Safeguarding in Luton

The Annual Report for Luton Safeguarding Adults Board

2022 – 2023 Annual Report

April 2024

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INDEPENDENT CHAIR - INTRODUCTION

It is with great pleasure that I present Luton's Safeguarding Adults Board's Annual Report for 2022/23. The report highlights the work carried out by the Board and its Partners, reflecting their commitment to the safety and wellbeing of adults with care and support needs. All partners are working towards the vision that no one should have to tolerate, or be exposed to abuse, neglect, or exploitation.

Safeguarding continues to be challenging and complex in Luton, and like many areas across the country we have seen the health and social care system having to cope with increases in demand. We have seen increasing volume and complexity of safeguarding issues and concerns where individuals experience severe and multiple disadvantages, including homelessness, domestic abuse, substance abuse, mental health, alcohol abuse, contact with the criminal justice system and exposure to sexual exploitation. These themes continue to be highlighted and analysed in a number of commissioned Safeguarding Adult Reviews (SARs).

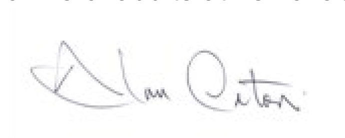
The purpose of a SAR is to identify improvements to be made to prevent deaths or serious harm occurring again. These reviews seek to inform effective learning and reduce the recurrence of similar incidents. This report highlights the 5 SARs that were undertaken by the Board in this reporting period. As I mentioned in last year's report, it is still taking some time to embed the learning into practice. I will continue to monitor the progress of learning from reviews to ensure learning is embedded and practice is improved.

During this reporting period the Board has also undertaken several multi-agency audits, where areas of good practice and areas for further development have been identified. These audits have highlighted that in the main partner agencies work well together. However, they also emphasised that we need to improve our approach when completing Mental Capacity Act Assessments, Making Safeguarding Personal and having a greater understanding of cultural competence. These audit findings remind us that every adult we support should be treated as an individual and by providing person centred approaches, we will achieve the best possible outcomes.

We are also working across other partnership boards including the Luton Safeguarding Children Partnership, the Luton Community Safety Partnership and the Luton Health and Wellbeing Board to ensure we are all coordinated in our approach to protecting and supporting adults at risk of abuse and neglect.

In conclusion, there are many strengths to the safeguarding adults' partnership in Luton. I have found a partnership that is open to scrutiny and challenge and one that strives to continually learn and improve practice. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged.

Finally, may I take this opportunity to thank all the organisations and individuals in the public, voluntary and private sectors who work tirelessly across Luton to improve the safety and quality of life of adults at risk of abuse and neglect.



Alan Caton OBE
Independent Chair

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1. EXECUTIVE SUMMARY

The overarching purpose of Luton Safeguarding Adults Board (LSAB) is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The LSAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in '*Making Safeguarding Personal*'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

CORE DUTIES

The LSAB has three core statutory duties. It must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria.

This annual report is structured to demonstrate how the LSAB has met these requirements.

KEY FINDINGS

The information in this report demonstrates how the LSAB has progressed its work from its intentions last year through to its achievements in the current year. The LSAB has continued to work on the established priorities during in 2022/23.

This annual report describes the work undertaken to seek assurance about the effectiveness of single agency and multi-agency adult safeguarding in Luton and to take forward the priorities in the strategic plan for practice development and sector-led improvement.

Board agendas have contained the presentation of assurance reports, as anticipated in the strategic plan, covering topics such as:

- Cybercrime
- Domestic Abuse
- Emotional Wellbeing and Mental Health

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- Implementing the learning from SARs
- Making Safeguarding Personal
- Board governance and structures
- Learning from reviews and experience

As part of its mandate to seek assurance about the effectiveness of adult safeguarding, the Board has received performance reports at each meeting, the overall summary of which is contained in this annual report. Work has been completed to understand what performance data is helpful, in addition to an independent audit of adult safeguarding practice within the local authority's adult social care department, which has proved especially informative and useful.

Robust interrogation of performance data will continue to be a feature of this Board's work. Completing safeguarding adult reviews, when the criteria in section 44 Care Act 2014 are met for either mandatory or discretionary reviews, is a third statutory duty.

This annual report provides the detail of the safeguarding adults review (SAR) published during the year and the implementation of the action plans, one of which is being monitored jointly by the Board and Luton Drug & Alcohol Board. The Board has also conducted a thematic SAR, publication of which is awaiting the conclusion of an inquest. An integrated SAR/Domestic Homicide Review (DHR) is nearly concluded and will await evaluation by the Home Office before publication. The Board has benefited greatly from contributions from family members and subjects of SARS in understanding how agencies worked with them and could make improvements to achieve agreed outcomes.

An integrated SAR / Child Safeguarding Practice Review (CSPR) is also underway which has significant learning for 'Whole Family' approaches. This was a key focus of our Joint Practice Day in January 2023 to ensure that practitioners across children's and adult services work collaboratively. The Board has revised a number of policies including its hoarding policy and escalation protocol and have reviewed the role of VARC to ensure effective practice for those working with vulnerable adults with complex and challenging presentations.

The Board has been actively monitoring the implementation of the recommendations from a Board review and other learning activity, such as learning for its audits. These have included themes such as Section 42 Timeliness Audit, Mental Capacity Act 2005, Legal Literacy and Cultural Competence. An ongoing theme across this year has been a continuation of our work on mental capacity, recognising that the understanding and use of the Mental Capacity Act (MCA) continues to be a challenge (as evidenced in both our local and nationally published Safeguarding Adults Reviews).

The LSAB has used its performance and scrutiny data to learn more about themes such as self-neglect, legal literacy, and the multi-agency aspects of section 42 enquiries timeliness through data analysis and audit. As part of its Covid-19 recovery plan, it has re-established key groups linked to its governance and priorities. This includes the Pan Beds Steering Group and Pan Beds Policy and Procedure Group. The LSAB and its partners has made progress in embedding the principles of Making Safeguarding Personal and maintaining this as an overarching priority weaved through all aspects of its works.

The LSAB has increased its communication of what safeguarding is through planned campaigns, and provided training around the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing. A very positive development this year for LSAB has been the establishment of our LSAB Voluntary

Subgroup. The LSAB acknowledges and thanks those colleagues on this new subgroup who are helping to bring a greater focus on this critical part of the LSAB's work.

RECOMMENDATIONS

LSAB SCRUTINY AND PERFORMANCE SUBGROUP

New metrics for the LSAB Scorecard and single agency highlight reports around:

- Cultural Competence
- Cybercrime and mate crime
- Drug and alcohol use
- Exploitation
- People subject to safeguarding enquiries MSP requirements.
- Person Centred Engagement
- SAR and rapid reviews
- Self Neglect and Hoarding
- Suicides following discharge to assess
- Transitional Safeguarding
- The impact of poverty

JOINT CASE REVIEW GROUP

- SAR Learning Development Day to be held to evaluate the impact of the activity undertaken against SARs over past two years in Q3
- Review the action plans from rapid reviews held in previous years
- Conclude and publish the ongoing reviews

JOINT EXECUTIVE GROUP

- Implement the revised structures and evaluate effectiveness of delivery plans
- Oversee the LSAB Strategic Plan and evaluate effectiveness
- Oversee delivery of the planned new accessible safeguarding website and online multi-agency safeguarding procedures which includes escalation pathways

JOINT LEARNING AND IMPROVEMENT GROUP

- Audit of section 42 enquiries conducted for mental health reasons under provider arrangements in Q1.
- Multi-Agency Drug and Alcohol audit in September 2023/24 which will be added for wider consideration and to link with the Adult D action plan evaluation.
- Development of audit schedule for whole of 2023/24
- Disseminate learning from audits and reviews in including escalation
- Deliver training on themes emerging from reviews and performance information

LSAB STRATEGIC BOARD

- Set strategic vision and direction holding partners to account for their contribution to safeguarding effectiveness

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- Receive assurance reports and provide challenge and scrutiny to ensure safeguarding effectiveness
- Ensure the LSAB has sufficient resources to meet its statutory requirements and core duties
- Develop the role of the LSAB Coproduction group to ensure there is real participation and engagement with the VCSE sector and those with lived experience.

Beverley McConnell
LSAB/LSCP Strategic Business Manager

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2. THE ROLE OF THE SAFEGUARDING BOARD IN LUTON

LSAB BOARD PARTNERS

The Board has the following organisations as statutory members and safeguarding partners:

Bedfordshire, Luton & Milton Keynes Integrated Care Board	**Bedfordshire Police**	**Luton Borough Council (*including Adult Social Care, Housing and Public Health*)**
Bedfordshire Fire and Rescue Service	**Cambridgeshire Community Services**	**Department of Work and Pensions**
East of England Ambulance Service	**East London NHS Foundation Trust**	**Healthwatch Luton**
Luton and Dunstable Hospital Trust (now Bedfordshire NHS Hospital Trust)	**National Probation Service**	**Voluntary Community Sector (*including Age Concern UK, Noah, ResoLUTiONs CGL*)**

Strategic Vision: The LSAB sets out its strategic vision for Luton to be a place where no one should have to tolerate, or be exposed to, abuse, neglect, or exploitation.

The Safeguarding Principles: The work of the Board is driven by the safeguarding principles, set out in the Care Act 2014:

- **Empowerment:** LSAB are working with partner organisations to firmly establish the working principles of Making safeguarding personal for practitioners in adult services across Luton.
- **Prevention:** The Board has used a safeguarding prevention group to bring together partners to discuss cases which cause concern. Alongside that, it is working with the Local Safeguarding Children Board on engaging with the community and faith sectors to improve their understanding of safeguarding and how they improve their practice in working with vulnerable people.
- **Proportionality:** The Board uses data on referrals for safeguarding and the outcomes to scrutinise the quality of services. There is evidence from the teams that deal with safeguarding enquiries that they are trying to ensure that people are supported and redirected to more appropriate services rather than safeguarding.
- **Protection:** The Board has used data and audit to review the timeliness of responding to adult safeguarding enquiries. Subsequently, all partners are actively monitoring the timeliness, and setting out actions to deal with any significant delays.
- **Partnership:** The Board has supported the move for Luton's Multi Agency Safeguarding Hub (MASH) to deal with adult safeguarding enquiries as well as children's. The MASH consists of partners from the Police, Luton Clinical Commissioning Group and the Local Authority children and adult services, adopting a think family approach to safeguarding.
- **Accountability:** The Board, through its performance and audits, can identify good practice and set out measures when practice needs to be improved.

