

Safeguarding in Luton

The Annual Reports for Luton Safeguarding Children Board and Luton Safeguarding Adults Board 2018/19



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This year we have taken the step of producing one safeguarding annual report for Luton with the Adults' and Children's data side by side. I hope this makes for more impact and helps convey to you the extent of efforts by the safeguarding partners to join up our approach to issues across generations in Luton. Children who need safeguarding very often have adults with care and support needs in their lives. In previous separate Annual Reports, one for the Children's and one for the Adults Safeguarding Boards for Luton, we outlined the areas where children's and adults' services work jointly on safeguarding families, but this format is intended to show where transition and join-up works well and to indicate where we can be more effective. The approach therefore, strategically and operationally, is not new, but the format of the report is. The Family Safeguarding Model is an example of innovation and multi agency working and it fits well with our efforts to present an account of safeguarding effectiveness in one place.

The legal framework for the Safeguarding Adults Board remains the Care Act 2014, but over the last two years, beginning in 2017, the senior leaders of the children's safeguarding system along with myself and the independent chairs of Bedford Borough and Central Bedfordshire authority, have been working together to prepare in good time for significant changes. The changes were imposed nationally, but government asked local partners to do what worked for them locally. Thanks to the openness and willingness of the council, the police, and NHS commissioners (the three Statutory Partners under the new relevant legislation, the Children and Social Work Act), we have clarified our purpose, reduced the number of meetings across Bedfordshire, but kept enough 'place based' focus and assurance in Luton.

Finally, because this is the first time we have put the data side by side, we are not always comparing 'like with like'. At both Boards we are curious about data and even if we cannot answer all our own questions, we use data from different sources to try and understand what is going on in the system. Both Boards had reports this year on ethnicity and safeguarding where not all the data could be directly compared but it prompted follow on actions to explore the things we could not immediately answer. It is this curious and questioning attitude that as leaders, we try and model, as we know that professional curiosity by all staff who have a role in safeguarding, is one of the things that can make a real difference to families in Luton. The Boards are on track with their priorities but again, applying that same idea of curiosity, each Board focuses on one priority at each meeting to ask if they are still right for Luton, and to understand progress, starting with the latest data.

I have chaired the Children's Safeguarding Partnership in Luton for four years now, and the Adults for nearly three years. Throughout that time I have been inspired, and the Boards have been more effective, for the input of our lay members from the town. I would like thank Amal Ibrahim, Emma Sullivan, Rashida Din, Kimberley Lamb, and Kauser Ahmed for all their wisdom and local knowledge. I would also like to thank the Boards' business unit team for their consistent work. With the partners who support the work of the Boards, we are together stronger than any organisation can be alone. During the year we have challenged each other and overseen changes which we hope will make the quality of safeguarding practice better, and the system safer.

1. THE ROLE OF THE TWO SAFEGUARDING BOARDS IN LUTON

LUTON SAFEGUARDING CHILDREN BOARD (LSCB)

LSCBs emerged from one of the recommendations of the Laming Inquiry and its functions are set out under Section 14 of the Children Act 2004:

- To coordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by such person or body for those purposes.

The Children and Social Work Act 2017 required new arrangements to be made to be led by the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) together with relevant agencies. A structure chart of the new arrangements can be found in Appendix C.

LUTON SAFEGUARDING ADULT BOARD (LSAB)

The LSAB is responsible for making sure that health and care agencies, work together to help keep adults in Luton safe from harm and neglect, and to protect their rights under the Care Act 2014, Mental Capacity Act 2005 and the Human Rights Act 1998.

The Care Act requires the Board to develop and publish an annual strategic plan, publish an annual report and commission safeguarding adult's reviews, where serious abuse or death has occurred, and learning can take place (see Care Act sections 6, 43 - 45 and Schedule 2 for more information).

BOARDS' PARTNERS

Both Boards have the following organisations as partners and lay members who are residents of Luton

Luton Clinical Commissioning Group	Bedfordshire Police	Luton Borough Council (including Housing, Public Health)
Cambridgeshire Community Services	National Probation Service	
East London Foundation Trust	BenCH	
Luton and Dunstable Hospital Trust	East of England Ambulance service	
East of England Ambulance Service	Bedfordshire Fire Service	

In addition, each Board has the following specific to each Board:

LSCB	LSAB
Representation from primary and high schools	POhWER (Advocacy Services)
Further education colleges	Healthwatch Luton

2. CONTEXT OF LUTON – DEMOGRAPHICS

The official estimate of the population of Luton is 214,700 in 2017. A combination of a high birth rate and high migration has led to an increase in the population in recent years. The population density of 50 persons per hectare is greater than many London boroughs.

Luton has a younger population than nationally. As of March 2018, there were approximately 57,043 people under the age of 18 in Luton. Over a quarter of the population (26.6%) are aged 17 or under.

ADULTS

Luton is ethnically diverse, with approximately 55 per cent of the population being of Black and Minority Ethnic (BME) origin, with significant Pakistani, Bangladeshi, Indian, East European and African Caribbean communities. In recent years the diversity of the population has increased. There has been a significant shift in the population, primarily driven by those arriving from newly EU acceded countries of Eastern Europe. There is increasing acceptance that Luton is a 'super-diverse' community.

The 65 and over age group represents 12% of the Luton population compared with 18% nationally.

Luton is currently ranked 70th most deprived area from 326 local authorities - this is an increase in ranking from 69th in 2010. Therefore, Luton is becoming relatively more deprived. Luton has nine output areas in the top ten per cent most deprived areas in the country.

In four of Luton's wards, 40% of the population live in poverty, with life expectancy as much as seven years less than other parts of the borough.¹

CHILDREN

A significantly higher proportion of families are living in poverty,² compared with regional and national averages. Research by the Centre for Research in Social Policy showed that more than a third of children in Luton are living in poverty.³ Luton is in the top quartile of England authorities for child poverty and is the 47th most deprived local authority in the country. The levels of deprivation affecting children in Luton are high, with several electoral wards in the top 10% most deprived areas in the country.

	Primary schools	High schools
The proportion of children entitled to free school meals	18% (national average is 16%)	20% (national average is 14%)
The proportion of children and young people with English as an additional language	52% (national average is 19%)	48% national average is 15%)

¹ [Luton Poverty Needs Assessment](#)

² <http://www.endchildpoverty.org.uk/wp-content/uploads/2019/05/child-poverty-indicators-2019-report-to-ecp-1.pdf>

³ Child Poverty Local Indicators 2017 Update, Centre for Research in Social Policy, Loughborough University

Children and young people from minority ethnic groups account for 61% of all children living in the area, compared with 22% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Asian and Asian British and Black and Black British. More than 120 languages are spoken in Luton. Half of all school children do not speak English as their first language.

3. THE WORK OF THE BOARDS 2018/19

WHAT MAKES AN EFFECTIVE SAFEGUARDING BOARD?

