Safeguarding in Luton

The Annual Report for Luton Safeguarding Adults Board

2024 – 2025 Annual Report

September 2025

Beverley McConnell – LSAB/LSCP Strategic Business Manager

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INDEPENDENT CHAIR - INTRODUCTION

As the new Independent Chair, I am really pleased to be able to share the Luton Safeguarding Adults Board Annual Report for 2024/25 with you. This report sets out the Board's achievements over the past year and highlights areas that may require closer attention.

I would like to start by thanking Alan Caton OBE, the outgoing Independent Chair for his commitment over the past five years to improving the safeguarding of adults in Luton.

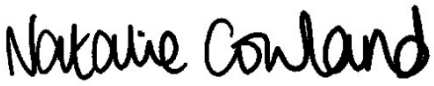
The peer review completed this year, will enable us to look at the Board's structure and take the opportunity to stream-line our sub-groups to improve governance. Safeguarding Adults Reviews have given us clear indications of other areas we need to improve in. We also know there is more to do in terms of how we use data to understand the safeguarding issues affecting adults in Luton.

The Board has led work to ensure learning from Safeguarding Adults Reviews drives systemic change and improvement in practices, enhancing risk reduction and multi-agency collaboration in our safeguarding efforts.

It continues to be a challenging time for all those involved in the safeguarding adult arena, with increased pressure on our systems, the complexity of safeguarding concerns, and need to address inequalities in access and outcomes, all of which require our continued attention.

Looking ahead, I am keen to work collaboratively with partners from across all sectors to ensure we provide the best possible services for our communities. I am committed to hearing the voices of people who use services and experience safeguarding processes so that adults in Luton are protected and empowered to live safe, independent, and fulfilling lives free from abuse and neglect.

I am extremely grateful to all Board partners who have supported and undertaken work for the Board over the last year.



Natalie Cowland
Independent Chair
Luton Safeguarding Adults Board

1. EXECUTIVE SUMMARY

The Luton Safeguarding Adults Board (LSAB) is a partnership made up of statutory and non-statutory partners. The statutory partners are:

- Bedfordshire Police,
- Bedfordshire, Milton Keynes and Luton Integrated Care Board
- Luton Borough Council.

The LSAB also has many non-statutory partners who provide a valuable contribution. The full list of partners and their LSAB core duties and purpose can be found on page 8.

KEY FINDINGS

The information in this report demonstrates how the LSAB has met their core duties and progressed its work from its intentions last year through to its achievements in the current year. It considers this work across its priorities and associated golden threads, to provide evidence of practice development and sector-led improvement against recommendations it made last year.

RECOMMENDATIONS OUTCOMES 2024-25

The LSAB Annual Report 2023-2024 set out that the Board had made progress in improving governance and in using some multi-agency data and audits to assure itself of the quality of practice, but that the LSAB needed to undertake further work in 2024/25 to focus collective efforts over the next two years, following the principle that we should concentrate our capacity on a small number of topics, in order to have significant impact, and focus LSAB resources:

1. Self-Neglect and Neglect of vulnerable adults
2. Domestic Abuse
3. Modern Slavery and Sexual Exploitation
4. Emotional Wellbeing and Mental Health

Rough Sleeping was added to the LSAB priorities following the Ministerial letter sent to all Safeguarding Adults Board in May 2024. ‘Golden Threads’ were also added to workstreams to flow through all its work. The summary below sets out LSAB achievements against its priorities and how this contributed to improving safeguarding practices, embedding learning, and enhancing multi-agency collaboration across Luton.

1. SELF-NEGLECT AND NEGLECT

Safeguarding Adults Reviews undertaken, along with regional and national learning, highlighted key learning in relation to self-neglect. There was crossover between self-neglect and the golden thread of Mental Capacity and MSP. The LSAB made significant progress against this priority in 2024/25 and has achieve the following key improvements and developments:

- The LSAB developed and launched a Self-Neglect Guidance, Pathway and Toolkit, improving recognition and response to self-neglect cases.
- Multi-agency workshops delivered to over 120 practitioners. Training enhanced to build practitioner confidence in identifying self-neglect and neglect and to support risk management for those identified with complex needs.
- Embedding of the Critical Adult Safeguarding Partnership Arrangements (CASPA) has enabled better coordination and safer outcomes for those who self-neglect or who are being neglected
- The learning from Family T supported identification of those needing carers assessments and promoted the implementation of whole-family approaches

- Some challenges remain in inconsistent recognition of self-neglect as a safeguarding issue and some delays in mental health assessment and multi-agency coordination.

