencing (Strengthening Families) will increase participation by C&YP.	
		Undertake an annual survey of Children subject to CP.	To ensure children and young people subject to CP are aware of CP Process and are involved in it where appropriate.	Nov 2012- **Completed** but response poor. Report to Dec Executive	
Strengthen communications between LSCB and the children's	Develop and issue a quarterly LSBC newsletters and policy briefings to the whole workforce.	LSCB Business Manager/Communication lead	Professionals are better informed on the role & remit of the LSCB	1st Publication – April 2012 2nd Publication – Nov 2012	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
workforce and the public	Conduct Practitioner Discussion groups with LSCB Independent Chair		Professionals are kept appraised of safeguarding activity ongoing in the Borough	**Completed**	
			Professionals are able to respond/comment on articles contained in the News letter		
	Continuing development of the LSCB website promoting access by Professionals, children, young people/parents and carers	LSCB Business & Training Units	The LSCB Website is the site of choice for safeguarding issues and information	**Completed**	
• 3. To ensure effective safeguarding policies and procedures are in place to support the work of professionals					•
Develop procedures to co-ordinate safeguarding activity	To continue to work with Central Bedfordshire and Bedford Borough Safeguarding Children Boards to develop 'common' safeguarding policies/protocols	LSCB Executive	Safeguarding activity is underpinned by policies and protocols in key areas of activity that affect LSCB member agencies.	**Review completed**	
	Review policies and understanding of CP Thresholds for Intervention at an annual – seminar (diagonal slice group)				

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
Respond to new legislation/guidance and to ad hoc issues that affect safeguarding activity	Ensure consultation responses are provided on behalf of the LSCB to all draft policies, procedures and guidance.	Executive	Ensure nationally, regionally and locally developed policy, protocol and guidance meet local needs	**Completed**	
	Identify, discuss and respond to new issues that result from government initiatives and national or local events.		The LSCB responds quickly to unpredicted but important safeguarding issues		
• 4. To improve the quality and effectiveness of safeguarding practice through evaluation, support and driving continuous improvement					•
To have comprehensive and integrated systems in place, which enable scrutiny of performance in key areas of safeguarding activity	To continually review the LSCB Quarterly Performance report to ensure the inclusion of shared performance measures across partner agencies and identify areas for further scrutiny.		There is consistency in recording and reporting on safeguarding activity across partner agencies	**Completed**	
To monitor compliance by organizations who have a duty under section 11 or section 175 of the Education Act 2002 to ensure they are	To implement & review s11 compliance process	LSCB Executive Group	The LSCB is assured that partner agencies have effective safeguarding standards in place	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
fulfilling their statutory safeguarding obligations	To publish results of the section 11 audit				
To evaluate the effectiveness of multi agency working by undertaking joint audits of case files involving frontline practitioners where possible. This should include an assessment of the effectiveness of help being provided to children and families (See Annual Audit Programme)	To evaluate the involvement of different agencies	LSCB Executive Group	Delivery of continuous improvement and effective outcomes for children and families	**Completed** See Annual Audit Programme An assessment of early help services will be included in the 12/13 annual report.	
	To evaluate the quality of practice				
	To identify and implement lessons to be learnt from multi agency/multi disciplinary practice				
	To assess the effectiveness and value for money of early help services, including early years provision.				
	To assess the impact of changes resulting from audit findings on children and young people and their families rather than confining attention to processes				
Ensure that the welfare of all vulnerable groups of children and young people are safeguarded e.g.	To receive requested assurance reports (either single agency report or joint report) in respect of identified	LSCB Executive	The LSCB is assured of the safeguarding arrangements for	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
• Living away from home	groups of vulnerable.		specific vulnerable groups of children to gauge how well their needs are being met, taking account of any practice guidance.		
• Trafficked					
• Children of parents with learning disabilities					
• Children with disabilities					
• Missing from home					
• Vulnerable parents					
• Children using or affected by alcohol or drugs					
• Children affected by Domestic abuse					
• Children Missing Education					
• Home Schooled Children					