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The LSAB is chaired by an Independent Chair to ensure accountability, effective governance, and the diligent working of the board with all partners and across all agencies to champion and promote the prevention of abuse and neglect to adults.

The LSAB Strategic Board meets four times per year and is responsible for making sure that agencies work together effectively to help keep vulnerable adults in Luton safe from harm and neglect, prevent abuse and neglect, and to protect their rights.

LSAB STRATEGIC OBJECTIVES

The LSAB Annual Report 2021-2022 set out that, while the Board had made progress in improving its governance and was using data and audit to assure itself of the quality of practice, it recognised it needed to undertake further work in these areas. The LSAB agreed to:

- **continue its work on the already established priorities** during in 2022/23 as detailed below.
- **use its Scrutiny and Performance space to learn more** about themes such as **self-neglect, legal literacy,** and the **multi-agency aspects of section 42 enquiries timeliness** through **data analysis and audit**.
- as part of its Covid-19 recovery plan, it needed to **re-establish key groups linked to its governance and priorities**. This includes the Pan Beds Steering Group and Pan Beds Policy and Procedure Group as there is a need to refresh several pathways and procedures across Luton and the Pan Beds Space including the **hoarding pathway and use of VARAC for complex presentations**.
- The LSAB and its partners had made partial progress in embedding the principles of **Making Safeguarding Personal** and agreed to maintain this as an overarching priority weaved through all aspects of its works.
- The LSAB determined it also needed to **ensure better communication of what safeguarding is**, and the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing.

LSAB Priorities for 2022-2023
Cybercrime
Domestic Abuse (Joint priority across Pan Beds adults and children's partnerships)
Emotional Wellbeing and Mental Health (Pan Beds joint priority)
Implementing the learning from SARs
Making Safeguarding Personal

LSAB Structures to support delivery
LSAB Strategic Board
Luton Joint Safeguarding Executive (shared with Luton Safeguarding Children Partnership (LSCP) to review cross cutting themes)
Luton Joint Learning & Improvement Group (joint with LSCP)
Luton Joint SAR/CSPR Group (joint with LSCP)
LSAB Scrutiny & Performance Group
LSAB Voluntary Sector Group
Pan Beds Steering Group (joint with CBBB SAB to review cross cutting themes)
Pan Beds Police and Procedures Group (joint with CBBB SAB)
Themed Task & Finish Groups to take forward identified themes

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The full LSAB Strategic Business Plan can be found here:

The LSAB meet their statutory objectives through a continuous improvement cycle of:

1.	Setting out annual priorities for assurance and improvement
2.	Measuring the effectiveness of local safeguarding arrangements
3.	Ensuring that safeguarding practice is person-centred, proportionate, and focused on improving outcomes
4.	Supporting partners and enabling them to work collaboratively to prevent harm and abuse
5.	Seeking assurances of continuous improvement with regard to safeguarding arrangements both as singe agencies and as a partnership
6.	Undertaking learning and driving improvements from Safeguarding Adults Reviews.

3. ACTIVITY UNDERTAKEN AGAINST LSAB PRIORITIES

CYBERCRIME

During 2022-23 the LSAB received limited partnership data around Cybercrime which did not provide a good picture of the prevalence of this issue for vulnerable adults in Luton. The LSAB Scrutiny & Performance Group have through their action plan for 2023/24 agreed new metrics for the LSAB Scorecard and single agency highlight reports.

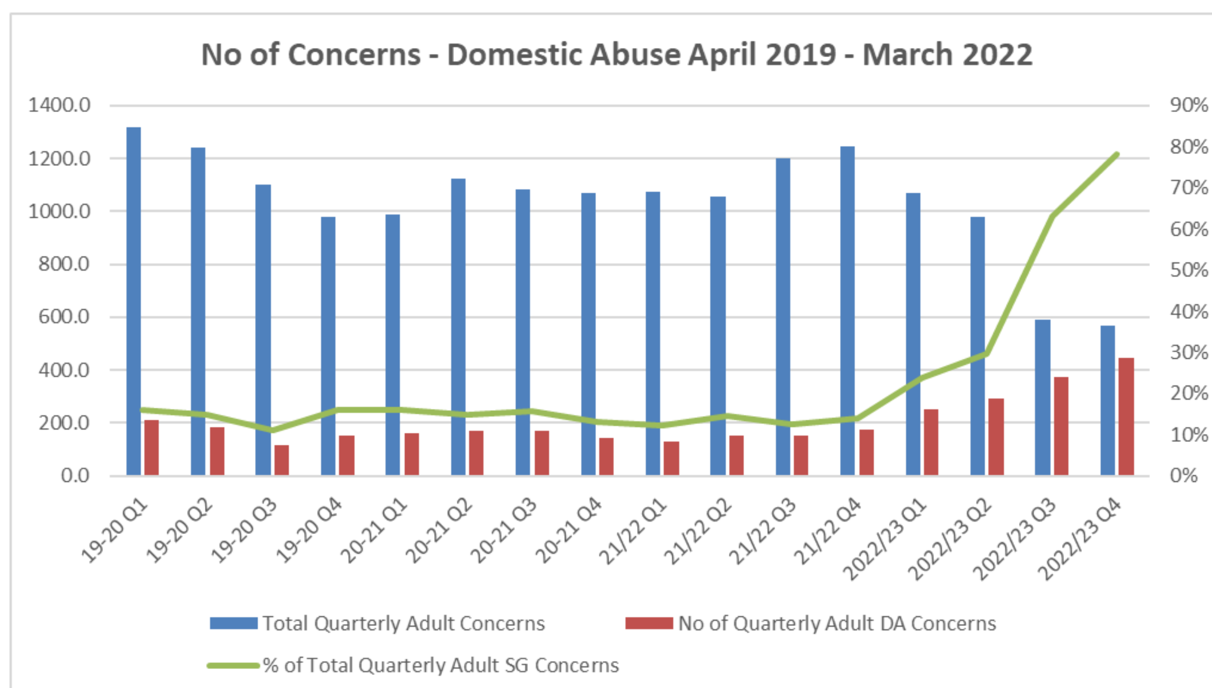
The LSAB published information on its website regarding the risks of cybercrime and how to stay safe online and in the digital environment. The LSAB plans in 2023/2024 to broaden its reach through the LSAB Voluntary Sector Group by increasing its membership and taking a themed approach where the group can lead on getting key messages to and from service users and community groups.

DOMESTIC ABUSE

The LSAB shares a joint priority across Pan Bedfordshire as well as with the Luton Safeguarding Children Partnership (LSCP). The LSAB is keen to understand the prevalence of domestic abuse for those adults who have care and support needs and also for those who have parenting or caring responsibility. The LSAB receives data as part of its scorecard regarding the trends and patterns for domestic abuse and assurance from single agencies as to their role in supporting people experiencing or at risk of domestic abuse.

The 2022/23 scorecard data for domestic abuse shows that, while the total number of safeguarding concerns halved in Q3 and Q4, the percentage of safeguarding concerns relating specifically to domestic abuse began to increase quarter by quarter, from 24% in Q1 to 78% in Q4. While domestic abuse concerns have been steady over the last three years the increase has been attributed to greater awareness of the needs to raise safeguarding enquiries for vulnerable adults at risk of domestic abuse.

FIGURE 1: NO OF CONCERNS DOMESTIC ABUSE MARCH 2019 - APRIL 2023



Luton Domestic Abuse Strategic Programme Group: provides oversight and traction in the development of the Domestic Abuse Act 2021 requirements across Bedfordshire and Luton. The purpose of the group is to:

- Ensure a co-ordinated multi-agency approach to address concerns about domestic abuse in Luton.
- To provide consistency in approach, explore and agree joint working opportunities and common messaging.
- To maintain a strategic overview of domestic abuse across Luton

The LSAB is represented on the **Luton Domestic Abuse Strategic Programme Group** who coordinate and provide strategic oversight of the local activity around domestic abuse in Luton on behalf of the Luton Community Safety Partnership. In 2022/23 highlight reports were provided on:

a. Agreement and launch of revised commissioning process for Domestic Homicide Reviews.
b. *Domestic Abuse, Recovering Together (DART)*[1] Programme has been re-commissioned.
c. Domestic Abuse Champions programme
d. Domestic Abuse Housing Award
e. Focus on adults and children in families and their lived experiences.
f. Further measures around safe accommodation, non-fatal strangulation, and consent to serious harm for sexual gratification not being a defence.
g. Independent Domestic Violence Advocates have been employed and now looking to employ two KIDVAs[2]
h. Perpetrator Focus and work to reduce male violence against women and girls.

[1] https://learning.nspcc.org.uk/services-children-families/dart

[2] https://bedsdv.org.uk/get-help/embrace-child-victims-of-crime-kidva-support/

i. Provision of safer accommodation
j. Survivors/victims voice with a Voice of Survivors group being implemented.
k. Work has been started to provide domestic abuse training to staff within the Home Office provided refuge accommodation.