2. DOMESTIC ABUSE

Safeguarding Adults Reviews undertaken by Luton SAB as well as Domestic Homicide Reviews, regional and national learning, has highlighted key learning in relation to safeguarding adults where domestic abuse exists in conjunction with drug and alcohol use. The LSAB has also established workstreams to better understand systems issues and our local response to safeguarding vulnerable adults requiring safe accommodation. Over the last year the impact of this has been:

- Increased safeguarding referrals and awareness through routine enquiry.
- Improved understanding of initiatives such as Clare's Law, IDVA services, Emergency Department Navigators as well as Stalking Protection Orders and the timeframe for introduction of Domestic Abuse Protection Orders and Domestic Abuse Protection Notices was also updated in the procedures and 7-minute briefings.
- The LSAB partners have participated in the delivery of targeted training and domestic abuse awareness campaigns alongside BDAP and included domestic abuse in their Level 3 safeguarding training
- There has been strengthened collaboration with the Domestic Abuse Luton Partnership Board and partners from the Voluntary, Community and Social Enterprise sector who have benefited from safeguarding training and procedures webinars.
- There has been Improved data collection and reporting, with domestic abuse related S42 enquiries rising from 9 in 2022/23 to 20 in 2024/25.

Challenges remain in the capture of data and sharing across the partnership, with possible under reporting of safeguarding concerns, enquiries and incidents.

3. MODERN SLAVERY AND SEXUAL EXPLOITATION

Local Safeguarding Adults Reviews, Domestic Homicide Reviews, rapid reviews and audits over last few years have identified evidence of vulnerable adults suffering abuse or neglect through Modern Slavery and Sexual Exploitation sometimes linked to earlier trauma.

- Developed a shared framework for identifying and responding to adult concerns for sexual exploitation and modern slavery as well as revised safeguarding procedures for exploitation concerns to automatically be reviewed under Section 42 enquiries.
- Enhanced multi-agency coordination and data sharing. This included the development of the Luton On-Street Sexual Exploitation Strategy to include early intervention and prevention strands, and promoting the recognition of sexual exploitation as a safeguarding concern for those with care and support needs.
- Evidenced increase in the number of vulnerable adults at risk of sexual exploitation and with dual diagnosis referred to CASPA
- Supported the increase and promotion of safe spaces and trauma-informed services.
- Delivered training and awareness sessions via Azalea and other VCSE partners.

Challenges remain with the low number of safeguarding referrals for modern slavery and in embedding awareness and consistent use of safe spaces for people at risk of harm.

4. EMOTIONAL WELLBEING, MENTAL HEALTH & SUICIDE

Local Safeguarding Adults Reviews, rapid reviews and audits over last few years have identified evidence of dual diagnosis mental health, substance misuse, suicide and diagnosis linked to earlier trauma. As a result the LSAB has seen the following achievements:

- Partners have delivered trauma-informed care training to over 4,000 staff across agencies, as well as other training such as Oliver McGowan training on neurodiversity.
- Reviewed the impact of SARs on practice linked to suicide, trauma and experience of abuse, sexual exploitation and domestic abuse.
- Promoted suicide prevention strategies and tools for care homes and ensured practitioners are aware of and can access the BLMK Suicide Prevention Hub.
- Strengthened Strategic Board membership to include an advocacy provider and promoted their role within SAR implementation and planning and improved multi-agency collaboration through the VCSE Coproduction Group.
- Highlighted the need for cultural competence and consideration of intersectionality in safeguarding assessments.
- Promoted policy, procedures and tools for whole family approaches.

Challenges remain in the development of trauma-informed services, consistent application of mental capacity assessments when required and legal literacy to support decision making.

5. ROUGH SLEEPING

Immediate work was undertaken to respond to the requirements of the ministerial letter to:

- Designate a named link board member and further embed housing staff in CASPA processes.
- Deliver workshops and seek assurance that specialist services for rough sleepers were commissioned and accessible to those with case and support needs.
- Improve multi-disciplinary responses and early intervention to rough sleepers.
- Embed and monitor the impact of learning of SARs involving rough sleeping.
- Develop a Complex Case Pathway and improved trauma-informed support for those with care and support needs who are rough sleeping.