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
• In conflict with the law					
• Parents/Carers with Mental Health issues					
• Children who are privately fostered					
Monitor the effectiveness of the Children's Trust Board in safeguarding children	Receive and evaluate regular reports from the CT Board	LSCB	The LSCB is kept appraised of the work of the CT Board	**Completed**	
Further development of mechanism to identify risk and issues within & between agencies on managing safeguarding issues	Review existing Risks and Issues log process	Executive	All agencies have opportunity to use process to identify & share issues/concerns	A review of the Risks and issues log is a standing agenda item at each Executive **Completed**	
The Safeguarding children Board will routinely monitor and where necessary challenge the performance of agencies and the LADO in relation to the management of allegations against people who work with children.	The LSCB will receive bi-annual reports from the LADO detailing activity for inclusion in the Performance Management report.	LADO	The LSCB is assured that allegations are dealt with effectively and quickly.	Annual Report to LSCB Dec 19th 2012 **Completed**	
• 5.To ensure the Children's workforce is supported by the provision of relevant and high quality single agency and multi agency Safeguarding training					•

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
To ensure the provision of a comprehensive programme of high-quality training linked to LSCB priorities and its Business plan.	Undertake a needs analysis of training requirements and evaluation of training provision to inform the review and revision of the training programme for those who work with or have regular access to children across Luton.	LSCB Training Unit	An up-to-date training plan is in place which meets the needs of LSCB member agencies, takes into account recommendations from inspections, audits, SCRs and findings of cases of special interest and is monitored by the LSCB.	February 2012 **Completed**	
Develop & Implement a mechanism for charging schools to attend LSCB Workshops	Identify a pricing structure Communicate structure and process to stakeholders Identify and implement administrative processes to manage process effectively	LSCB Training Unit	Pricing Structure agreed in line with other Local Authorities with Pan Bedfordshire charging policies. Written correspondence and briefing undertaken at Head Teachers Meeting.	February 2012 **Completed** January 2012 **Completed** April 2012 **Completed**	
To monitor and evaluate the effectiveness of single agency and multi agency training and report on this in the annual report.		LSCB Training Unit		**Completed** For inclusion in 12/13 Annual Report	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
Using national research as well as local knowledge to shape a safeguarding training programme and adopt a range of delivery methods to increase accessibility including the third sector.	Deliver a twelve month programme of multi-agency training included within a published brochure	LSCB Training Unit	Appropriate training is provided to all those who work with or have regular access to children.	May 2012 **Completed**	
To implement a process to evaluate the Impact of training at the time of delivery and at recurring intervals		LSCB Training Unit	Organisations can learn about what is working well and identify emerging problems and adapt accordingly.	QA Process now in place **Completed**	
• To learn from serious case reviews, child deaths and other serious incidents					•
Disseminate and implement the learning that has been identified via the Luton & Bedfordshire CDOP process	Develop a communication method to disseminate learning from cases discussed at the CDOP.	CDOP Manager	The LSCB is assured that the reasons for a Child's death is understood, the needs of other children and family members have been addressed and all lessons identified are disseminated	29.09.12 – Action Plan in place monitored via CDOP **Completed**	
Ensure the SCR Panel is constituted with chairing and membership that comply with Government guidance	Timescales, notifications and process arrangements comply with statutory guidance	SCR Panel & Chair	The panel is WT 2010 compliant	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
Ensure all Serious Case Reviews implemented adhere to statutory guidance	If the LSCB Chair so decides convene the panel & undertake a Serious Case Review.	SCR Panel Chair	The panel is WT 2010 compliant	**Completed Completed**	
Ensure that referrals which appear to meet the criteria for a Serious Care Review are acted upon & the Chair of LSCB is advised of the Panel recommendation.	Additional meetings arranged as required	SCR Panel Chair	The panel is WT 2010 compliant	**Completed**	
Consider and address 'Ofsted' evaluations of SCRs to ensure practice improves in response	Recommendations & Action Plans are monitored by the SCR panel	SCR Panel Chair	The LSCB is assured practice improves as a result of lessons learnt	**Completed**	
Ensure an appropriate review is instigated on cases which although do not meet the threshold of a SCR, significant safeguarding issues have been identified.	1.All notifications of serious incidents are reviewed by the SCR Panel 2. The SCR Panel initiate and monitor an appropriate review process 3. Learning identified is notified in report format to the Executive group 4. Findings of all such additional reviews will be summarised in the LSCB annual report to ensure	SCR Panel Chair	All relevant staff are aware of when SCRs are required or should be considered	**Completed**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
	transparency for the public				
Disseminate wider findings of national and local SCRs	1. SCR panel to review national and regional findings of SCRs and significant individual SCRs and to agree how they are best disseminated taking into account local agency and multi-agency partnership training arrangements. 2. Regular briefing of LSCB "trained trainers" on SCR findings 3. Commission specific briefings if agreed appropriate	SCR Panel Chair	Practitioners are alerted to key themes arising from both local and national SCRs/serious incidents reviewed	This work is a continuous activity and will be ongoing in 13/14 Business Plan	
• 7. To co- ordinate safeguarding arrangements in three specific areas: • Faith Communities • Children at risk of/involved in Sexual Exploitation • Protect children experiencing neglect through effective use of the Graded Care Profile (GCP) tool.					•
The LSCB will implement a T&F group to scope the scale & nature of sexual exploitation and make appropriate recommendations	1. Plan & deliver professionals seminar 2. Complete audit to ascertain scope scale of CSE across Bedfordshire & Luton 3. Review current	Executive Group	The LSCB is informed of the scope & nature of CSE across the County and processes are in place to support	**Completed – T&F group in place**	