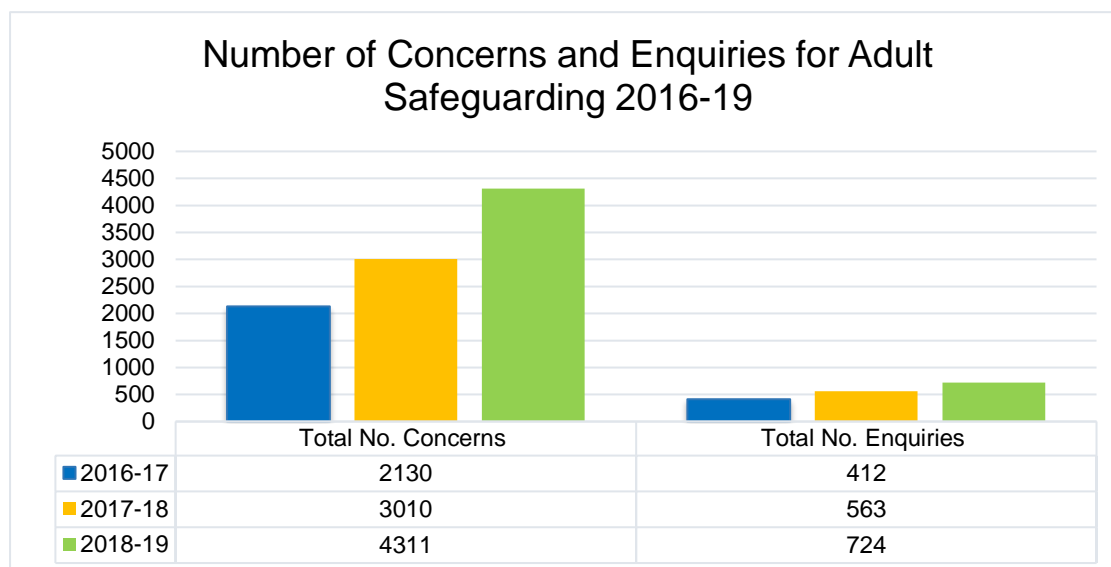
The National Association for Independent LSCB Chairs have suggested that effective Boards are able to demonstrate a number of attributes:

- a) Have an informed understanding of safeguarding arrangements and performance in single agencies and an authoritative oversight of the quality of front-line multi agency practice.
- b) Have effective governance arrangements and operating structure, with clear lines of accountability with other strategic partnerships, and be able to demonstrate its influence on the work of those partnerships. Boards have a strong culture of challenge that is the responsibility of all Board members.
- c) Ensure learning from audits, case reviews, Serious Case Reviews, Significant Incidents and Safeguarding Adult Reviews is identified and is used to develop practice and service provision.
- d) Ensure the provision of high quality multi agency safeguarding training and evaluate the impact on practice of such training

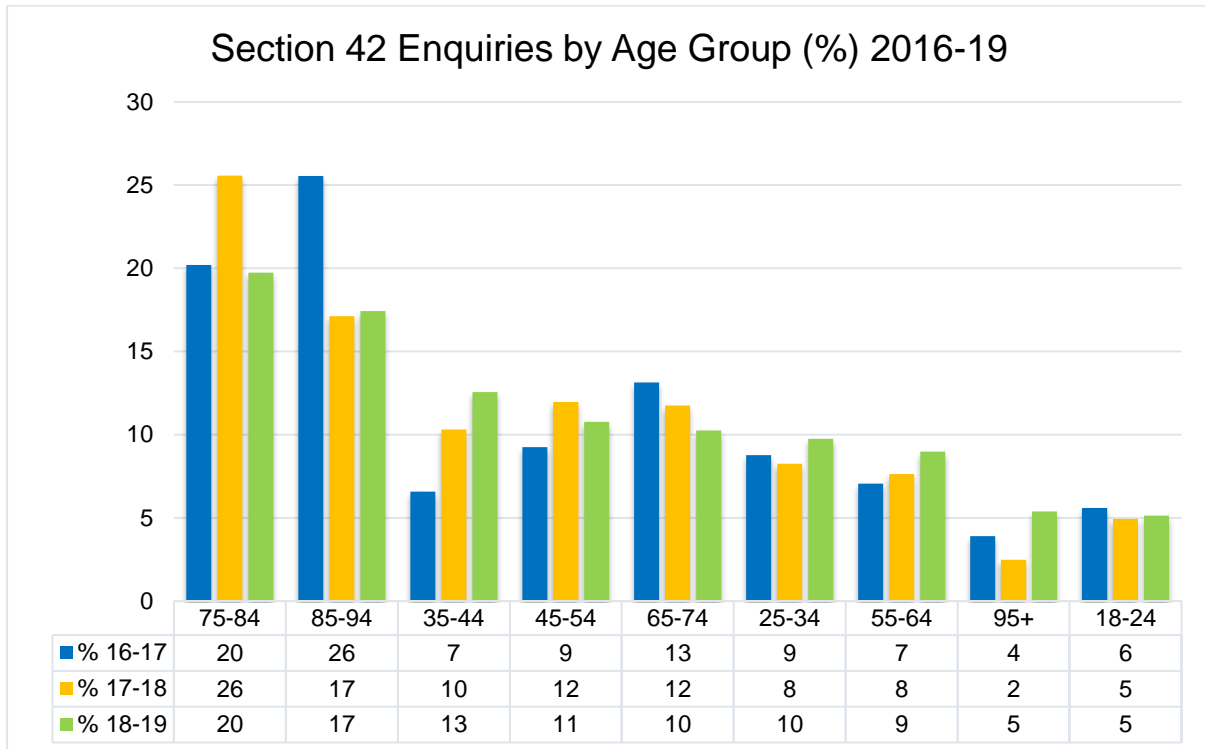
A) Safeguarding Performance

Both Boards have had sub groups monitoring performance,. Both safeguarding systems have seen increasing demands. As can be seen from the data presented below, both adults and children's safeguarding systems are seeing a continual increase in demands.

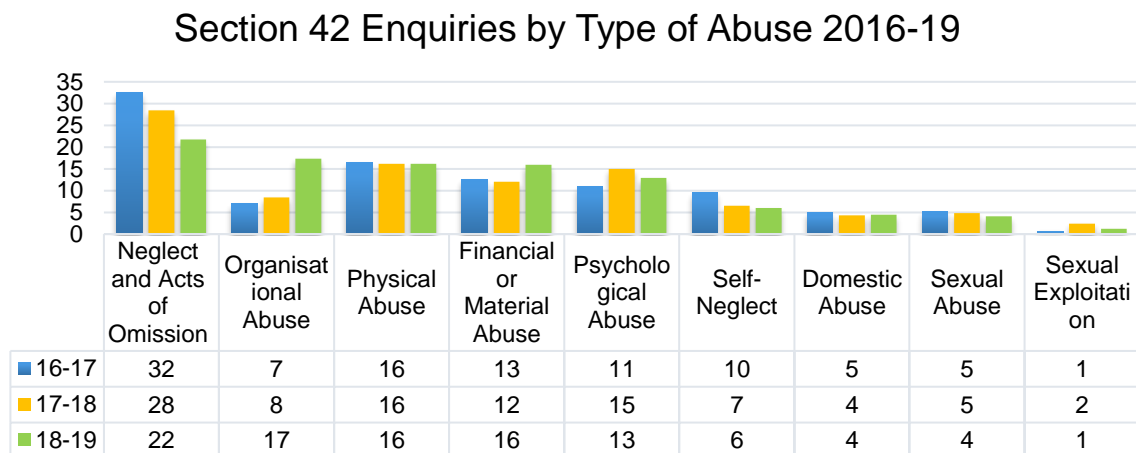
ADULTS



The number of concerns and enquiries raised, has increased every year, with a 43% increase in safeguarding concerns raised since 2017/18. The Board has regularly discussed how to manage the number of concerns coming in. Bedfordshire Police ran workshops with partners in May 2018 to look at its processes, and in Feb 2019 introduced a mental health pathway which should, over a period of time, lead to a reduction in inappropriate referrals from the Police for adult safeguarding.

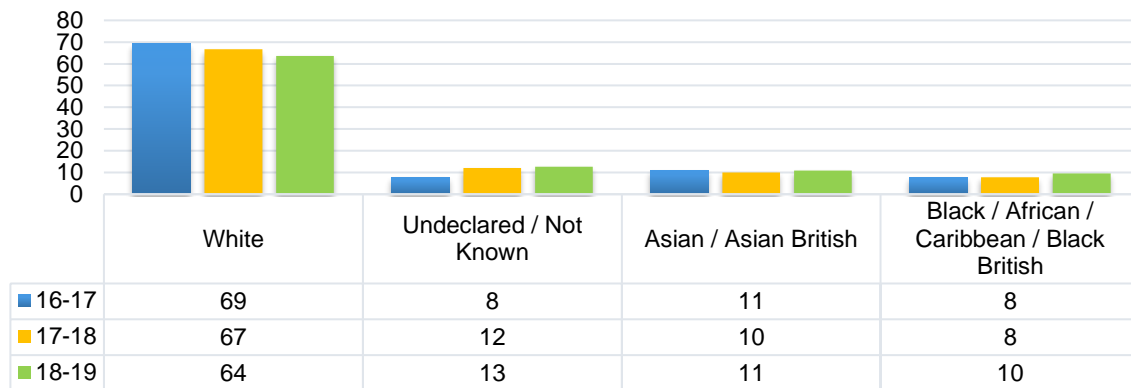


55% of the enquiries related to the 65+ age groups, are primarily presenting with care and support needs, and this would be in line with national norms. The Board is considering whether the number of referrals for people aged 25-34 is low given that Luton has quite a young adult population.