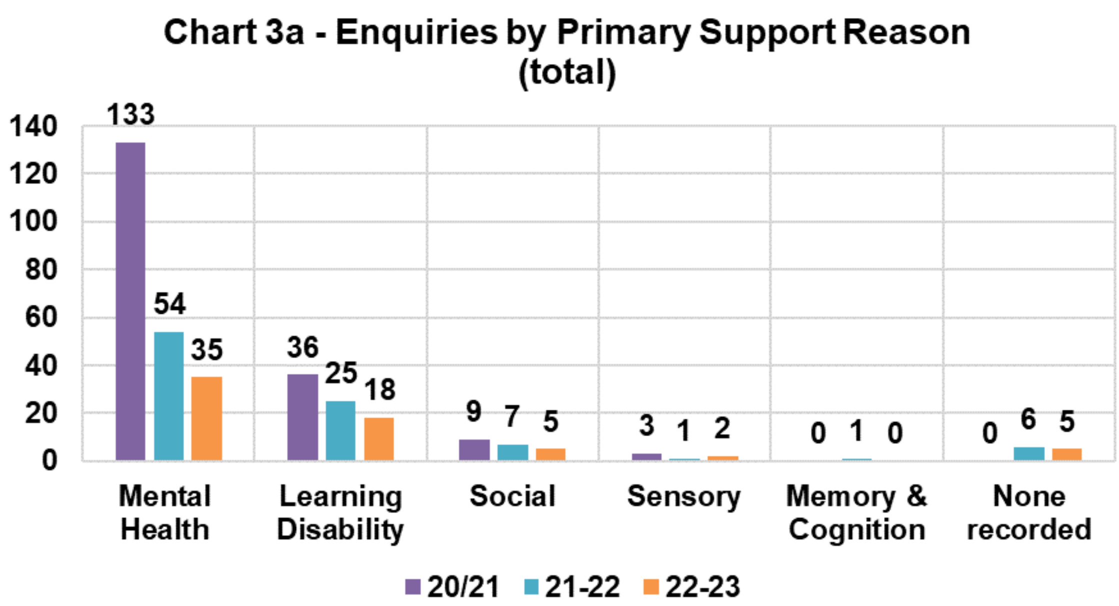
Domestic Abuse – Sixteen Days of Action: As part of the 16 Days of Action to End Gender Violence campaign, the Bedfordshire Domestic Abuse Partnership held a community led event in Luton Town Centre on 25 November 2022. This highlighted that there continues to be a terrible and tragic reminder of the devastating impact of gender-based abuse and violence towards women and girls. There were 109 women and girls' names on the #*TooManyNames* list of those who had lost their lives to male violence over the previous 12 months. The event sent a strong and clear message from all local partners that addressing gender violence is everyone's business and that no one individual or organisation can tackle the issue alone.

The Bedfordshire Domestic Abuse Partnership and the High Sheriff of Bedfordshire also launched their annual Domestic Abuse Recognition Awards scheme during this year's 16 Days of Action against Gender Violence Campaign. The LSAB used their website to highlight this campaign and provide links to Bedfordshire Domestic Abuse Partnership BDAP website.

EMOTIONAL WELLBEING AND MENTAL HEALTH

The LSAB identified through its Scrutiny & Performance activity that Mental Health remained its highest primary support reason in 2022/23 although the numbers of S42 enquiries had dropped by 74% in 2022/23. The LSAB sought assurance through single agency highlight reports as to how agencies were identifying and responding to vulnerable adults with mental health needs.

FIGURE 2: NO OF ENQUIRIES BY PRIMARY SUPPORT REASON MARCH 2021 – APRIL 2023



With regards to the involved person's support need, Physical Support was the most common followed by Mental Health Support. This is also the same as the previous year. The assurance reports received on partner approaches to mental health showed that there were some

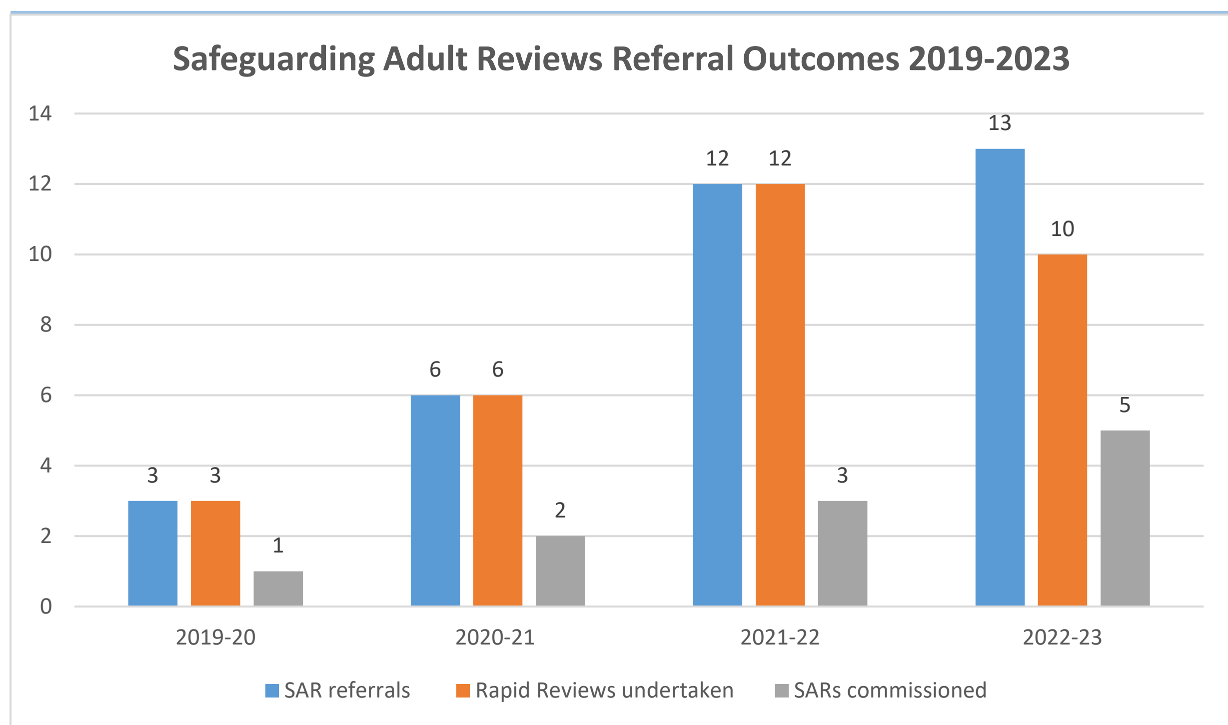
inconsistences that required further exploration. In March 2023, it was agreed to complete a deep dive on the section 42 enquiries conducted for mental health reasons under provider arrangements and this audit will take place in Q1 of 2023/24.

The LSAB has also contributed to developing the Luton collaborative all age mental health strategy which will be published in 2023/24. Tackling inequality in Luton using Marmot's health equity approach and UNICEF's child friendly town Luton has been designated a 'health equity town'. This recognises the health inequalities experienced by many of the residents of Luton. Some people experience more poverty, less employment, poorer housing, less social support, more exclusion, and more discrimination linked to being from any type of minorities group, such as their race or ethnicity or disability, or sexuality, or lived experience status, and these can lead to poorer health, as well as more difficulty accessing health services, and high-quality health care.

IMPLEMENTING THE LEARNING FROM SARS

Section 44 of the Care Act states that the LSAB must conduct a Safeguarding Adult Review (SAR) if the criteria are met. This is so lessons can be learned where an adult with care and support needs has died or been seriously harmed, abuse or neglect is suspected and there is concern around how well agencies worked together. It is about improving practice not to blame any individual or organisation.

FIGURE 3: SAFEGUARDING ADULT REVIEW REFERRAL OUTCOMES MARCH 2019 - APRIL 2023



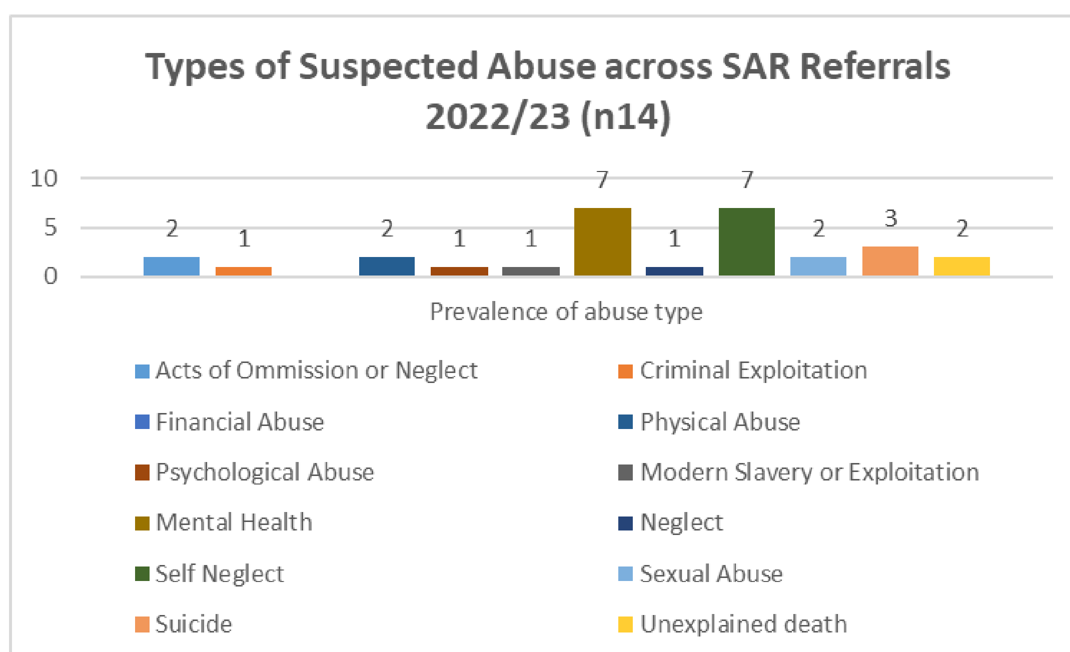
The Board received **13** SAR referrals in **2022/23** and completed **10** rapid reviews (which is an initial scoping of the review in a timely way to extract the immediate and emerging learning for system improvements in multi-agency safeguarding of adults.

The **four** SARS commissioned involved **seven** individuals and were:

- **Adult Anna** (Integrated SAR/DHR): concluded awaiting Home Office sign off for publication.
- **Adult Kiara** (Incomplete suicide, interfamilial abuse, and honour-based violence): due to conclude in 2023/24
- **Thematic Self-Neglect SAR** (involving two individuals who died in separate circumstances but with similar elements of medical self-neglect and hoarding and a further individual who died by suicide): due to be concluded in 2023/24.
- **Family T** (Integrated SAR/CSPR - self-neglect, disability, and child neglect): due to conclude in 2023/24.

THEMES FROM REFERRALS, RAPID REVIEWS & SARS

FIGURE 4: TYPES OF SUSPECTED ABUSE ACROSS SAR REFERRALS MARCH 2022 - APRIL 2023



The above chart shows the types of suspected abuse and factors occurring within the referrals received. The **four** SARs commissioned in 2022-23 all including multiple factors. Self–Neglect and Mental Health remain the highest occurring factor in referrals for consideration of a Safeguarding Adults Review. While Financial Abuse, Learning Disability and Transitional Safeguarding did not feature as factors in SAR referrals in 2022-23.