Objective	Key Tasks	Responsibility	Outcome Required	Completion Date	Priority RAG Rating
	Professional training workshop 4. Consider options for improving awareness with wider community		young people at risk of or experiencing CSE.		
To improve response to children through consistent use of the GCP tool in cases of Neglect as an objective measure of care provided and to measure progress	1. Plan & deliver professionals seminar 2. Monitor use & effect of GCP in cases of Neglect	Executive Group	The GCP tool is consistently used in all cases of Neglect	**The use of the GCP tool remains low**	
• To raise awareness in faith communities as to how they can contribute to safeguarding and promoting the welfare of children	1. Review VAL Evaluation Report on SAFE Project for outcomes & value for money 2. Determine options for continuing engagement	Executive group	Faith Groups are supported to work within a framework of safeguarding standards.	**Project in place**	

LSCB Meetings

The LSCB continues to fulfil its core functions at its meetings four times a year: to monitor partners are effectively meeting their safeguarding duties (e.g. through Section 11 audits); to ensure that safeguarding practice is effective (e.g. through multi-agency audits); to develop and monitor the safeguarding projects in the LSCB business plan; and to produce an annual report. Each meeting includes a progress report from the Executive group detailing the activity of each of the sub and task and finish groups. A particular priority for the LSCB strategic board throughout 12/13 has been to maintain a sharp focus on the action plan developed following the Ofsted inspection of Safeguarding and Looked After Children in March 2012.