The highest category for abuse was neglect and acts of omission (21%), followed by Organisation abuse (18%), Financial and material abuse (17%) and Physical Abuse (16%)

Section 42 Enquiries by Ethnicity (%) 2016-19

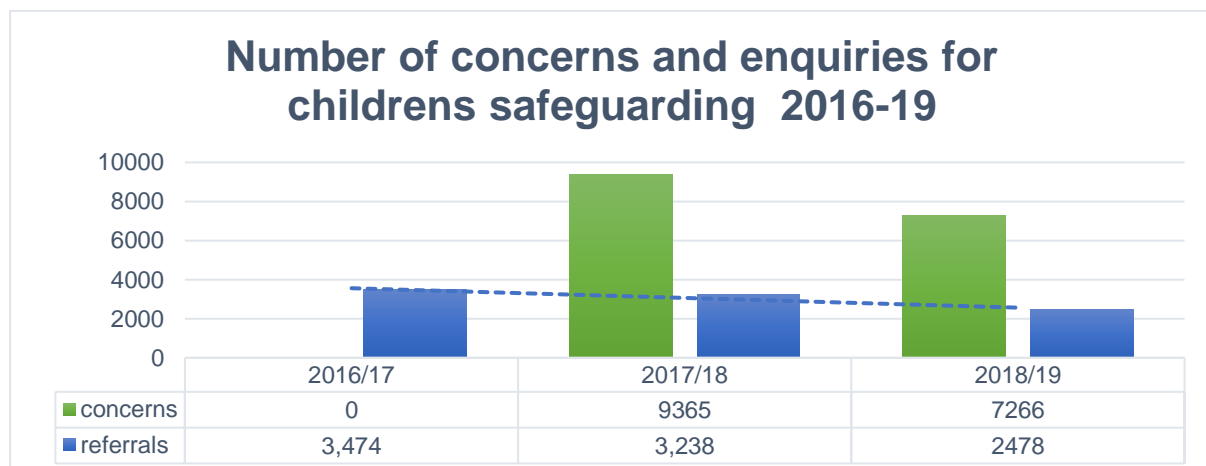


The Board and sub groups have looked at the demographic analysis in relation to ethnicity, as Luton has a “super diverse” population. The highest number of enquiries remains the white ethnic group accounting for 63% of all enquiries. There were slight increases in the number of enquiries relating to the Asian and Black ethnic groups. Detailed analysis of ethnicity in quarter three highlighted that:

- Learning disability was the primary support reason for enquiries within the Asian ethnic group
- Mental health was the primary support reason for the Black ethnic group; figures appeared to be high (13%) and disproportionate compared to this group representation in the 2011 census (10%).

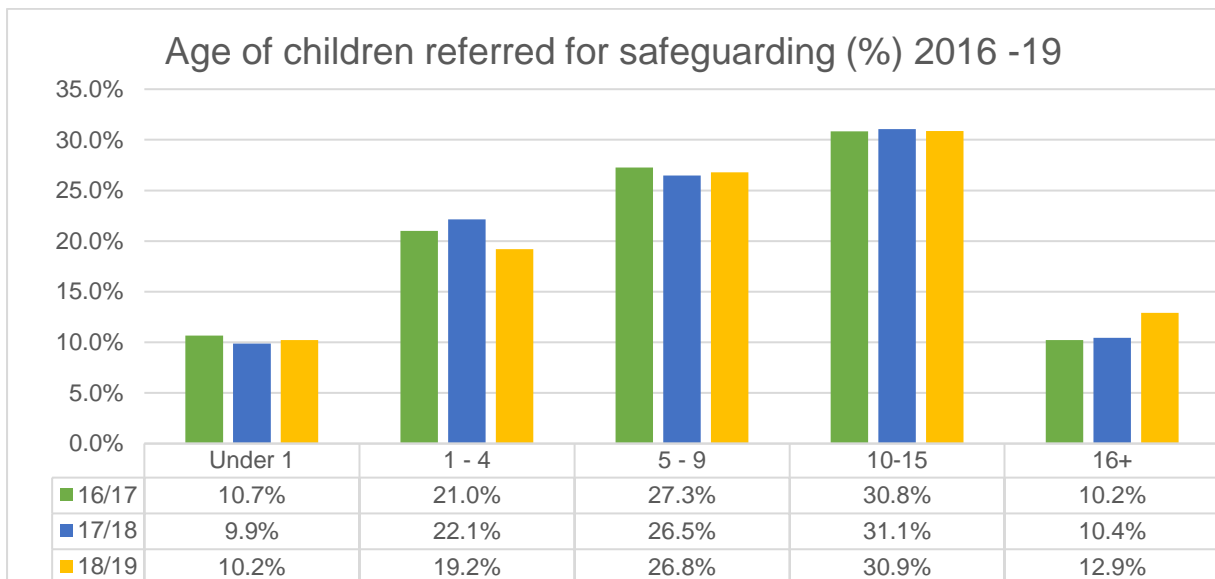
Audits on S42 enquiries have been undertaken on a quarterly basis, with LCCG, LBC, CCS, ELFT, LDUH and the Police participating. Over the year, there is evidence from the audits to show an improvement in the quality of recording and decision making. The performance data and audit also led to the Board seeking assurance on the length of time organisations are taking to complete S42 enquiries.

CHILDREN'S DATA

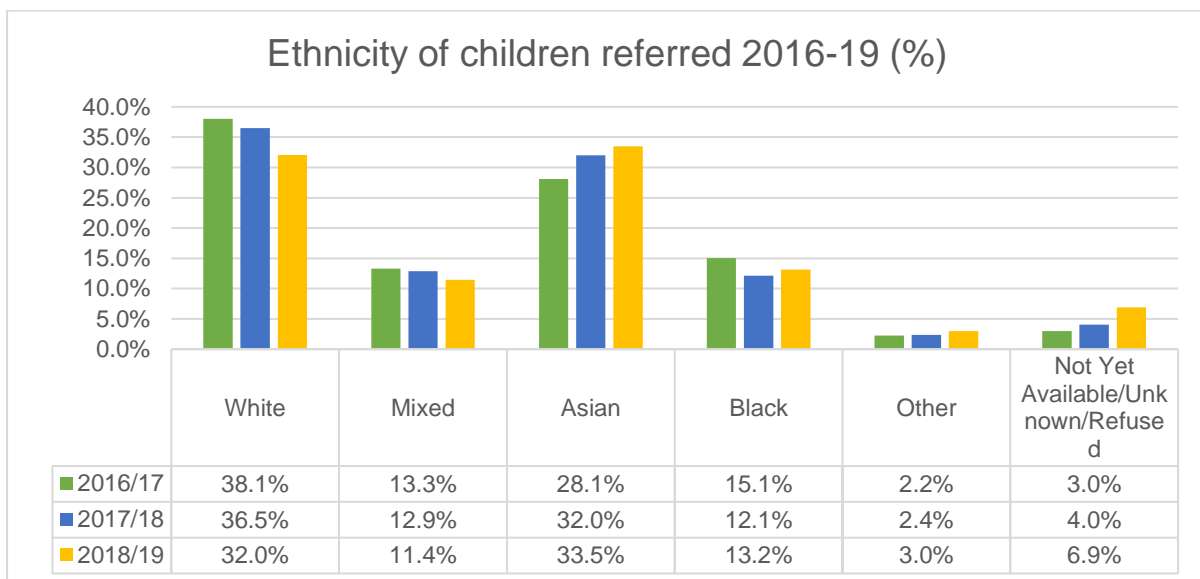


The local authority and partners introduced a Multi-Agency Safeguarding Hub in 2016 which manages all concerns and the initial part of enquiries. As the MASH was introduced part way through 2016, it isn't possible to provide a figure for the number of concerns in that year