THEMES FROM CONCLUDED SARS

In 2022-23 the LSAB concluded a review of safeguarding case and concluded SARs that resulted in serious injury or death and considered the learning over a twelve-month period. These cases were not initially referred but were later identified for either a safeguarding enquiry (s42, CA 2014) or a Safeguarding Adults Review (SAR).

These cases, combined with two historical SAR reports, were included as the sample for a thematic analysis. In each case there were key episodes or breakdown in the system which may have contributed to a failure to prevent harm to an individual or a member of the public. Areas such as risk management, communication, information sharing, pathways and the role of multi-agency working were all examined and considered with an aim of evidencing improving safeguarding practice.
Theme 1: Working with complex needs: focus on Mental Heath Discharges from Acute Settings
Theme 2: Making Safeguarding Personal: Hearing the Adult at Risk's (AAR) Voice
Theme 3: Inter-agency Agreement of Shared Standards of Safeguarding Practice (including single-agency practice) and LSAB oversight
Theme 4: LSAB Governance, Quality Assurance Framework and Standards of Safeguarding Systems
Theme 5: Pathways of Communication between Strategic and Operational Domains / Interagency Domains (Health and Social Care)

Considerable work has been undertaken within the partnership around improving shared understanding of thresholds, discharge pathways and Vulnerable Adults Risk Assessment Conference (VARAC) role. The work on Making Safeguarding Personal and Co-production begun in 2021/2022 and has continued into 2022/2023 with two new subgroups being set up. Work has also continued using the key concepts below on the interface between the Care Act 2024, Safeguarding and Mental Capacity Act 2005:

- Promoting Engagement / Discussion (promoting professional curiosity)
- Sharing Best Practice and Expertise (including Legal Literacy)
- Empowering the frontline
- Pathway for Listening and Learning

As part of the dissemination and implementation of learning the LSAB Board has:
a) Fed learning into Pan Bedfordshire's LSCB training unit workshops and events.
b) Brought learning into Luton Borough Council the festival of Learning and partnership practice development days.
c) Produced executive summaries of each SAR and its findings.
d) Received assurance reports at LSAB Strategic Board.
e) Impact is being checked through the analysis of data and theme-based audits as highlighted previously.
f) Luton Multi Agency Audit subgroup.
g) Worked with Central Bedfordshire and Bedford Borough Safeguarding Adults Board (CBBB SAB) to promote and evaluate the learning from their MAX SAR.
h) The LSAB has also worked on a thematic approach to its work under the following headings.
    - Direct Practice
    - Interagency Practice
    - Organisational Practice
    - SAB Governance

SARS PUBLISHED IN 2022/23

The LSAB published the SAR report into Adult D in July 2022, which can be found here:
Adult D SAR Full Report July 2022
Adult D SAR Report Briefing July 2022

The recommendations and their outcomes are detailed below:

Recommendation A: Substance misuse service commissioners and Resolutions, as the local substance misuse provider, should ensure that the specific needs and impacts of chronic, change resistant and dependent drinkers are identified in needs assessments, addressed in any future commissioning plans, and addressed in internal service development plans. In particular, investment in assertive outreach capacity for this group of clients is required.

- *ResoLUTiONs have two specialist assertive outreach teams. These have been created to respond to the increased need to be adaptable to the needs of chronic and change resistant service users.*
- *The Rough Sleepers Initiative Team (RSI) which was created in 2020. This team is comprised of 1 team leader, 4 substance misuse outreach navigators and 1 outreach worker.*
- *The High Intensity Team (HIT) evolved around 2021 to cover its current criteria of: Sexually exploited, Unmanaged mental health, Frequent Emergency Department/ hospital presentations, engaging in an untraditional way with support services in Luton (including ResoLUTiONs), Attending in crisis at ResoLUTiONs and is currently or has previously experienced domestic abuse. This team is comprised of 1 team leader and 3 outreach recovery workers.*
- *These teams are also being informed, updated, and trained utilising the current guidance provided from Alcohol Change UK and well as ARBD and Blue Light training. Adult accommodation pathways for individuals with drug and alcohol issues has commenced. Implementation of Complex cases review panel (for drug and alcohol). The terms of reference (TOR) and the panel membership is agreed.*

Recommendation B: Substance misuse service commissioners should review the local alcohol detoxification pathway to ensure that it is fit for purpose and adheres to NICE guidance. In particular, it should be flexible in its response to drinkers with complex presentations.

- *Detoxification is incorporated into the ResoLUTiONs CGL treatment and recovery contract. ResoLUTiONs CGL policy was revised and updated March 2023 and training on this is delivered to all staff at induction, as well as workshops and training delivered by ResoLUTiONs CGL clinical team. Formal policy written and disseminated.*

Recommendation C: Those who commission and plan the development of alcohol treatment services need to ensure that frontline staff consider residential rehabilitation as an option for clients and that it can be accessed without undue barriers. In particular, a path from inpatient to residential rehabilitation should be possible for complex clients.

- *Commissioners and CGL have reviewed the internal and external pathways to residential rehabilitation. New protocol and pathways are signed off by stakeholders.*
- *The redevelopment includes implementation of the Social Worker position to oversee rehab pathways and procedures, ensuring timely panels. Resulting in a reduction in waiting times for service users, ensuring improved engagement and higher numbers of those accessing treatment, with an increase in potential successful completion.*
- *CGL whole service ethos of consideration of residential rehabilitation from the beginning of treatment will continue, further embedding the practice as supported by the new protocol.*

Recommendation D: All appropriate frontline professionals (and their managers) require training on the application of the Mental Capacity Act to people who are dependent on alcohol. This should include a recognition of the role of executive capacity and, in particular, that the physical health impacts of drinking can affect cognition and impulse control and therefore mental capacity. It is important that this training includes lessons from this and other SARs and other serious case reviews.

Recommendation E: The SAB should ensure training is available to enable participants to make effective use of multi-agency meetings and on the most effective way to chair and manage these meetings. Simply holding multi-agency meetings is not enough, they have to be forums which can deliver action and where:

- ❖ colleagues can professionally challenge each other.
- ❖ the membership is sufficiently senior to drive action and
- ❖ there is a means for escalating concerns about failures in the care pathway.

Recommendation F: The SAB should ensure that there are robust escalation pathways which can support agencies to try more creative approaches to managing complex and potentially costly clients. The Plymouth Creative Solutions group offers a model. This will require a mapping of existing multi-agency groups and a decision on an escalation pathway including timeframes for a response to any escalation.

- *Recommendations D, E and F all relate to findings relating to the complexity of Adult's needs and the application of legislation, procedures, and pathways to ensure a robust multi-agency response that respond to challenge and escalation of multi-agency disputes regarding outcomes. This has required a triangulated response to these recommendations both within the LSAB remit but also within the Drug and Alcohol Board. As a result:*
  - ❖ Outreach teams have completed Alcohol Related Brain Damage (ARBD) training in 2022/23. This training has been rebooked to complete with all ResoLUTiONs staff with invitations being extended to local partners. Three half day ARBD training days with a capacity of 30 each have been booked. Two full days, Bluelight, train-the-trainer days have also been booked for Outreach teams and selected local partners.
  - ❖ Following this and other SARs and serious case reviews ResoLUTiONs are also looking to explore a specific ARBD pathway and have been discussing this with Alcohol Change UK, the national approach is in development.
  - ❖ Luton Borough Council, Adult Social Care and Legal Services have delivered training to a cohort of 60 practitioners regarding the application of the Mental Capacity Act including for the role of executive capacity in those with ARBD and other alcohol related illnesses.
  - ❖ The LSAB has produced practice guidance regarding holding effective multi-agency meetings, professional challenge, and an escalation pathway. A session on 'Professional Curiosity: questioning and challenging' was presenting to over 80 frontline practitioners and safeguarding managers as part of its Practice Day in January 2023.
  - ❖ The existing Pan Beds Vulnerable Adults Risk Assessment Conference (VARAC) which had already undertaken mapping of multi-agency groups to manage complex and potentially costly clients. The VARAC terms of reference were reviewed to ensure:
    - VARAC enables a grounded appreciation and intimate understanding of specific client circumstances and need and an important triaging tool for high priority need.
    - VARAC is a mechanism of escalation with positive flow on effects for other client care needs, allowing the client to more quickly engage on a path out of vulnerability.
    - VARAC elevates clients to other safeguarding areas, which results in a better refinement of the processes or actions that have to be undertaken to address complex client needs.
    - VARAC would be reviewed in twelve months to seek evidence of impact.

Recommendation G: The SAB should ensure that people experiencing domestic abuse in the context of homeless and marginally housed communities receives the same response as other people experiencing abuse.

- *The LSAB has written new guidance for working with domestic abuse including for those who are homeless. The LSAB has also received assurance from the Domestic Abuse Luton Programme Group regarding the multi-agency response to domestic abuse for those who are homeless or in marginally housed communities.*

Recommendation H: The SAB should ensure that practitioners across all relevant agencies receive training in how to support a "victimless" approach to a prosecution. Practitioners will need to understand what evidence would support such a prosecution, how that can be recorded and reported in a way that supports the Police's efforts to undertake a prosecution.

- *Inter-agency training was provided to two cohorts of practitioners on the evidential burden of proof for criminal prosecutions and the use of evidence led (victimless) prosecutions. There are plans to repeat this training in 2023/2024 and to consider the impact of this on discontinue of prosecutions due to the lack of victim cooperation.*

Recommendation I: Housing Services and Adult Social Care should consider whether specialist accommodation with on-site support should be commissioned locally. This is likely to be from a specialist provider.

- *The Domestic Abuse Luton Programme Group (DALPG) action plan includes provision of suitable housing for those that need safe accommodation. Further work is required in this area and the LSAB will continue to work in partnership with other strategic bodies / partnerships responsible for delivering domestic abuse support and safe accommodation.*

Recommendation J: The Clinical Commissioning Group need to consider whether there are ways in which the extent of brain injury or cognitive impairment in clients like Adult D can be understood without the expectation of three months sobriety.