Partnership Attendance at LSCB Meetings: 2012/2013

NO.	NAME	AGENCY	TITLE/POST	MEETING TIMES	NO. ATTENDED	ABSENT NO APOLOGIES	NO. REPRESENTED	APOLOGIES	COMMENTS
1	Karena Thomas	Beds Police	Detective Superintendent	**4**	3	0	0	1	Nigel Stone was in post until March 2013
2	Andy Brogan	SEPT	Dir. Of clinical Governance & Quality	**4**	2	2	0	0	
3	Anne Murray	NHS Beds & Luton	Director of Quality and Nursing	**4**	3	0	1	0	
4	Anita Briddon	Youth Offending	Head of Youth Offending	**4**	4	0	0	0	

NO.	NAME	AGENCY	TITLE/POST	MEETING TIMES	NO. ATTENDED	ABSENT NO APOLOGIES	NO. REPRESENTED	APOLOGIES	COMMENTS
		Service	Service						
5	Jo Fisher	Luton Borough Council	Head of Prevention and Early Intervention	**4**	3	0	0	1	Anne Futcher previously in post Jo fisher in post from September 2012
6	Patricia Reid	L&D Hospital	Chief Nurse, Luton & Dunstable Hospital	**4**	4	0	0	0	Marion Collict was in post in June 2012
7	Colin Peak	NSPCC	Regional Head of Services	**4**	3	0	0	1	Dan Russell previously in post
8	Chris Bagley	UK Border Agency	Assist Director	**4**	3	1	0	0	
9	Catherine Barrett	LSCB	Business Manager	**4**	4	0	0	0	
10	Mandy Renton	Cambridgeshire Community Services	Chief Nurse	**4**	2	1	1	0	
11	Christine Lenihan	Lea Manor High School	Head Teacher	**4**	3	0	0	1	
12	Adele Chadwick	Beds Crown Prosecution Service	Assist. Dist. Crown Prosecutor	**4**	0	0	0	0	

NO.	NAME	AGENCY	TITLE/POST	MEETING TIMES	NO. ATTENDED	ABSENT NO APOLOGIES	NO. REPRESENTED	APOLOGIES	COMMENTS
13	Graeme Tolliday	East of England Ambulance service	Assistant General Manager	**4**	1	0	0	3	
14	Dr. Om Prakash Srivastava	NHS Luton	Designated Doctor	**4**	3	0	0	1	
15	Emma Osborne	Beds Probation	Assistant Chief Officer	**4**	2	0	0	2	
16	Graham Cole	LBC	Principal Solicitor	**4**	3	0	1	0	
17	Jane Stuart	CAFCASS	Service Manager	**4**	1	3	0	0	
18	Jennifer Meara	Someries Infants School	Head Teacher	**4**	2	1	0	1	
19	Hilary Griffiths	LBC	Head of Integrated Services	**4**	2	0	0	2	
20	Nasim Goni	LSCB	Lay Member	**4**	4	0	0	0	
21	Pastor Lloyd Denny	LSCB	Lay Member	**4**	3	0	0	1	

NO.	NAME	AGENCY	TITLE/POST	MEETING TIMES	NO. ATTENDED	ABSENT NO APOLOGIES	NO. REPRESENTED	APOLOGIES	COMMENTS
22	Brenda Whittaker	Luton Sixth Form College	Associate Director	**4**	3	1	0	0	Lynn Thackway represented FE Colleges left in May 2012.
23	Martin Pratt	LBC	Corporate Director, Children & Learning	**4**	3	0	0	1	
24	Mo Harkin	LBC	Head of Housing Strategy & Private Sector Housing	**4**	0	1	2	1	
25	Michael Preston-Shoot	University of Bedfordshire	Independent Chair	**4**	4	0	0	0	
26	Patrick Ayre	University of Bedfordshire	Senior Lecturer	**4**	1	2	0	1	
27	Sue Steffens	Luton CCG	Designated Nurse/ Assist. Director	**4**	2	0	0	2	
28	Waheed Akbar	LBC	Councillor	**4**	2	0	0	2	