6. CROSS-CUTTING ACHIEVEMENTS

- Governance: Streamlined subgroups and improved accountability of delivery.
- Learning: Published two SARs; Conducted three thematic audits on transitions, good referrals and dual diagnosis; Produced thirty 7-minute briefings; Launched new safeguarding policy, procedures, practice guidance and website content, with LSAB highest users.
- Performance: Development of a multi-agency scorecard and thematic highlight reports.
- Training: Delivered blended training on a range of safeguarding topics including mental capacity, complex cases, using multiagency guidance and trauma-informed care.
- VCSE Engagement: Strengthened VCSE coproduction and provider participation.
- Peer Review: Sector-led governance review identified areas of strength and informed 2025/26 planning with eleven recommendations for strengthening delivery.

The LSAB has made significant strides in improving safeguarding practices, embedding learning, and enhancing multi-agency collaboration. While challenges remain, particularly around data collection and lived experience engagement, the Board has demonstrated a strong commitment to continuous improvement and delivering better outcomes for vulnerable adults in Luton. The strength of the partnership is also evident in their enthusiasm and commitment.

RECOMMENDATIONS 2025/26

The LSAB recommendations for improvement and development are detailed on page 47. The new Independent Chair will be overseeing implementing recommendations from the Sector Led Peer Review. In setting a key focus for the key deliverables, leads, activities, impact measures and timescales the LSAB will set a new Strategic Business Plan and Delivery Plan for 2026/28 with priorities agreed as *Transitional Safeguarding, Mental Capacity Assessments, Domestic Abuse* and *Multiple Vulnerabilities* (as a provisional working title).

2. LUTON SAFEGUARDING ADULTS BOARD ARRANGEMENTS

Luton Safeguarding Adults Board (LSAB) is an independent statutory body with a strategic responsibility to work with its members and partners to protect and support adults with care and support needs from abuse, neglect and self-neglect in Luton.

LSAB STRATEGIC VISION:

The LSAB strategic vision is for '*Luton to be a safe place for its residents where no one should have to tolerate, or be exposed to abuse, neglect, or exploitation'*. In delivering its strategic vision the LSAB leads the adult safeguarding arrangements across Luton, and oversees and coordinates the safeguarding work of its member and partner agencies.

This requires the LSAB to develop and actively promote a culture with its members, partners and the local community to 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.

LSAB OVERARCHING PURPOSE:

The overarching purpose of a Safeguarding Adults Board 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 Care Act 2014 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 role of the LSAB is distinct from its member organisations in that, while member organisations provide safeguarding services and support individuals in need of help and protection, the LSAB works strategically across its membership and wider organisations to ensure there are effective safeguarding arrangements in Luton. This role is set out in legislation: "*The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does*"

The Board's coordination role includes:

- Provision of multi-agency safeguarding adults policy and procedures to ensure we are working together and with the person at risk
- Quality assurance processes around multi-agency working
- Identifying and sharing local, regional and national learning
- Promoting awareness of safeguarding amongst the community
- Learning from lived experiences
- Learning from best practice as well as where practice could have been better

LSAB CORE STATUTORY DUTIES

The LSAB also 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.

The LSCB's role also involves gaining assurances from its members that effective arrangements are in place to help and protect adults with care and support needs through:

- Multi-agency and single agency audits
- Assurance regarding embedding the learning from reviews and their impact
- Assurance that the board priorities are demonstrating impact.

The LSAB therefore undertakes a programme of learning from experience, undertaking audits, delivering training as well as communicating partners' roles and responsibilities.

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	**Bedfordshire NHS Hospital Trust**	**Cambridgeshire Community Services**
Department of Work and Pensions	**East of England Ambulance Service**	**East London NHS Foundation Trust**
Healthwatch Luton	**National Probation Service**	**Voluntary Community & Social Enterprise Sector (*including Azalea, Community Connex, ResoLUTiONs CGL*)**

LSAB STRATEGIC OBJECTIVES FOR 2024/2025

KEY PRIORITIES: LSAB have identified four priorities to focus their collective efforts, following the principle that they should concentrate their capacity on a small number of topics, in order to have significant impact, and focus their limited resources. Based on their analysis across Luton we have identified the following priority areas:

LSAB Priorities for 2024-2025
• Self-Neglect and Neglect
• Domestic Abuse (*Joint priority across Pan Beds adults and children's partnerships*)
• Modern Slavery and Sexual Exploitation
• Emotional Wellbeing and Mental Health (*Pan Beds joint priority*)
• Rough Sleeping *(added in May 2024 in line with ministerial letter*)

We also identified the following Golden Threads that should be evident in our work:
• Application of Mental Capacity Act 2005
• Cultural Competence
• Cybercrime
• Implementing learning from SARs and relevant CSPR's
• Legal Literacy
• Making Safeguarding Personal and responding to personal lived experiences
• Whole family approaches