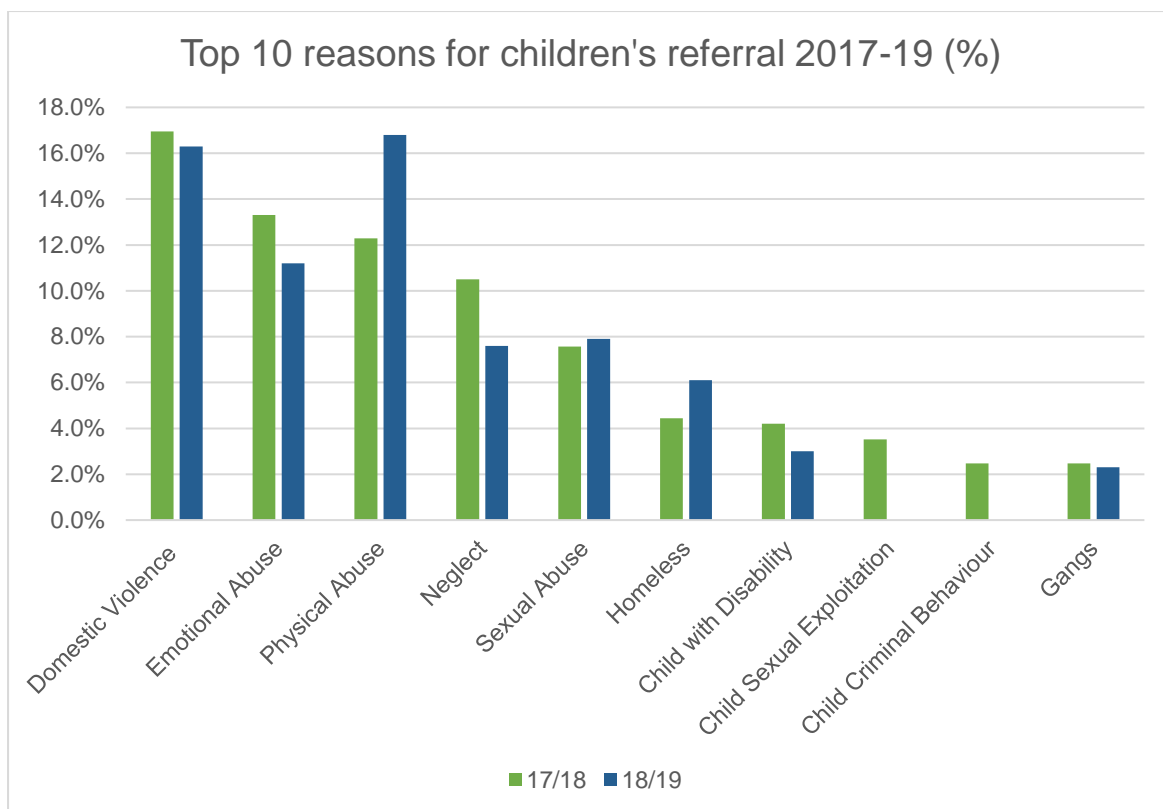
because of the change in processes. Some changes in what is counted partly explains the reduction in number of concerns over the period.



The age profile of children referred is broadly in line with national data.



The breakdown by ethnicity does demonstrate a disparity given the significant BME population of children and young people in the town. The Board has undertaken some further analysis to better understand whether there are specific safeguarding issues for different communities.



The top 10 reasons for referral has changed over the period. Physical abuse has increased from (12.3% to 16.8%) as has homelessness (from 4.4 % to 6.1%). Referral for neglect has fallen from 10.5% to 7.6% and this is likely to be related to the use of Graded Care profile 2, which is enabling neglect to be identified much earlier and therefore reduce the need to refer to children’s social care.

Audit – The Board has undertaken three audits in partnership with the two other Bedfordshire LSCBs. The themes for audits were based on shared interests and were:

- Missing Children
- The use of Graded Care profile 2 in neglect cases
- Child Sexual abuse in the family

All relevant partners/organisations have participated in the audits, and an example of the findings can be found in the appendices.

B) Do the Boards have effective governance arrangements and operating structures in place?

Two key issues have supported the governance and structures - the merging of the business units, and the increase in collaboration with LSCBs and LSABs in the rest of the county. The two business units merged in Feb 2017 with one business manager overseeing the work of both Boards in collaboration with the Chair and the Boards. It has enabled greater alignment and consistency across both Boards, but more importantly it is enabling an improved consideration of how both safeguarding systems consider the needs of the children, families and vulnerable adults. A good example is an adult safeguarding audit which identified a gap in relation to information sharing with the sexual health provider. Rather than a meeting with

LSAB partners it was agreed there would be a joint LSAB/LSCB partner event with sexual health.

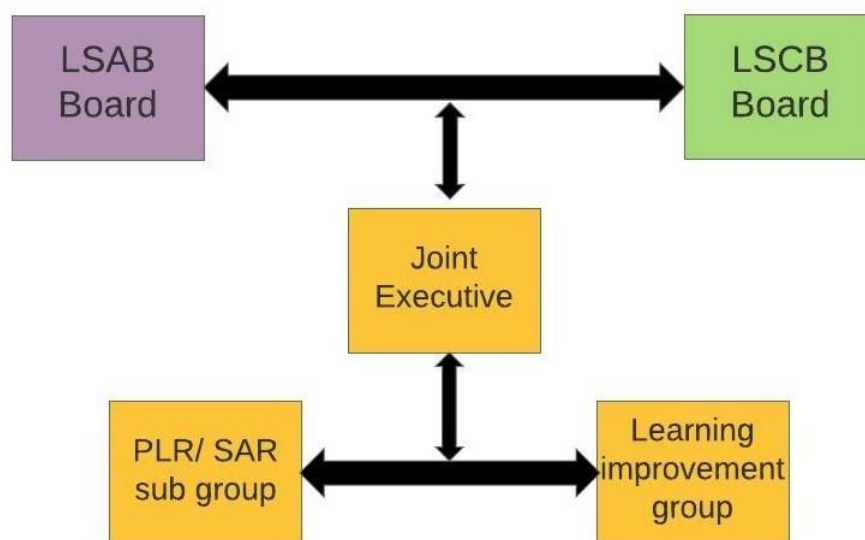
The LSCB has been working with the other two LSCBs over the last few years, and has increased the amount of work that is undertaken on a Pan Beds rather than Luton basis. The LSAB has actively worked to develop the same level of cooperation and continuation. A significant step forward has been the agreement to one set of Bedfordshire multi agency procedures for adult safeguarding.

There has been significant progress with the effectiveness of performance monitoring for the LSAB. The LSAB Board has discussed performance regularly, and partners have worked on identifying and resolving a range of issues, which have impinged on the system. Multi agency audits now take place on a quarterly basis, and have focused on how well practitioners are assessing safeguarding concerns. The sub groups were rationalised over the year following discussions with partners on reducing the number of meetings.

The LSCB has reviewed its structure and operation in the light of the Children and Social Work Act 2017. Over the year, a group of senior leaders developed and sought agreement on the new arrangements. The arrangements have been in place since 1st Sept 2019. A chart of the Pan Beds structures and its relationships with the Luton Boards can be seen in Appendix C.

This year, due to closer working between LSAB and LSCB has also led in the year to a move to one set of joint sub groups which feed into the respective Boards. (see below)

BOARD AND SUB GROUP STRUCTURES IN LUTON



C) Ensure learning from audits and case reviews is identified and is used to develop practice and service provision.

D) Ensure the provision and quality of high quality multi agency safeguarding training

The Learning and Improvement group has the lead for ensuring the dissemination of learning and working with others, and on the provision of multi-agency learning and training opportunities. One of the benefits has been having staff from across adults and children's services discussing learning, as it is starting to enable some cross fertilisation and greater understanding across adult/children's divide.