Appendix 4 :Safeguarding and Looked After Children Action Plan

Recommendation	Progress February 2013	Rag rating
Cross Cutting Actions		
Within three months		
Take action to reduce caseloads in the neighbourhood team and increase the time available to care planning and direct work with children	We have maintained the reduction of caseload in the neighbourhood Teams reported in the last update Average care loads in the neighbourhood teams stood at 30 children per social worker in December 2011 with considerable discrepancies between different neighbourhoods. In February 2013 the average	**Good progress** We have achieved a significant reduction in case loads. Further reduction should result

	case load size was x with very similar caseload size between teams. We hope to further reduce caseloads through the introduction of Deputy Team Managers. Funding has now been identified for this and recruitment of interim staff is in progress while formal processes to amend JDs and team structures is completed	from the implementation of the Deputy Manager role
Improve the quality and consistency of casework supervision and the consistency of recording of management oversight in case records.	• We have reviewed the learning and development needs of Team Managers. • An accredited module on reflective supervision (Supervising for Quality) has been developed with the University of Bedfordshire. 4 managers are undertaking this with another course planned for Sept 2013 • Some managers have attended additional supervision training • We have implemented a new process for recording management decisions on CareFirst • Supervision remains inconsistent however this will be resolved through the appointment of deputy Team managers expected by April. Once the DTMs are in place an audit of supervision will be completed	**Some progress** We have taken action to improve skills and recording, however further progress is dependent on recruitment to Deputy Manager role
Ensure the effective use of chronologies on all cases.	• Information has been provided to all staff on the importance of completing chronologies • The functionality of CareFirst in providing effective chronologies has been reviewed. • Soft market testing of IT systems reveals that no IT provider has an effective way of enabling chronologies to be generated • Work is currently underway with OLM (CareFirst provider) to implement more effective chronologies	**Some progress** Required changes to CareFirst now being addressed. This will provide improved chronologies but this is not yet in place

Within six months		
Take action to improve the efficiency and effectiveness of the electronic case recording system.	Action is being taken to: • Replace CareStore (the EDRMS component of the system) by Civica W2. This will be implemented in April 2013 • Updated version of CareFirst (Version 6.11) with improved functionality has been installed. • Actuate Reporting Tool to improve data reporting from CareFirst has been adopted and is starting to generate reportsQ4/12. • The first stage of the review of processes has been completed and implemented which includes revisions to assessments and CIN documentation. The soft market testing has made recommendations to LBC re potential replacement of CareFirst . This is being reviewed within LBC	**Good progress** Steps have been taken to improve the functionality of CareFirst both as a case management tool and to produce management information. Implementation of the first stage of this has been well received with a reduction in SW time spent recording.
Safeguarding		
Within three months		

Improve the quality of assessments so that they more consistently address individual children's needs, views and feelings and are more analytical so that families can be helped and challenged to make positive changes more effectively	A training programme for assessments has been delivered and further training is planned A range of assessment tools have been reviewed and launched although their use is not yet embedded Work on revising assessment templates within CareFirst for the full range of social work assessments has been completed and implemented. New format supports emphasis on analysis and children's feelings and views We will be developing a single assessment model based on best practice elsewhere once the new statutory guidance has been issued (Working Together to Safeguard Children). This work is being supported through our work as a Munro development demonstration site. We have an ongoing programme of audit	**Good progress** Training has been provided and audits show some improvement in quality of assessments. Further work on developing assessment needs to be based on the new government regulation which are not yet published
Ensure all child protection plans are outcome focused, clearly setting out the changes necessary and how these will be supported and evaluated	• Audit of quality of CP plans has been reported to LSCB • In the longer term, work is being undertaken looking at different models of completing child protection conference which improve engagement of families with the child protection plan. Any new approach will be implemented during 2013/14 • Team managers continue to work with social workers to enable effective core group meetings in order to develop and refine child protection plans. More effective multi-agency engagement in core groups has recently been addressed at LSCB executive and	**Good progress** Improvement to continue to be monitored through audit