The Safeguarding Principles: The work of the Board is driven by the safeguarding principles, set out in the Care Act 2014 and are addressed by the LSAB as follows:

Empowerment	**People being supported and encouraged to make their own decisions and informed consent.** ***"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."***
Prevention	**It is better to take action before harm occurs.** ***"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."***
Proportionality	**The least intrusive response appropriate to the risk presented.** **"*I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."***
Protection	**Support and representation for those in greatest need.** **"*I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."***
Partnership	**Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.** ***"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."***
Accountability	**Accountability and transparency in delivering safeguarding.** ***"I understand the role of everyone involved in my life and so do they."***

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.**

SAFEGUARDING ADULT REVIEWS

One of the three core objectives of a SAB is to commission Safeguarding Adult Reviews (SARs) for any cases which meet the national criteria below:

(1) Section 44 of the Care Act states that the LSAB must conduct a SAR if the following criteria are met under the Care Act 2014, for a case involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if:

(a) There is reasonable cause for concern about how the SAB, members of it or persons with relevant functions worked together to safeguard the adult, and
(b) either of the following conditions are met:

(2) Condition 1 is met if:
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it is known about or suspected there was abuse or neglect before the adult died).

(3) Condition 2 is met if:
(c) the adult is still alive, and
(d) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
(e) *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.*

The purpose of a SAR is to identify learning in order to improve practice, rather than to attribute blame to any individual or organisation.

FIGURE 1: SAR REFERRAL OUTCOMES APRIL 2019 - MARCH 2025

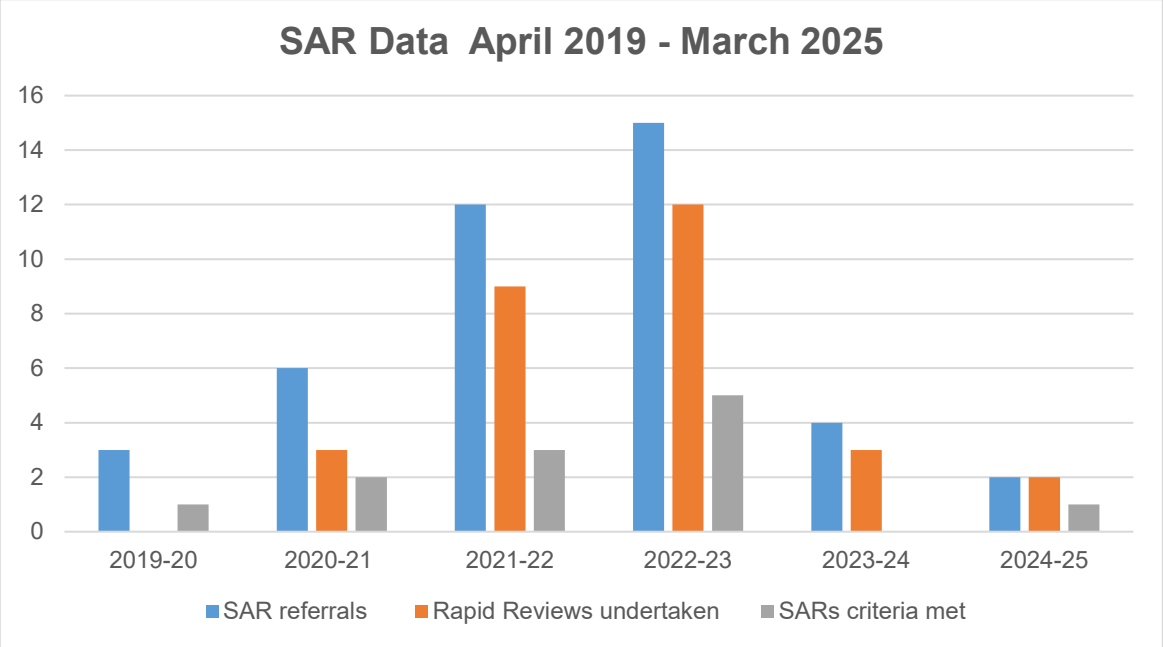


Figure 1 above sets out the SAR data from April 2019 to March 2025 and details:
- the number of cases where a referral for a SAR is received,
- the number of rapid reviews undertaken (*which is an initial scoping of the case in a timely way to extract any immediate and emerging learning for system improvements and make recommendations around any SARs to be conducted*)
- and the number of cases resulting in multi-agency SAR.