- *The Supplementary Substance Misuse Treatment & Recovery Grant (SSMTRG) was born out of Dame Carol Black's from Harm to Hope review and supports the government's 10 year drug strategy to cut crime and save lives. The Strategy sits under the Serious Harm Board and is coordinated by the Drug & Alcohol Board by Public Health.*
- *The 3 key indicators of this strategy and the shared responsibility required from partners towards achieving these aims through this action plan and the Luton Drug & Alcohol Partnership Board are:*
  - *Increasing numbers in treatment*
  - *Improving Continuity of Care, and*
  - *Reducing Drug and Alcohol Related Deaths*
- *Part of this strategy includes prevent, treat and recover and covers work to increase use of appropriate legislation to support the care needed for this target group.*

Recommendation K: Those who commission and plan the development of alcohol treatment services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group, or new legislation to better meet their needs.

- *The LSAB in conjunction with Luton Drug & Alcohol Board and Public Health continue to consider lobbying national government. They continue to work towards better use of existing and new legislation, among frontline staff. With an aim to improve access to services and support for service users. We continue to be part of the Bluelight Project UK and support initiatives to help us understand better support for service users.*

These recommendations have been regularly reported at Strategic Board and at other strategic boards who have responsibility for commissioning some of the services required. There are clearly areas of improvement as highlighted within this report. However, the theme of safe accommodation still needs to be addressed and the LSAB is scrutinising the approach alongside the Community Safety Partnership and DALPG.

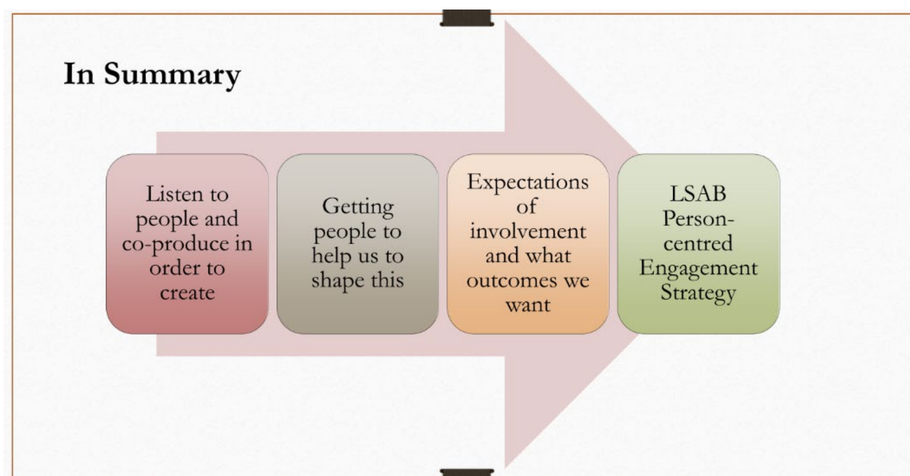
Further testing of the impact of activity will be undertaken at a SAR Learning Development Day which has been profiled for later in 2023/24. This will review all learning and impact of action plans from the recent and past SARs. There is also a plan for a Multi-Agency Drug and Alcohol audit in September 2023/24 which will be added for wider consideration and to link with the Adult D action plan evaluation.

MAKING SAFEGUARDING PERSONAL

Making Safeguarding Personal (MSP)[3] is not simply about gaining an individual's consent, although that is important, but also about hearing people's views and wishes about what they want as an outcome. The approaches of agencies and services to adult safeguarding should be person-led and outcome-focused. The Care Act 2014 emphasises a personalised approach to adult safeguarding that is led by the individual, not by the process.

The LSAB has agreed an approach which has been shaped by the **Care Act 2014's** statutory guidance, which encourages a Co-Production approach through partnerships. The mechanism is intended to:

a. assist the Luton Safeguarding Adults Board (LSAB) with raising awareness of Adult Safeguarding and the role of the LSAB, in the Luton Community
b. support the Board to learn more about Adult Safeguarding, from the individual's perspective, by having direct access to the individuals, who have experience of Adult Safeguarding's system or processes in Luton, whose lived experience make them *Experts by Experience*.
c. provide an opportunity for the individual's voice to be heard and to be central, so as to influence and shape the strategic pathways of the LSAB.
d. Work alongside Voluntary Organisations, who are working with people, using services, or caring for someone who has experience of safeguarding in Luton can share trends of concerns, so that these views can be reflected in the work the LSAB does, including preventative work.
e. e) promote communication and learning between partners, promoting MSP (Making Safeguarding Personal) in the strategic work the LSAB conducts and give a strong 'voice' to the vulnerable adults that we support.



It is vital that the adult feels that they are the focus, and they have control over the process. This means that people are given opportunities at all stages of the safeguarding process to say what they would like to change. A key focus for 2023/24 will also be to gather data on whether people subject to safeguarding enquiries were asked about the outcomes they would like to achieve as part of the process.

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[3] 3 Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances as outlined in 'Making Safeguarding Personal'

5. SCRUTINY AND PERFORMANCE ACTIVITY

UNDERSTANDING THE CONTEXT OF LUTON – DEMOGRAPHICS

Population

- The estimated population of Luton is 225,300 with a younger than average population.
- Luton is densely populated with a higher population density than some London boroughs.
- Luton's population increased by 11 per cent between 2011 and 2021.
- Luton is an ethnically diverse town with more than half of the population being from non-white ethnic backgrounds.
- There is a very high level of population change since 2011 with 50% churn. There are an estimated 150 languages and dialects spoken in Luton.
- Life expectancy is lower in Luton than the national figure for both males and females. Female life expectancy is higher than male life expectancy in Luton.
- Population forecasting models have been projecting the town's population to rise with the largest increases in the older age groups.

Economy

- Luton's economy had been growing strongly prior to the Covid-19 pandemic. The airport has contributed to this.
- There had been strong wage growth in Luton, but wage growth has not kept up with inflation.
- Low paid, unstable work has also increased in the town leading to an increase in in work poverty.
- There is a higher proportion of low skilled jobs in Luton than the nationally.
- The Covid-19 pandemic has had a strong impact on Luton with unemployment increasing at a faster rate than nationally and impacting the more deprived areas most severely.

Employment

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

Education

- 1 in 10 working age adults have no formal qualifications.
- 67% of 16–64-year-olds educated to level 2 or above compared to 78% nationally.

Housing

- The median house price in Luton is £258,000 – 34% increase since 2015.
- The Median house price is 8.5 times the median gross annual earnings for residents.
- Luton has a higher-than-average proportion of residents privately renting.
- There are high levels of over-crowding and homelessness in the town.
- House prices and rental costs have been rising, putting pressure on household budgets.
- 15,000 additional homes required by 2031.

Outstanding Location

- Located at the centre of the Oxford-Cambridge arc.
- 22 minutes from London by rail.

Poverty and deprivation

- Luton is ranked as the 70th most deprived (out of 317) local authority in the country.
- Areas in Farley, Northwell and South are in the 10 per cent of most deprived areas in the country.
- The sixth most deprived area in East of England by Indices of Multiple Deprivation, Biscot, Dallow and Saints wards are within the 10% most deprived in the country.
- 26% of working households are in relative Poverty.

Skills

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

Health and Wellbeing

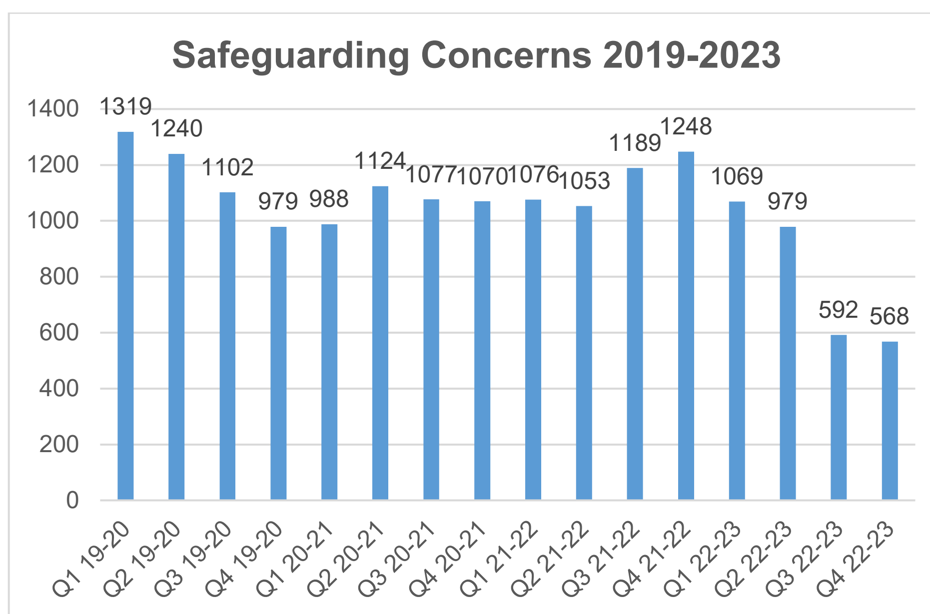
- Life expectancy gap of 6.9 years between women in Luton's most deprived and most affluent wards – for men, this gap is 5.1 years.
- Male life expectancy in Luton one year less than the national figure.
- The Board and its subgroups have looked at the demographic analysis in relation to ethnicity, as 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 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%).