	actions developed to address this.	
Improve arrangements for the identification of children being privately fostered.	• A number of awareness raising activities have been undertaken with professionals across the partnership and private fostering is raised in a range of safeguarding training including for hospital and school staff. There has been a very recent increase in the numbers of children notified • A publicity campaign is planned for 2013 raising awareness for members of the public • We will continue to review numbers through regular performance monitoring	**Some progress** Awareness raising campaign has been undertaken but with little impact on numbers notified. Further awareness raising is planned
Within six months		
NHS Bedfordshire and Luton must ensure that the level of safeguarding training meets or exceeds minimum expected standards for all staff groups	Designated Nurse continues to monitoring to maintain overview NHS Trust's have reviewed their training packages and data collection with work progressing with the LSCB training dept to ensure programmes meet the LSCB criteria for training. L&DH – overall 65% with Level 3 staff at 28% which is a 15% increase since inspection. Junior Doctors move on at 6 monthly intervals, therefore do not add to the improvement figures.	**Good progress** Training rates have improved significantly NB update from Nov 2013

	NHSL/LCCG – 81% for staff and 70% GPs which is a 30% increase since the inspection. Many more GPs have been trained but are not currently working in Luton therefore are not counted against our figures. Six further dates for GP training arranged. SEPT has a 100% take up of training for their staff and will continue to monitor this CCS – 94% overall	
NHS Bedfordshire & Luton and the LSCB must ensure the impact of training on changes to practice to protect children from harm and that safeguarding supervision are both well embedded throughout all health providers	All NHS Trust's have a supervision policy in place. Peer review sessions are taking place in health, led by the L&D hospital. Further work is progressing to improve learning and development to move forward into the new NHS through safeguarding networks. Supervision audits are being undertaken with one completed in CCS.	**Completed**

Looked After Children		
Within 3 months		
Improve the quality and consistency of care planning, including more consistent use of parallel planning when appropriate, and effective use of care planning documentation to evidence and support comprehensive care plans.	• Work is in hand to revise the care planning documentation in CareFirst. Planned to be complete by April 2013 and fully implemented by June 2012 • Training in permanency planning has been provided and more is planned • Findings from a senior management review of all children in care planned initiated in November 2012 shows with a few exceptions, permanency plans are being progressed for all children for whom they are appropriate however permanency planning meetings are not being held sufficiently regularly • Recent case audit reported to LSCB shows practice in permanency planning is still too variable • Performance indicators for adoptions demonstrate significant improvements in numbers of children placed for adoption (from 6 in 2010/11 to over 20 predicted in 2012/13) and recently published data shows some improvement in timescales • Recently completed legal "deep dive" reviewed 10 recently completed care proceedings and identified areas for improvement in addressing delays particularly in relation to assessments pre-proceedings and case tracking. Work is in hand to address these using Adoption Reform Grant and building on experience of pilot areas. •	**Some progress** Implementation of changes to documentation dependant on improvements to CareFirst Some evidence of improvements in permanency planning but this is still too variable. Adoption Reform Grant will be allocated to achieve improvement
Ensure the timing and location of looked after reviews takes full account of children's	Service has ensured that • Child's placement is considered as the first choice of venue for	**Good progress**

wishes and feelings	reviews by social workers in their work with children prior to reviews. • Alternative venue to be sought where this is not appropriate in line with children's wishes and feelings. The service is not able to resource fully meeting children's wishes for reviews to be held outside of school hours	Staff are aware of the need to respect children's views, although resource implication mean this is not always possible
NHS Bedfordshire and Luton must ensure that all care leavers are enabled to access health services and receive a copy of their health histories to ensure that they are able to make future life choices.	• Young people have seen and commented on the draft health passport and changes have been made as appropriate. The document was signed off on 18-02-13 and will be used with immediate effect • Evaluation is planned with report to Corporate Parenting Board in Dec 2013	**Good progress** Passport now in place
. NHS Bedfordshire and Luton must ensure that all looked after children and young people receive age appropriate health education and promotion information, and that this is recorded in their health assessments.	• Other areas of good practice have been reviewed for this area and the way forward identified • Packs have been reviewed and materials for inclusion have been decided • Improving monitoring is in progress	**Actions complete** Health promotion packs are available to be used
NHS Luton and Bedfordshire and LBC must ensure that the SDQ's outcomes are reviewed as part of the emotional health	New designated nurse is now in post and pathway is now being developed – target date is 1st April 2013	**Some progress**