Children: Learning has focused on issues emerging from audits and the Boards' priorities. Training is commissioned through the Pan Beds LSCB training unit which offers a breadth of e-learning and face to face safeguarding for all organisations supporting children in the county. In Luton 914 staff completed face to face training and 3676 online learning. A spotlight event in March 2019 on sexual abuse in the family environment, enabled front line practitioners and managers to identify and assess the challenges when supporting children and young people. It also focused on processes and pathways throughout the stages of identification and assessment.

Child Sexual Exploitation has been an issue that the LSCB and partners have maintained a focus on. Concerns around low reporting in relation to children led to a specific seminar on boys also being held in March 2019

Adults: There have been positive developments with the LSAB commissioning the Pan Beds LSCB training unit to deliver the adult safeguarding training for organisations in Luton. A new multi-agency one day course focusing on the multi agency challenges in adult safeguarding was piloted, and very well received by participants in the Spring of 2019. This is now available to all adult care providers in Luton. A further course is being developed and piloted over the winter of 2019, which will focus on mental capacity. A range of e-learning courses are also available through the training unit website.

4. PRIORITIES

Both Boards are required to agree and undertake work on a set of priorities. The table below sets out the priorities the Boards' agreed to for 2018/19.

LSCB	LSAB
Tackling Child Neglect in Luton	Drive up practice in understanding what service users want from the safeguarding processes by Making Safeguarding Personal
Missing Children (outwith education settings)	To put together a comprehensive picture of risk in Luton to inform our longer term strategy for 2019 – 2022
Self Harm and suicide in young people	To build on the last 12 months' development of its governance

LSAB

The Board decided to continue with the priorities set in 2017/18. As noted earlier, there had been significant improvement in governance, with sub groups meeting actively and being able to complete various activities such as multi agency auditing and shaping the content of new LSAB training.

Partners and other organisations contributed to the initial development of a risk profile for Luton. This was important as it identified some new areas of risk such as the implementation of Universal Credit and the Homelessness legislation which would impact on vulnerable adults. Further work was undertaken in terms of understanding the communities' views on what safeguarding is, and what they see as risk. (more will be said in the section on community and faith engagement)

Making Safeguarding Personal: The focus has been on using performance and audits, to review the quality of practice.

LSCB

Tackling Child Neglect in Luton: The Board introduced the use of Graded Care Profile 2 in 2017, as a tool to support the identification and assessment of neglect. An independent evaluation in 2018 identified a number of positives in the implementation, and especially in terms of practitioners reporting more confidence in identifying neglect. An action plan emerging from the evaluation has been implemented. One new development is a screening tool that is currently being piloted and will enable staff in housing, culture and leisure and other such services to help them identify concerns. There is also regular reporting on the use of the tool, with the last Pan Beds audit continuing to show its value for families and professionals.

An allied piece of work was the development of a campaign targeting children and young people on neglect. This was developed in conjunction with the NSPCC and other Bedfordshire LSCBs, and was based on discussion with young people in Luton (Luton Sixth Form College, and the LAC participation group). The front cover of the annual report is from the leaflet for young people and the image overleaf is one of the images developed as part of the poster campaign.



Alongside traditional posters, a short leaflet was published and a campaign on SnapChat, which had a lot of pick up. (Over the two separate weeks the campaign ran, there were 831,000 views).

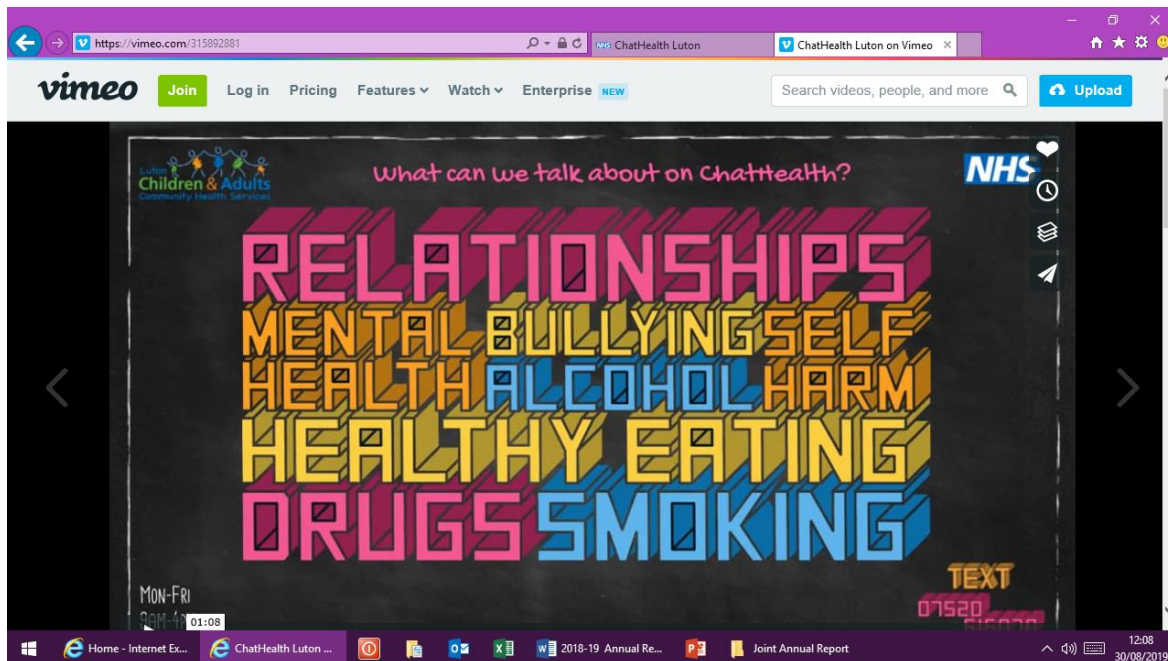
	Impressions	Swipes	Views of Videos
First run	380,089 (expected 84,000)	3073 (expected 1500)	18,554
Second run	451,003	3805	20,378
Total	831,092	6878	38,932

The implementation of the Family Safeguarding Model has also been important element. At the high end of neglect are families where there may be issues related to parental mental ill health, substance abuse or domestic violence. The teams are multi – disciplinary with specialist mental health, domestic abuse and substance misuse workers. This enables a better joined up approach and thereby is reducing the number of children coming into care.

Mental Health: Three pieces of work were undertaken at a Pan Beds level - a practitioner survey, an audit which was followed up with a conference. The audit identified that whilst there was good support for a young person once they were accepted by Child and

Adolescent Mental Health services (CAMHS), there were significant gaps in terms of support for young people who did not meet the criteria for CAMHS. In Luton, an emotional wellbeing strategy has been developed by the Children's Trust. It has led to a range of new commissions including:

- having CAMHS workers linked with Luton schools;
- practitioners access to a duty clinician so they are able to seek advice quickly; and
- the launch of a text service [ChatHealth](#), run by school nurses for 11-19 year olds where young people can raise a number of queries



The LSCB also initiated and ran an event with NHS East of England on self harm and suicide for practitioners in June 2019, which was well received and led to a development of a comprehensive range of resources for practitioners.

Children Missing from Education settings: The Board decided to focus on the aspects relating to unregulated settings and the movement of children into and out of the borough. The Board received assurance on activity from the Council Education services on the work undertaken by Education Welfare and others on working with settings to improve safeguards and learning. The business unit worked with Cambridge Community Services, housing and schools admissions on identifying how information was shared. Data between the three identified that typically there could be 100 families moving into or leaving Luton on a monthly basis, and this posed significant challenges to all in terms of being able to follow up if there were concerns.

Community engagement

The LSCB/LSAB have a joint Voluntary, Community and Faith (VCF) Advisory group, which meets regularly to discuss safeguarding in these sectors and how key messages from and to the community can be communicated and any issues can be effectively addressed.

The group is in the process of commissioning a provider service, which will deliver a series of briefing/training events, targeting the faith and community sectors in Luton, which will

contribute to the overall aims of the Community Engagement Framework and Action Plan for both Boards.