Further population information for Luton regarding ethnicity, age and gender breakdown can be found here:

PERFORMANCE DATA

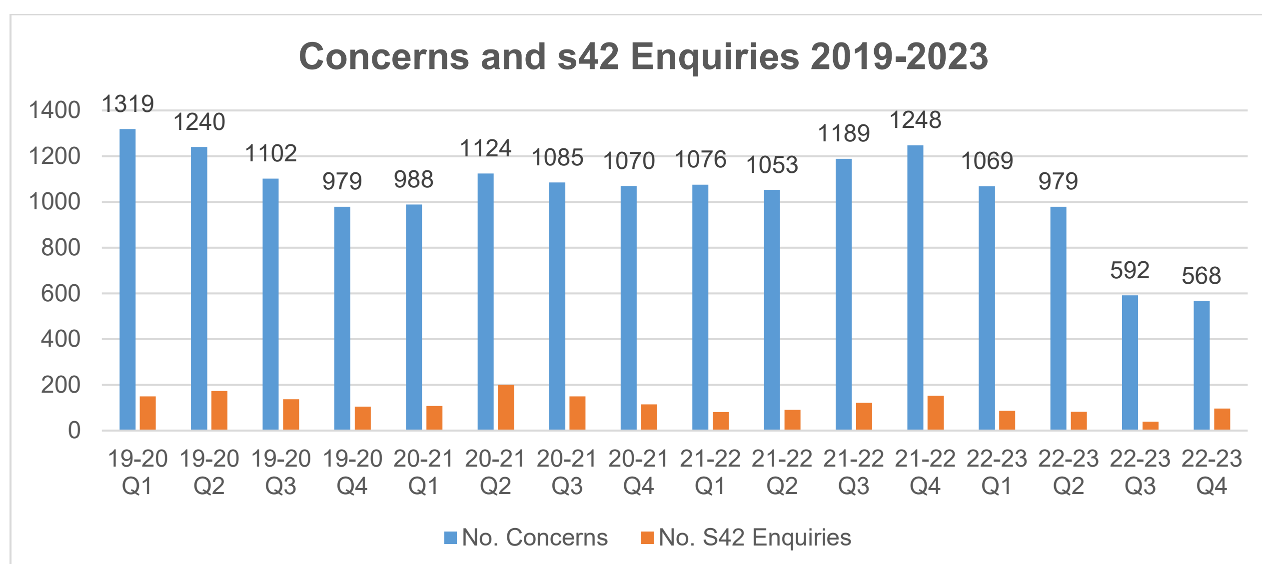
The LSAB Scrutiny and Performance Subgroup reviewed performance data that provided an overview of the approach to safeguarding and promoting the welfare of adults with care and support needs. The below data is from Luton Borough Council adults social care service.

FIGURE 5: SAFEGUARDING CONCERNS MARCH 2019 - APRIL 2023



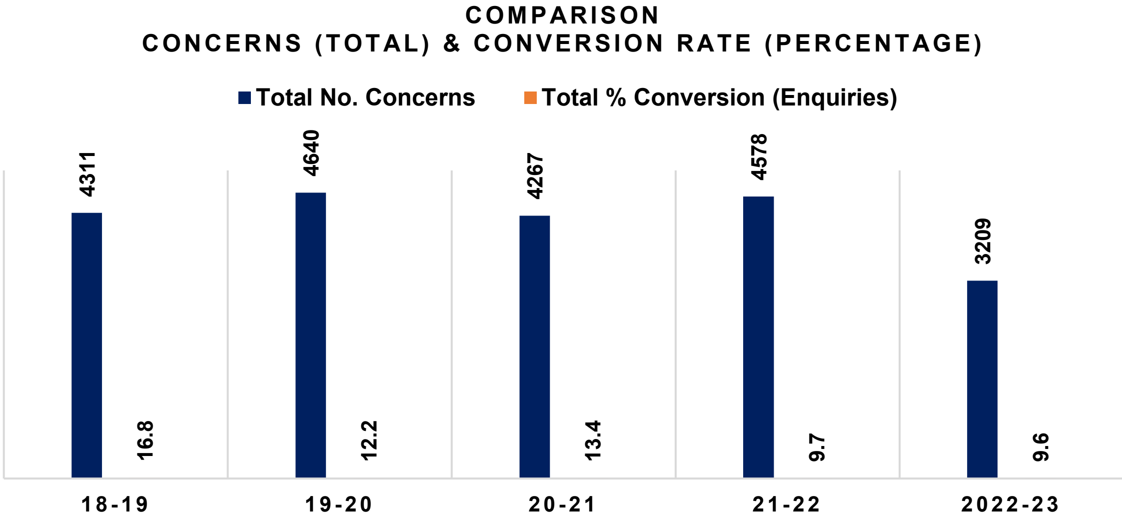
In the period 2022–23, there were **3208** concerns raised, compared to **4566** for 2021-22 equating to a **29%** reduction. The reduction in concerns has generally been explained by a robust screening process which has directed adult social care requests sent via the Adults MASH to the appropriate support and assessment front door. Prior to redirecting these referrals back to the referrer or other support service appropriate risk assessments were conducted including a safe handing over process.

FIGURE 6: SAFEGUARDING CONCERNS AND SECTION 42 ENQUIRIES MARCH 2019 - APRIL 2023



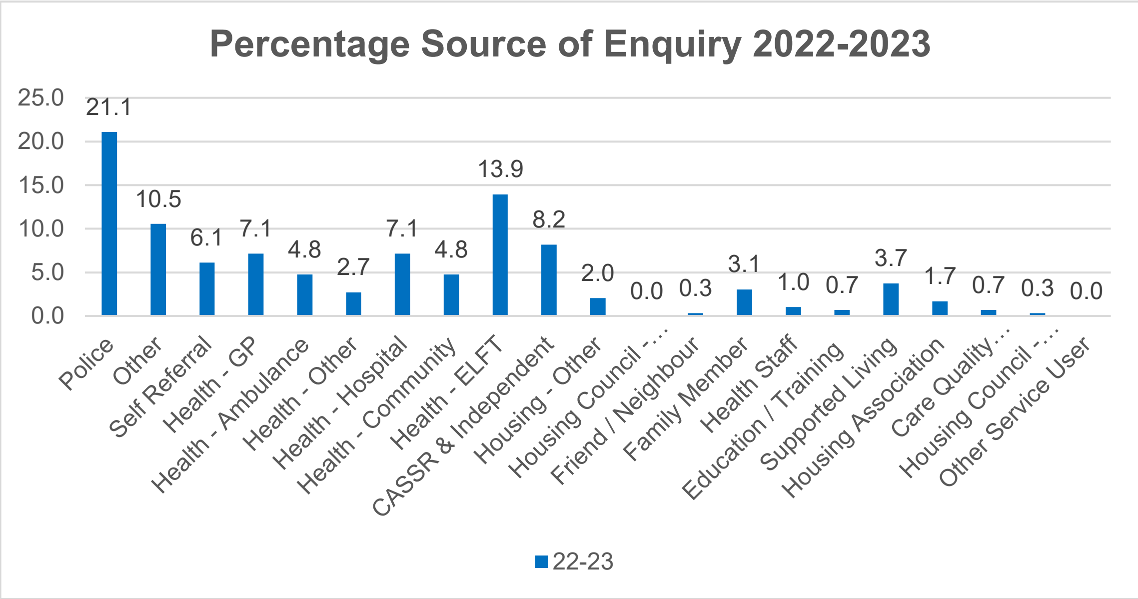
For 2022-23 of the **3208** concerns received, **306** concerns proceeded to a S42 Enquiry, resulting in a final conversation rate of **9.6**%. There is no recognised target for conversation rate, and it is widely acknowledged that authorities approach it differently, however the national conversion rate average is currently **34%**. The Conversation rate against the national average in 2022-23 is closer to the average and it is anticipated that there will be further change in 2023-24 due to partnership training regarding concerns being raised, where other interventions would be more warranted.

FIGURE 7: COMPARISON SAFEGUARDING CONCERNS(TOTAL) AND CONVERSION RATE (PERCENTAGE) MARCH 2018 - APRIL 2023



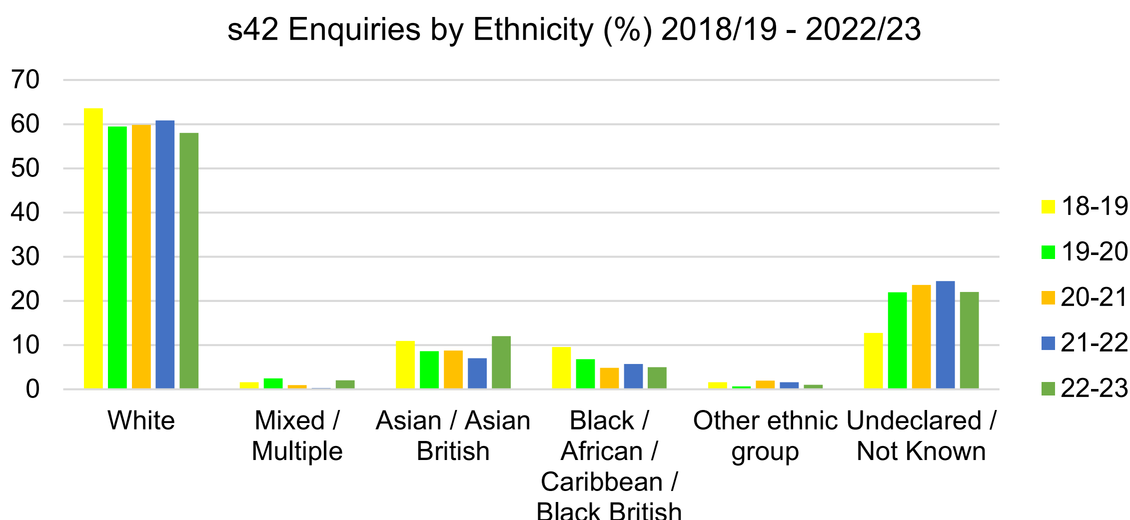
Most referrals to adult social care are appropriate referrals however the conversion rate remains low because most of these concerns do not require further enquiries under safeguarding, but more appropriate care management interventions such as increasing care support, reviewing support and funding suitable accommodation.

FIGURE 8: PERCENTAGE SOURCE OF ENQUIRY MARCH 2022 - APRIL 2023



Historically the Police raised most safeguarding concerns, with a small percentage being converted to section 42. These peaked in 2021- 22 at **32.8%** but the rate has been reduced to **21.1 %** during 2022-223. With the next highest referrer being from ELFT (who provide Community Mental Health Services) at **13.1%.** It is anticipated that referral rates from partners will continue to harmonise in 2023/24.

FIGURE 9: PERCENTAGE S42 ENQUIRIES BY ETHNICITY MARCH 2018 - APRIL 2023



In terms of ethnicity, White is the highest group for both Concerns and Enquiries, followed by Asian / Asian British and then Black / African / Caribbean / Black British. This is the same as the previous year. However, White is not the majority ethnicity which has led the LSAB to consider further work to better understand the interplay and issues of cultural competence in terms of approaches to safeguarding.