The five year SAR data shows that following a spike in SAR referrals (15), rapid reviews (12) and SARs (5) in 2022/23 there was a significant drop in the SAR referrals received in both 2023/24 and 2024/25. The Board received only **two** SAR referrals in **2024/25** and completed rapid reviews in both cases. Only one of these cases met the criteria for a SAR. The rationale for the reduction in the number of SAR referrals received is because there is a better

understanding of the criteria for a SAR and practice has improved over time through embedding SAR learning. Closer governance of the scoping and decision making process to progress to a SAR has resulted in less SARs being undertaken.

THEMES FROM REFERRALS, RAPID REVIEWS & SARS

FIGURE 2: TYPES OF SUSPECTED ABUSE AND FACTORS ACROSS SAR REFERRALS APRIL 2022 – MARCH 2025

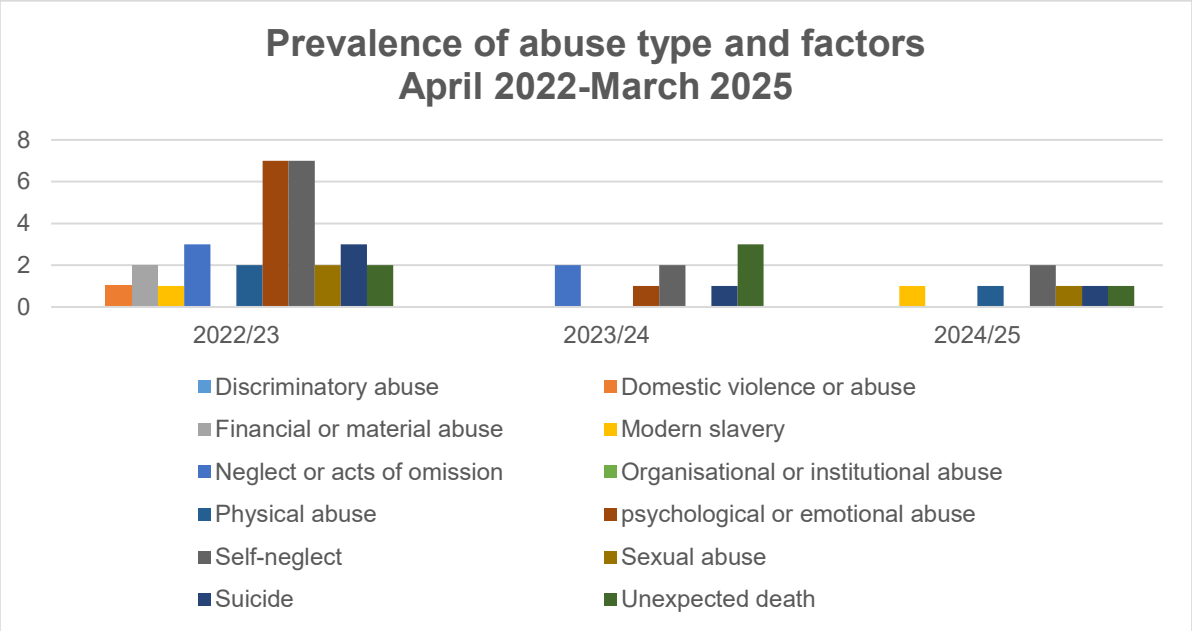


Figure 2 shows the types of suspected abuse and factors occurring within the twenty SAR referrals received between April 2022 and March 2025. While SAR referrals have reduced significantly over this period SAR referrals received tend to include multiple factors and were mostly in relation to either an unexpected death or suspected suicide. Self-neglect, remained the highest occurring type of abuse in SAR referrals received in 2024/25. Suicide has remained a significant factor in referrals and SARS over the last 4 years with 5 deaths by suicide.

SARS PUBLISHED IN 2024/25

The LSAB published two legacy SAR reports in 2024/25:
Family T Integrated Child Safeguarding Practice Review (CSPR)/SAR Sept 2024 - Severe self-neglect, escalation, Graded Care Profile (GCP2), poor physical health and disability, housing, hoarding, adults' needs prioritised above the children's needs, lack of whole family approaches. The integrated child safeguarding practice review considered the practice across a range of agencies working with both the adults and the children in the family and made the following findings and recommendations for the LSAB:

Key Findings:

1. **Chronic Neglect of Children**: Arnie and Ruby experienced extreme chronic neglect over several years, with no sustained improvement in their living conditions or care. Their physical and emotional needs were not adequately met, and their roles as young carers were overlooked.
2. **Focus on Parents Over Children**: The needs and views of the parents were often prioritised over the children's welfare. Professionals were reluctant to challenge the parents due to their disabilities, leading to delays in decisive intervention.