Future priorities

The Boards have agreed to continue work on these priorities for 2019/20.

LSCB: The Board is of the view that there has been some good progress in relation to neglect. Discussion at the Pan Beds neglect group has highlighted the positive steps Luton has made in trying to identify impact. The Board is reassured the quality of practice is improving; however, some significant incidents have led to the commissioning of two SCRS which are neglect related. The Board therefore wants to ensure that progress is maintained and that learning from the two SCRs does enable further practice and organisational improvement.

In relation to mental health, there is a range of work to be undertaken in order to ensure the range of support is available to young people and their families. Allied to that is ensuring appropriate training is available to practitioners across all sectors.

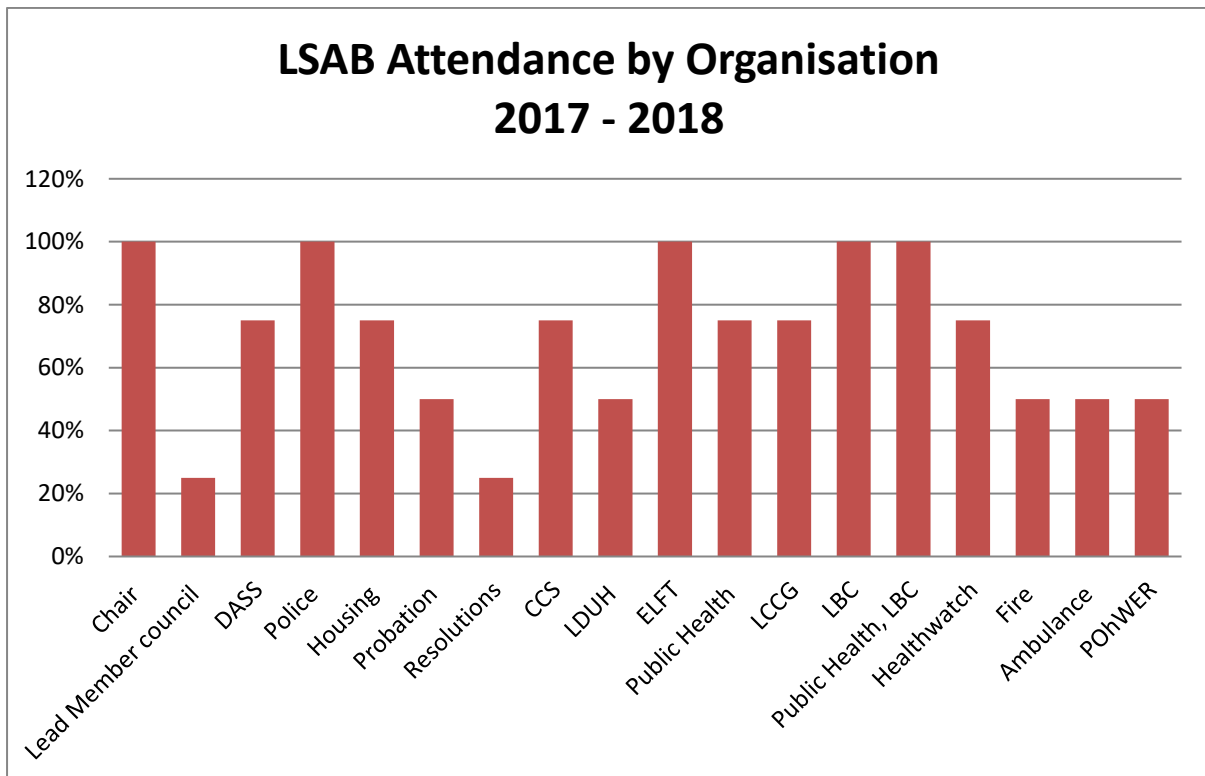
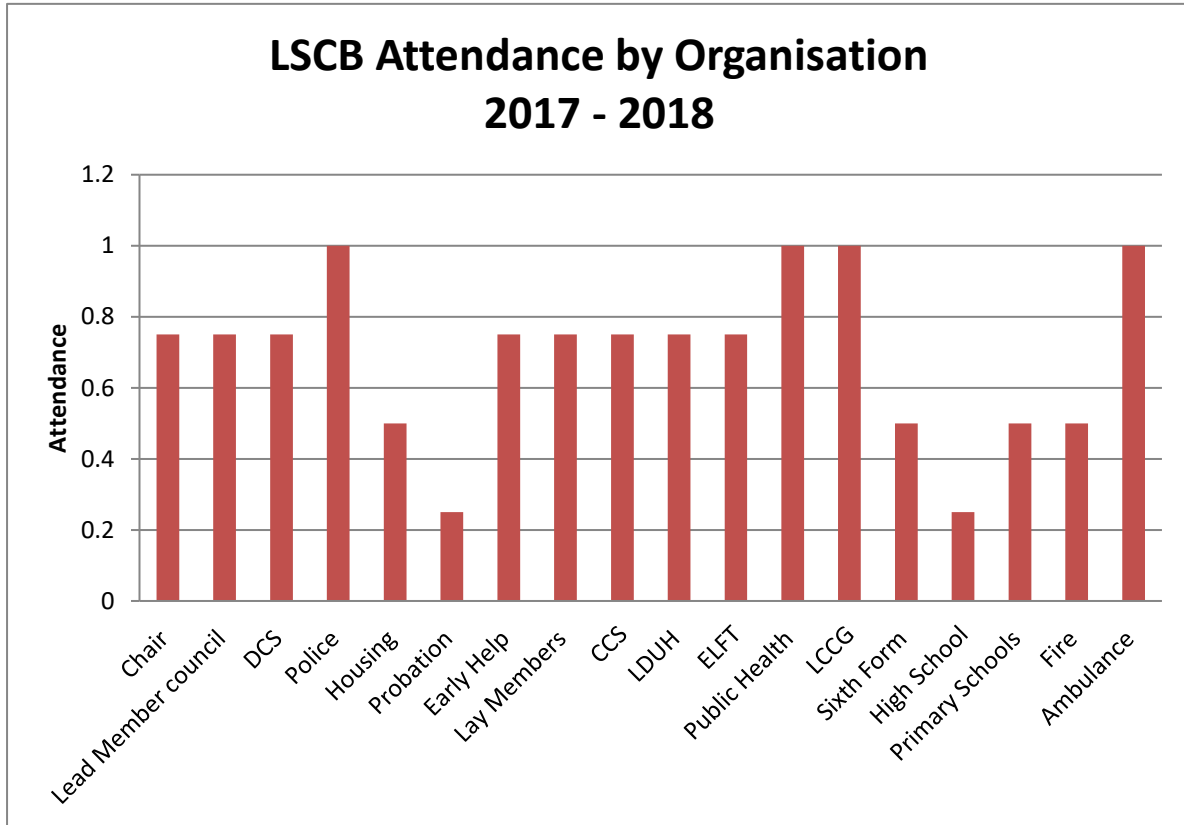
The work on missing has flagged some gaps. The Board therefore wishes to ensure that work is undertaken by partners on filling some of the gaps and in ensuring quality of practice is consistent.

LSAB: The Board has made progress in improving governance and is using data and audit to assure itself of the quality of practice. The Board recognises that it has only made partial progress in embedding the principles of Making Safeguarding Personal; hence it agreed it needed to maintain the priorities.

Both Boards are supporting the work of engaging with the faith and community sectors. One of the tasks identified is the need for better communication on what safeguarding is, and the role that all people can play in providing support and advocacy to enable a person/child to disclose the harm or abuse they are experiencing.

5. BOARD FUNCTIONING

Agency attendance at Board 2017- 2018



BOARD REPORTS

SARs/SCRs

Both Boards are required to investigate when an adult/child in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The Boards are required to appoint an independent reviewer and publish a report on the findings.

LSCBs publish Serious Case Reviews (SCR) (from Sept 2019 they will be called child safeguarding practice reviews - CSPRs).