MULTI-AGENCY AUDITS

The LSAB has undertaken several audit pieces within 2022/2023 including audits on the Timeliness of section 42 enquiries, Mental Capacity, and a frontline survey on Legal Literacy. These are all themes outlined in the LSAB Annual Report 2021-2022 as needing further attention. There were also presentations regarding Cultural Competence made through the Pan Beds Harmful Practices which the LSAB and its partners contributed to.

SECTION 42 TIMELINESS AUDIT JUNE 2022

An audit was undertaken due to performance data suggesting only 6% of section 42 enquiries were completed within the locally agreed timescale of 56 days and there was a significant number that had been open more than 100 days. Many of these section 42 enquiries had been passported to provider organisations to complete. The audit looked at delayed closure of section 42 enquiries, the process for tracking those passported to provider organisations for completion, and the process for closure. The audit also looked at what is working well across agencies, and next steps now and in the future to improve the process, considering the different recording systems used across the provider agencies and adult social care.

The audit identified that the timeliness figure was inaccurate due to skewed data resulting from the other provider agency recording systems not being able to link to adult social care, requiring double entry of closure details. It was agreed that a data cleansing response would be put into place and to ensure that all people still subject to an open section 42 safeguarding enquiry still had live safeguarding concerns requiring an assessment or safeguarding plan.

Review of the MASH data in December 2022 has continued on a quarterly basis, with all agencies participating in the review of data through the LSAB Scrutiny & Performance Group. Work has also taken place to evidence improvement in the quality of recording and decision making within agencies. The performance data also led to LSAB seeking assurance on the time provider organisations are taking to complete S42 enquiries and the robustness of tracking within adult social care. Assurance reports have demonstrated improvement in both timeliness and robustness of tracking and the application of 56-day completion exemptions as required.

Strengths

- There was evidence that capacity was considered, and any decisions made on behalf of a person considered to lack capacity, were taken in line with Mental Capacity Act 2005 and Care Act 2014
- There was clear evidence of benchmark for section 42 enquiry being met.
- There was clear evidence for decisions made throughout the safeguarding process.
- Advocacy was considered in the safeguarding process in the majority of cases.
- Evidence of a safeguarding adult's conference taking place and including the relevant person was evident.
- There was clear evidence within safeguarding plans of consideration of risk to others.
- Where any less than expected practice was identified, a notification of concern was completed and sent to the relevant safeguarding lead for an MDT review.

MENTAL CAPACITY ACT 2005 AUDIT AUGUST 2022

The main aims of the audit were to measure compliance with completion of the mental capacity assessment /best interest forms in line with Mental Capacity Act 2005

Methodology

A total of 21 mental capacity assessment / best interest forms were completed and a data collection tool was used to collate the data.

The findings are summarised below in relation to the underlying principles of the Mental Capacity Act:

1. **A person has capacity until proven otherwise.**
   90% of the forms audited identified and evidenced that the person was supported to make decisions for themselves wherever possible.
2. **A person should be supported to, wherever possible, make their own decisions.**
   86% of the assessments identified all practicable steps to support the person to understand the decision to be made have been taken. However, the detail of the reasonable adjustments/ support identified and/or used within the assessment was not evidenced in the forms reviewed.
3. **If they have capacity, a person has the right to make an unwise decision.**
   95% of the assessments evidenced clear documentation of why there is doubt about the individual's capacity to make a specific decision at a specific time.
4. **Any decision made or action taken on behalf of someone who lacks capacity must be done so in their best interests.**

95% of the Practitioners had completed this part of the assessment paperwork. There was evidence in **81%** of the forms audited that the Practitioner had complied with the Best Interest checklist.

5. **Any best interest decision made must be the least restrictive option.**
   86% of the assessments identified that the decision was made in a person's Best Interests, clearly evidencing the least restrictive option chosen. However as previously noted this high percentage may in part be due to the specific reason for the mental capacity assessment /best interest forms were completed, that is, for request for authorisation for Deprivation of Liberty Safeguarding.

The audit outcomes were fed into the wider themed workstreams and reported on within the LSAB Scrutiny and Performance Group as well as the Joint Learning and Improvement Group. It has been apparent through work undertaken in 2022-23 that there are gaps in understanding of the requirements of the Mental Capacity Act 2005 and its application in practice.

LEGAL LITERACY SURVEY SEPTEMBER 2022

The purpose of the survey was to assess how practitioners use the law around the application of the Care Act 2014, Mental Capacity Act (2005) and the implementation of Liberty Protection Safeguards. This was defined into a tool that sought views and Legal literacy confidence in terms of understanding:

- Best Interest Assessments,
- Court of Protection,
- Understanding other legal options such as police powers.

The survey results are on the table below, and it was found confidence in the application of the law was a practice area where practitioners were struggling less confident. However, it was agreed we have the resources and staff are willing to intervene and to do / think creatively about legal literacy. The key issue for the board is ensuring professionals as equipped as possible and able to implement the learning into practice. The LSAB as a learning organisation wishes to bolster confidence in professional curiosity. In terms of particular areas of law practitioners told us that they wanted further support with:

- Mental Capacity Act 2005 assessments
- Whole Family Approaches and understanding Care Act 2014 and Children Act 1989 requirements for assessing eligibility of services for those adults with caring responsibilities of children as well as children transitioning into adult social care.
- The implementation of the Liberty Protection Safeguards (2018) as the proposed replacement for Deprivation of Liberty Safeguards (2009) due in October 2023.
- The difference between criminal and social care thresholds for burden of proof.

As a result, several themed practice-based workshops were held across the year to support practitioners across agencies with these areas of practice. A Joint Practice Day was held in January 2023 with 100 practitioners from both adult facing and children's service to address some of these themes. The sessions included:

- 'The importance of language': the differences between terms within adult and child facing services and possible barriers and challenges to effective practice
- 'Implementing Cultural Competence in a Think Family & Whole Family Approach': led by Dr Sharon Raymond as keynote speaker.
- 'Legal Literacy and the Law': the challenges in practice and peer reflection on solutions

- ‘Introduction to COP DoLS’: setting out the use of the Court of Protection for Deprivation of Liberties effectively ahead of plans for implementing Liberty Protection Safeguards.
- ‘Professional Curiosity’: how to reflect, question and challenge the presenting factors in cases working across the whole family.
- ‘Transitions’: working together to achieve a smooth transition from children’s to adult facing services.
- ‘Learning from SAR MAX’: https://www.bedford.gov.uk/media/5024/download?inline regarding the suicide of a young care leaver with a history of mental health problems, drug use and experiences of exploitation and cuckooing.

CULTURAL COMPETENCE

Matters of cultural competency have been reviewed and developed through LSAB Scrutiny and Performance Group and within the Pan Beds Harmful Practices. In July 2022 two cases studies of people with care and support needs at risk of forced marriage were reviewed and considered against best practice experiences. Both cases were of South Asian extraction and one case also had Learning and Disability issues. The cases were presented by the police who had been involved in both cases and explored the use of *Forced Marriage Protection Orders* and *Removal Orders* used in these cases. Key learning was how all staff working with a vulnerable person can be aware of their learning needs. Additionally, there was exploration of best practice when the vulnerable adult is receiving services from members of their own community and ensuring the focus is on their own needs and ensuring confidentially.

ENSURING BETTER COMMUNICATION OF WHAT SAFEGUARDING IS

To support the LSAB’s to improve communication of safeguarding key messages several website pages were developed. These formed the basis of individual campaigns or provided ‘golden threads’ running through the work of the board and were highlighted within LSAB Strategic Board meetings and provided as resources for sharing with practitioners. This helped to bring together the various outputs in a cohesive way, increasing the reach and impact of the board in particular areas. Broadly, the key messages can be broken down into:

1. **Awareness raising / campaigning**: these are the specific topics that the board has identified as priority messages for the coming year. This are in response to engagement, events, trends or identified needs among the key audiences. Generally, these offer short term focusses throughout the year, and change annually. LSAB also selected relevant national campaigns and awareness days to support. In 2022/23 the LSAB supported the national safeguarding week campaign which had a different theme each day and publicised material and resources on the theme on a daily basis.

2. **Training**: promoting training and learning through both formal events, informal articles and sharing resources among those working with adults at risk to improve safeguarding practice and work in strengthening preventative safeguarding practice. The LSAB offered 140 places on face-to-face training courses, 20 different free e-learning courses including adult safeguarding at level 2 and level 3, as well themed courses such as Managing Challenging Conversations, Modern Slavery and Exploitation and Awareness of Forced Marriage.

3. **Golden threads**: key messages focussed on ways of working or embedding new ideas and best practice into how we see and understand safeguarding. These are the threads that should be visible throughout the work of the board. This year's golden threads were identified as Mental capacity, Professional curiosity and Making Safeguarding Personal.

6. BOARD FUNCTIONING AND GOVERNANCE

The LSAB reviewed its existing priorities in July 2022 and started to profile areas where it needed more data or audit work to test out theories around emerging issues. These practice themes were added to the LSAB audit plan, single agency reports and scorecard development. The emerging priorities are listed below and are reported on throughout this report. The LSAB undertook a governance review, renaming and reshaping some of its subgroups This includes work jointly with Luton Safeguarding Children Board to further support culturally appropriate practice. Further work will also be considered around the training needs of the workforce on this theme in 2023/23.

Two new subgroups emerged from the LSAB's plan to re-establish key groups linked to its governance and priorities. These were:

- LSAB Voluntary Sector Subgroup
- LSAB Experts by Experience Groups.