and wellbeing assessment during the review of the health assessments		Action is now being taken to address this
Within 6 months		
Ensure there is comprehensive tracking of the educational attainment and progress of all looked after children and that this informs personal education planning	• Collection of achievement data by School Improvement Advisers is collected termly. Achievement of individual LAC is produced for termly ASPIRE meetings to be used by SIAs to inform discussion with head teachers on LAC progress. Progress data informs PEP targets. • Virtual School has significantly increased attendance at PEP meetings for Luton children placed outside of Luton (52 PEP meetings in Autumn term) enabling progress data to be used to set PEP targets. • Key Stage 1,2 and 3 data now on LATS. More work to be done by LATS team to include Early Years and Key Stage 4. Key Stage 4 data inputted onto previous achievement tracker. 90% Virtual School trained on LATS Jan 2013. • Baseline is now activated on LATS but needs to be fine-tuned. LATS are developing their package for Virtual Schools; this is a new development for them.	**Good progress** Close links secured with schools to track attainment and progress. Refinement to current systems sought through regular reviews with senior staff.
Following the planned team re-structuring, review whether there is sufficient management capacity in the neighbourhood and disability teams.	• Review has identified that there is insufficient management capacity in the neighbourhood and disability teams. • Additional resources have been identified for Deputy Team Managers for the neighbourhood teams and restructure will ensure ISCAN Deputy Team manger can supervise staff. • Implementation planned for April 2013	**Good progress** Review has been completed and plans in place to address issues

References

1. Dfe: (department for Education) 2013. Working Together to safeguard Children: A guide to Interagency Working to Safeguard and promote the welfare of children.
2. Ofsted Report (2012): Inspection of Safeguarding and Looked After Children Service. Luton
3. Journal of Epidemiology and Community Health: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465587/
4. LBC C&L report to LSCB Executive group Oct 2012: Annual Report on Home Schooled Children
5. Dfe (department for Education) April 2013: New Learning from Serious Case Reviews: a 2 year Report for 2009 – 2011
6. SEPT report to LSCB Executive Dec. 2012: Assurance Report on Safeguarding Arrangements for Parents/Carers with Mental Health Problems
7. SCIE (Social Care Institute of Excellence) Feb 2005: SCIE Research Briefing 14: Helping Parents with Learning Disabilities in their Role as Parents
8. LBC C&L report to LSCB Executive group Sept. 2012: Assurance Report on Safeguarding Arrangements for Deaf Children including Benchmarking Against the Deaf Children Audit Tool
9. NHS Public Health report to LSCB Executive group Jan 2013: Assuring the Welfare and Wellbeing of Children Using or Affected by Alcohol and Drugs
10. LBC C&L Report to LSCB Dec 2012. LADO Annual Report
11. LBC C&L Report to LSCB Executive group Jan 2013: Report on Safeguarding Concerns re. Families with no Recourse to Public Funds
12. LBC C&L Report to LSCB executive March 2013: Assurance Report on Safeguarding Arrangements for Trafficked Chidlren.
13. LBC C&L Report to LSCB Executive Group March 2013: Assurance Report on the Safeguarding Arrangements for Children and Young People Living Away from Home
14. Office of the Children's Commissioner July 2012: Accelerated Report on the Emerging findings of the OCC's Inquiry into Child Sexual Exploitation in Gangs and Groups with a Special Focus on Children in Care

15. DCSF (now Dfe) Research Report March 2010: Research into Private Fostering: Catherine Shaw et al.