LSAB publish Safeguarding Adult Reviews (SAR)

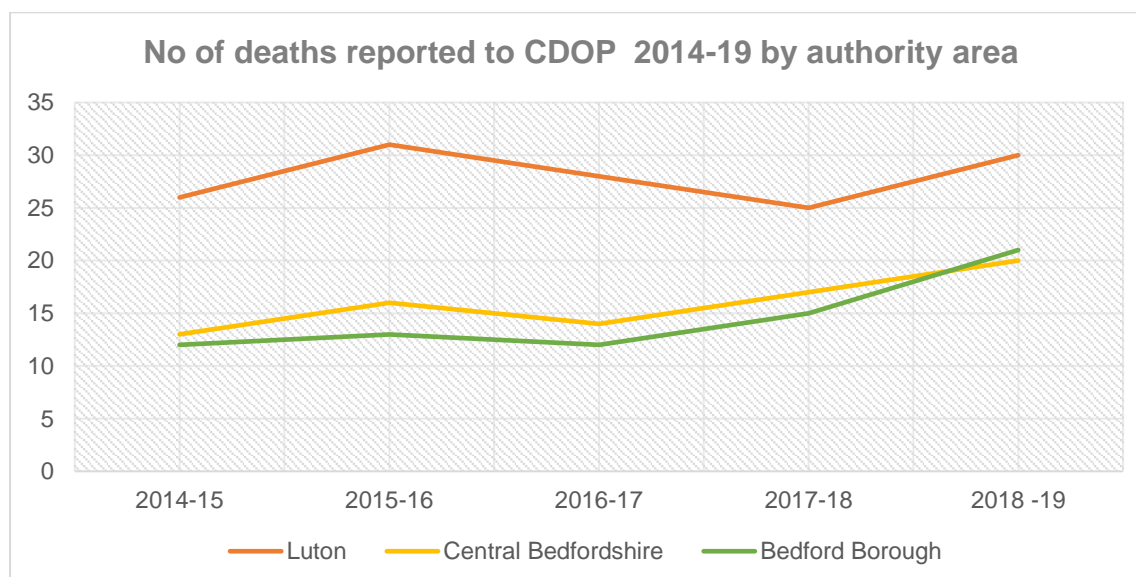
In this period the LSAB published a SAR on Helen (which was summarised in the previous LSAB annual report). The Board currently has three SARs underway, which will be published in 2019/20.

The LSCB completed two SCRs in 2018/19 which are due to be published, and has three SCRs underway which are due to be published in 2019/20.

THE LEARNING DISABILITY MORTALITY REVIEW (LEDER)

Is a new initiative by NHS England, which requires all deaths of a person with a learning disability to be reviewed to check whether there was something that went wrong, and to promote learning so that people receive the best quality of care. This has been put into place and in the summer of 2019 the first reviews were being discussed.

CDOP



During the period April 2018 until March 2019 there were 71 deaths reported across Bedfordshire - this is a notable increase on the previous year; it is not possible to comment on this trend in comparison to national data, as figures have not been released since 2017. Unexpected deaths accounted for 22% of the total deaths reported which is similar to the previous year where 21% of the deaths were unexpected, but a notable decrease from 2016-17 where 31% were in this category. The highest proportion of cases in 2018-19, were

closed under the category (7) of chromosomal, genetic and congenital. These accounted for 32% of the total reviews, which is an increase on the previous two years

In Bedfordshire the number of deaths of children under one year of age reviewed during 2018-19 was 67%; this is similar to the previous year (65%), but higher than in 2016-17 (55%). Of the deaths reviewed at panel this year 54% were male and 46% were female, which is similar to last year whereby 52% were male and 48% female. This is a similar trend to the national data which shows that boys' deaths account for over half of the deaths reviewed (56%). Whilst in the year 2017-18 the percentage of deaths reviewed from Asian backgrounds was 33%, this year (19%) is similar to national trend of 15% (2017 statistic).

PRIVATE FOSTERING - awaiting

LADO - awaiting

BOARDS' BUDGETS

Income

	LSCB	LSAB
LBC	155,479	£92,337.60
Health agencies CCS, LDUH, ELFT, LCCG	87,073	72,984
OPCC	21,767	18,246.00
BENCH/NPS	1,639	
CAFCASS	550	
Total	266,508	
Specific projects		
NHS	10,000	
OPCC (County Lines)	26,500	
Total	303,008	£183,567.60
Underspend 17/18 carried forward	43,967	

Expenditure

	LSCB	LSAB
Salaries - Permanent Staff	124,698	58,184.52
Salaries - Agency Staff		88,897.60
Transport Expenses	1,535	293.57
Premises (including room hire)	2,286.40	1,441.80
Supplies & Services	20,558.08	57.27
Communications & Printing	1,745	716.00
Board Business Costs - Chairs, SCR's, L&I Events etc	157,277.75	33,976.84
Total	308,100	183,567.60

Board Members in 2018/19

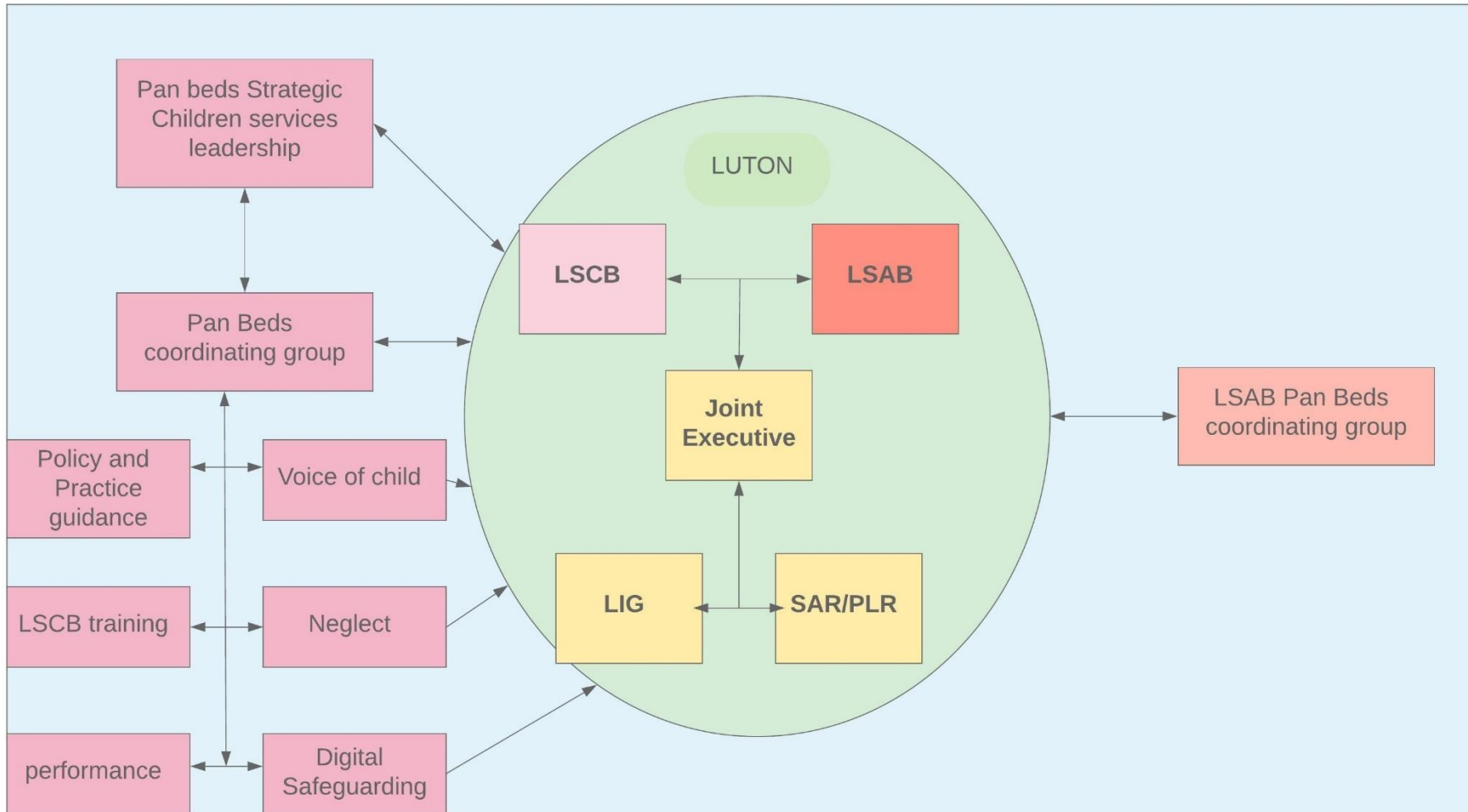
LSCB Board Members	LSAB Board Members
Fran Pearson (Independent Chair)	Fran Pearson (Independent Chair)
Amanda Lewis (LBC - Director People Directorate)	Amanda Lewis (LBC - Director People Directorate)
Vijay Patel (LSCB/LSAB Business Unit Manager)	Vijay Patel (LSCB/LSAB Business Unit Manager)
Julia Sirett (Cambridge Community Services NHS Trust)	Julia Sirett (Cambridge Community Services NHS Trust)
Anne Murray (Luton Clinical Commissioning Group)	Anne Murray (Luton Clinical Commissioning Group)
Liz Lees (Chief Nurse Luton & Dunstable Hospital)	Liz Lees (Chief Nurse Luton & Dunstable Hospital)
Sarah Wilson (East London Foundation Trust)	Michelle Bradley (East London Foundation Trust)
Agnes Adentan (East London Foundation Trust)	Claire McKenna (East London Foundation Trust)
Pat Oparah (LCCG Safeguarding Lead and Named Nurse Children)s	Julie Hall (LCCG Safeguarding Lead and Named Nurse Adults)
David Tamarro (East of England Ambulance Service, NHS Trust)	David Tamarro (East of England Ambulance Service, NHS Trust)
Kimberley Campbell-Lamb (Lay Member)	Emma Sullivan (Lay Member)
Rashida Din (Lay Member)	Kausar Ahmad (Lay Member)
Amal Ibrahim (Lay Member)	
Cllr Mahmood Hussain (LBC Portfolio Holder for Children and Young People)	Cllr Javed Hussain (LBC Portfolio Holder for Adult Social Care)
Graham Cole (LSCB Legal Advisor)	Vicky Sowah (LBC Legal Advisor Adults)
Glen Denham (LBC Quality Assurance & Performance Improvement Lead)	Glen Denham (LBC Quality Assurance & Performance Improvement Lead)