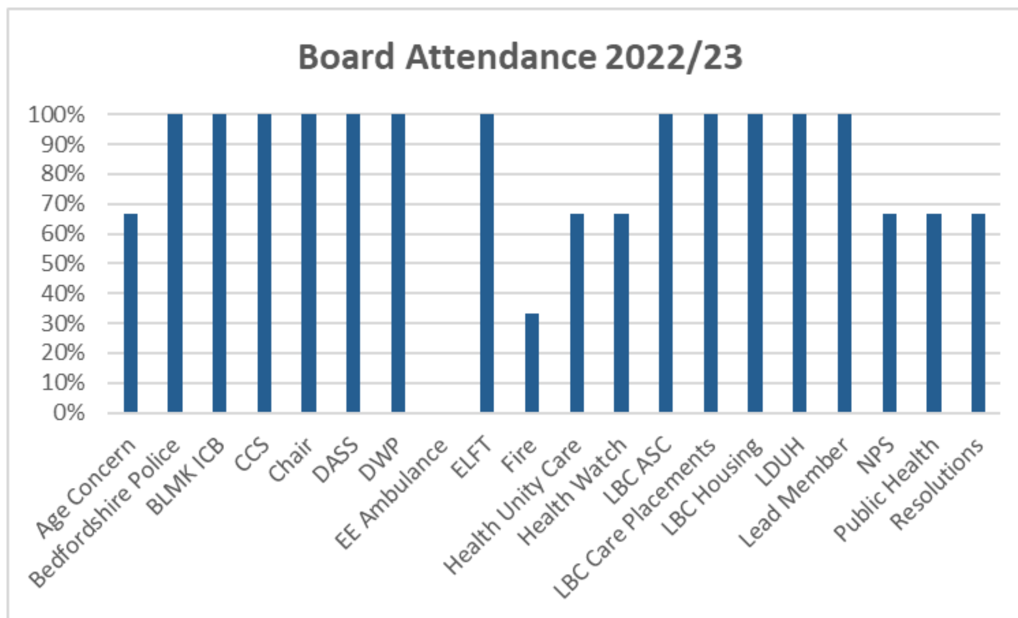
The LSAB also re-established:

- Pan Beds Steering Group
- Pan Beds Policy and Procedure Group
- Pan Beds Hoarding Pathway
- Revised VARAC TOR for supporting those with complex presentations.

These groups had been stood down during the covid-19 pandemic. Their work plans are being further developed in 2023/24 as there is a need to refresh several pathways and procedures across Luton and the Pan Beds Space. These structures will support the plans for a new online accessible multi-agency safeguarding procedures and a combined Pan Beds Safeguarding website hosting information from the LSAB, LSCP and the other Pan Beds safeguarding partnerships in one place.

AGENCY ATTENDANCE AT BOARD 2022 – 2023

FIGURE 10: BOARD ATTENDANCE MARCH 2022 - APRIL 2023

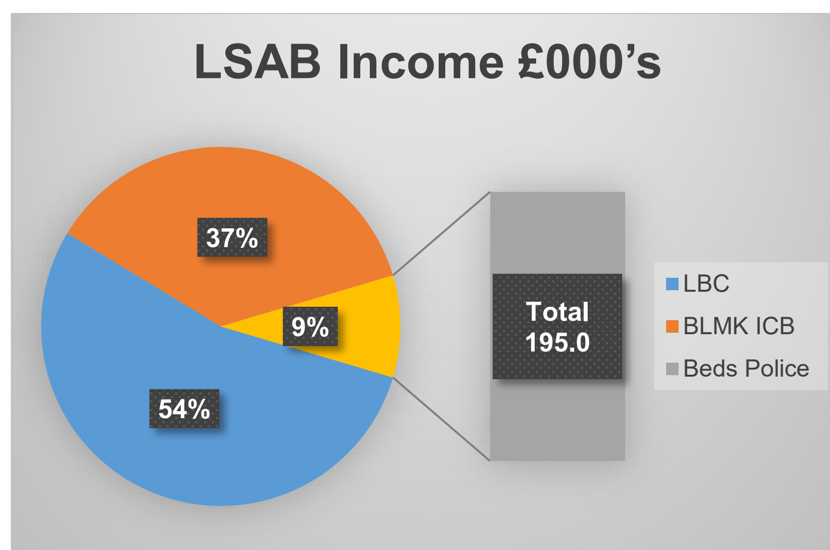


LSAB Strategic Board meetings have continued to be held via Teams and attendance has continued to be good. Some board partners have not attended strategic board meetings but have contributed fully to audits, rapid reviews and Safeguarding Adults Reviews as required.

BOARDS' BUDGETS 2022/2023

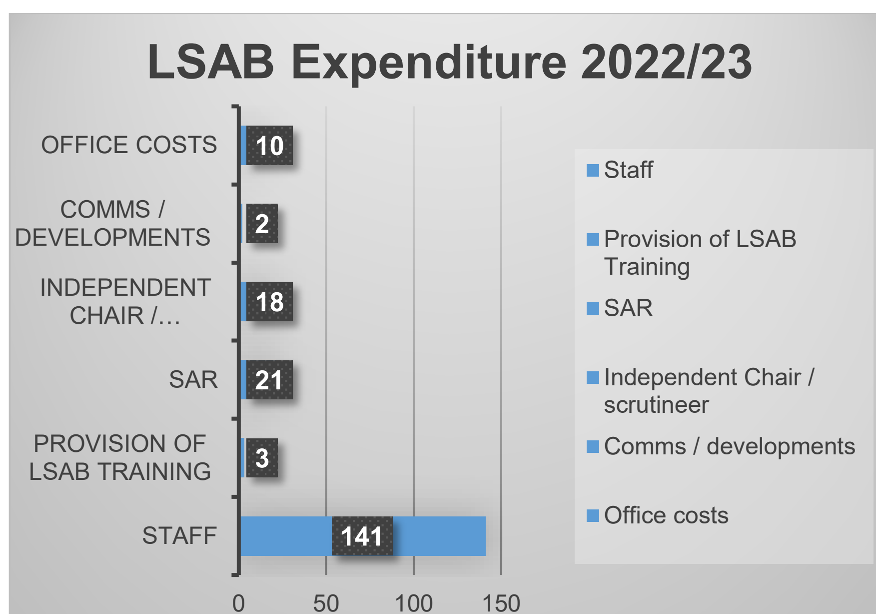
The LSAB budget has remained static over the last five years with income contributions shown below. The Local Authority provides **54%** of the income at **£105,500**, BLMK ICB provides **37%** at **£71,600** and Bedfordshire Police **9%** at **£17,900**.

FIGURE 11: LSAB INCOME MARCH 2022 - APRIL 2023



LSAB Expenditure is predominately on its staff which takes up **72%** of its budget and SARs account for 11% of spend at £18,000. Expenditure on reviews has increased significantly due to the number of reviews undertaken. The partners have sought to balance the budget by reducing spend on training and development. However, in 2023/34 should the SAR costs exceed the profiled budget statutory finding partners will be asked for additional contributions.

FIGURE 12: LSAB EXPENDITURE MARCH 2022 - APRIL 2023



7. SUMMARY OF OUR ACHIEVEMENTS AND FUTURE PLANS 2023/24

There are good working relationships with the Safeguarding Children Partnership, as we share an Independent Chair to ensure that where possible we address activities together. There is more focus and join up on the whole system response to some of the issues that affect each group such as domestic abuse, exploitation and substance misuse, and mental health. A wider protocol for joint working has been developed with shared Subgroups, development sessions and plans for joint practice development days covering cross cutting themes.

Having a shared Joint Learning Improvement Group has supported the connectivity across services and helped to identify possible gaps in legal literacy, transitional safeguarding, and cultural competence. Key assurance has been sought and evidenced around the priorities and how they have made a difference to outcomes for adults with care and support needs.

There has been a challenge for the partnership given the increase in volumes of work linked to reviews and additional pressure within the system to maintain their focus on their statutory duties confident that funding is available and at the appropriate level. This has required challenging strategic leadership, supported by the Strategic Business Manager, around the number, purpose and frequency of meetings, held both place based and across the Pan Beds partnership landscape. This has resulted in a significant

reduction in the number of meetings held across the LSAB while ensuring strong governance remains to take forward the work.

While the Board has made progress in improving governance and is using data and audit to assure itself of the quality of practice it recognises it needs to undertake further work. LSAB and its partners has only made partial progress in embedding the principles of Making Safeguarding Personal, hence it has agreed it is maintained as an overarching priority weaved through all aspects of its works. It also wishes to extend its work in the Voluntary and Community Sectors and ensure those with lived experience can offer their view on the LSAB Priorities and how well they are meeting the six safeguarding principles.

The LSAB will look to its Scrutiny and Performance Subgroup to help it describe the impact of the work of the LSAB and also to understand some of the emerging priorities from 2023/24 such as:

- Cultural Competence
- Self Neglect and Hoarding
- Person Centred Engagement
- Transitional Safeguarding
- Suicides following discharge to assess
- Drug and alcohol use
- Exploitation
- The impact of poverty

The LSAB needs to ensure better communication of the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing. The LSAB Voluntary subgroup has identified in its work plan the need to encourages co-production as a local approach that can help the LSAB meet their duties under the Care Act 2014, through partnerships and has been described as '*the relationship where professionals and citizens share power to design, plan, assess and deliver support together*'. It recognises that everyone has a vital contribution to make to improve quality of life for people and communities.

Without a doubt the focus for practitioners accessing learning has been a challenging one, both for the service in its planning of virtual delivery, and in the practitioners and services ability to consider learning and balance that, with managing the day. It has continued to be difficult to meet the multi-agency audience requirements and enable a good mix of attendance with lower numbers, due to course capacity and virtual experience limitations. It is intended to move forward with a mixture of face to face, virtual learning experiences or blended learning experiences for those courses available. There is a real challenge for the partnership to provide accessibility for its practitioners and to achieve value for money.

As shown in the budget section above, LSAB expenditure on SARs has significantly increased in 2022/23. This has meant that delivery of training and development activity was reduced to balance the budget. Another focus for 2023/24 is to ensure the balance of LSAB expenditure is switched to ensure delivery of training and development of

practice improvement across the LSAB regardless of SAR activity. The LSAB is also mindful that it needs to ensure it provides focus on specific priority areas and that it cannot spread its limited resources too wide. It also needs to secure its Business Unit establishment as it has been carrying two significant vacancies since July and September 2022 respectively as hard to recruit posts.

Collaborative working between partner agencies has improved, communication pathways still need to be more robust so that safeguarding concerns for adults within families and with caring responsibilities for children are understood and actioned effectively. Single agency safeguarding reports are attached as Appendix A. We have examples where the escalation process has not been followed properly by both partners and practitioners within the SAB and this led to significant drift and delay for two vulnerable adults and their family for which we are holding an Integrated SAR/CSPR.

The issue of escalation is therefore an area that needs further work as well as application of the levels of need, risk and intervention and development of digital multiagency procedures and an accessible safeguarding website. However, the LSAB as a strong and supportive partnership we will continue to hold challenging conversations and develop its Strategic Business Plan for 2023/24 and onwards to improve the outcomes for vulnerable adults in Luton.