Gerry Taylor (LBC Corporate Director Public Health)	Gerry Taylor (LBC Corporate Director Public Health)
Damian Elcock (LBC Children Service Director)	Maud O'Leary (LBC Head of Adult Social Care)
Patrick Odling-Smee (LBC Head of Service, Housing & Community Living)	Patrick Odling-Smee (LBC Head of Service, Housing & Community Living)
John Wrigglesworth (LBC Head of Service Support, Challenge and Intervention)	Samantha Parker (LBC Service Manager Strategic Adult Safeguarding)
Adesua Osime (LBC Head of Area Integrated Services, Prevention & Early Integration)	Vicky Hawkes (LBC Neighbourhood)
Stuart Auger (Bedfordshire Fire Service)	Stuart Auger (Bedfordshire Fire Service)
John Murphy (Bedfordshire Police Service)	Mohammed Aziz (Bedfordshire Police Service)
Catherine Howes (CAFCASS)	
Alison Harding (Bedfordshire Probation)	Alison Harding (Bedfordshire Probation)
Chris Day (Head Avenue Centre)	
Clare Banks (Luton Sixth Form College)	Lucy Nicholson (Healthwatch Chief Executive)
Lisa Shepherd (Central Beds College)	Asimah Naseem (POhWER)
Jo Travi (Head Bushmead Primary School)	
Monica Austin (Head Ashcroft High School)	
Sarah Pollard (Head Southfield Primary School)	

Timeline for LSCB/LSAB 2018 - 2019

March 2018	Pan Beds Multi-Agency Audit Mental Health Audit
April 2018	LSAB Risk & Protective factors workshop
May 2018	Beds Police Multi agency workshops on MASH
	LSAB Multi agency audit
June 2018	Seminar to discuss the findings of an independent evaluation of the implementation of Graded Care Profile 2
	Pan Beds LSCB Mental health conference
	LSAB Development day
9 July 2018	Pan Bedfordshire Children and Young Person Missing audit
July 2018	Newcastle SCR/SAR Learning Review
Aug 2018	SAR on Helen published
Sept 2018	LSAB Multi agency case audit
October 2018	Pan Beds Multi agency audit of use of Graded Care Profile 2
	LSCB Section 11 Roundtable
Oct 2018 – March 2019	Campaign on neglect rolled out across the county. delivered in partnership with the NSPCC. Focus on reaching adolescents with information and sources of support around neglect.
Nov 2018	LSCB Pan Beds CSE conference
	LSCB Voice of the Child workshop for professionals
27 February 2019	Pan Bedfordshire CSA Audit Child sexual abuse in the Family environment
March 2019	LSCB Pan Beds CSA audit
March – May 2019	Performance of County Lines drama production to high schools across Luton funded by Office of Police and Crime Commissioner

Appendix C: Relationships between the Boards and Pan Bedfordshire work



Pan Bedfordshire LSCB Multi-agency Graded Care Profile 2 (GCP2) Audit 2018

This summary is aimed at managers and practitioners working with children and young people and provides information about the re-audit of the GCP2 and the key findings & recommendations from the audit so please share with your colleagues.

Background

Working Together to Safeguard Children (2015) requires Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files. Neglect is a priority for each of the Bedfordshire LSCBs and the use of the Graded Care Profile 2 has been implemented across the three LSCB areas. The Pan Bedfordshire Neglect Group is responsible for monitoring the Pan Beds Neglect Strategy and requested that a re-audit of GCP2 be completed in order to assess the impact of the tool on practice. This audit was a follow on from a GCP2 Audit completed in October 2017.

Definition

Graded Care Profile 2 (GCP2) helps professionals measure the quality of care being given to a child. It's an assessment tool that helps them to spot anything that's putting that child at risk of harm. It's important we find children who are at risk of harm as early as possible so we can get them the right help. GCP2 shows: **strengths – weaknesses - what needs to be changed**. By working out what parents can do better, it's easier for the person working with a family to get them the right support to improve the life of their child.

Aim/objective:

The audit aimed to look at decision making and consistency across Bedfordshire; the quality of care planning and any evidence of outcomes and impact of using the GCP2.

Methodology

Each of the GCP2 Leads in the 3 Local authorities picked 3 cases to be part of the audit - 1 case for a child aged 8-9 and 2 cases for children aged 11 plus

Audit Process:

The Identified cases were audited by the practitioners who undertook the GCP2 using an audit tool provided to them. On the 30th October all the agencies below came together to an as 3 multi-agency panels from the three LSCB areas and each Panel reviewed 3 cases 1 from each LSCB area.

Agencies who took part in the audit:

Central Bedfordshire Council Children's Services, Public Health and Early Help Services – Bedfordshire Clinical Commissioning Group – Cambridge Community Services – Luton Borough Council Children's Services, Early Help and Flying Start, School Improvement Team and Early Help Team – Luton Clinical Commissioning Group - Bedford Borough Council Public Health, Children's Services and Early Help Team – Bedford Hospital – Bedfordshire Police - Pan Bedfordshire LSCB Training Unit

Did you know that poor oral health could be an indicator of neglect?

Poor oral health impacts on children and families wellbeing. It suggests wider health and social care issues such as poor nutrition, obesity, the need for parenting support, and in some instances safeguarding and neglect. Children who have toothache or who need treatment may have to be absent from school.

Public Health England

Healthmatters Levels of tooth decay in England



A quarter of 5-year-olds have tooth decay with on average 3 or 4 teeth affected



The majority of tooth decay in children under 6 was untreated

There were 7,926 episodes of children aged under 5 years having 1 or more teeth extracted in hospital because of tooth decay