3. **Lack of Joint Working**: There was insufficient collaboration between adult and children's services, resulting in disjointed practice and gaps in information sharing. Agencies often worked in isolation, focusing on either the adults or the children without considering the family as a whole and ensuring both needs were met.
4. **Housing and Living Conditions**: The family lived in cramped, unhygienic, and unsafe conditions, which significantly impacted their lives. Professionals struggled to resolve the housing issues due to complications with the joint tenancy and a lack of clear responsibility among agencies.
5. **Missed Opportunities for Early Intervention**: Despite escalating concerns, there was a lack of decisive action at an earlier stage. Professionals often restarted interventions without considering the historical context of neglect, leading to delays in addressing the children's needs and understanding of the adults self-neglect.
6. **Inadequate Assessments**: Assessments of both the children and parents were incomplete and lacked depth. The children's roles as young carers were not formally identified, and the parents' mental health and capacity to parent were not sufficiently assessed.
7. **Professional Disputes and Escalation**: There were significant delays in resolving professional disagreements and escalating concerns. Agencies did not consistently use formal escalation procedures, leading to fragmented responses.
8. **Voice of the Children**: The children's lived experiences, wishes, and feelings were not adequately recorded or acted upon. Ruby expressed her unhappiness about her responsibilities at home, but these concerns were not addressed effectively.
9. **Impact of Neglect**: The cumulative impact of neglect on the children's development and well-being was not fully appreciated. Professionals underestimated the long-term harm caused by neglect and adultification, where the children were expected to take on adult responsibilities. The enduring self-neglect by the adults was not assessed and despite them having significant care needs and not being able to keep themselves safe, practitioners did not consider their mental capacity to make unwise decisions.
10. **Systemic Issues**: High staff turnover, inadequate supervision, and poor-quality assessments contributed to delays and inconsistent casework. Professionals lacked curiosity and critical thinking, leading to missed opportunities to understand the family's dynamics and risks.

1. The review highlights the need for better multi-agency collaboration, timely intervention, and a child-centred approach to safeguarding while also recognising the safeguarding risks to adults from self-neglect. It highlights systemic challenges, including the normalisation of neglect, lack of professional curiosity, and insufficient focus on lived experiences of the family. Partner agencies should review and improve the local understanding and application of joint working together to safeguard adults and children. Develop a Multi-Agency Protocol for working with disabled parents at all levels of intervention.
    - Protocol and supporting resources published Luton joint protocol for working with parents with disabilities (*updated June 2025*)
    - Young carers and young adult carers (August 2024)
    - Seven Step Briefing Adults / Young Carers
    - Launch of protocol, webinar, and briefing planned (October 2025).
    - Audit of young carers completed (March 2025), with mixed evidence of support under Section 17Z Children Act 2024 and Care Act 2014.

2. The Luton SAB and the Children Safeguarding Partnership should seek assurance that the partners, understand each other's roles and that they are working collaboratively to ensure that the child is at the centre of all decision making. This should include a strengthening of the current case escalation procedures.
    - Revised Neglect Guidance developed as detailed in priority.

- There have been a number of joint practice sessions held across the partnerships to share the learning and establish how to work collaboratively in similar cases with adult self-neglect and parental neglect.
- Revised case escalation protocol published LSAB escalation and resolution of professional disputes (April 2024)
- Improved partnership working, escalation routes, and referral outcomes.

3. Safeguarding training for professionals must stress the importance of exercising professional curiosity to ensure that professionals consider all the adults in a child's life, both from a strengths and risks perspective from the adult to the child.
   - Safeguarding training includes learning from this review and promotes all the revised guidance referred to in the SAR activity and impact update.
   - LSAB 7 minute briefing professional curiosity published
   - LSAB 7 minute briefing - think family and whole family approaches published
   - LSAB 7 minute briefing Risk Management (Sept 2024) published.

4. Partnerships to consider whether given the importance of housing in this case (and others) housing should be involved routinely in multi-agency safeguarding arrangements.
   - Strategic Housing lead now sits on LSAB/LSCP boards.
   - Housing roles embedded in MASH processes.
   - Strong linkages established with homeless and rough sleeping teams.

Thematic SAR Self-Neglect Sept 2024 – self-neglect, hoarding, poor engagement with and by agencies, concerns re mental capacity assessments, mental and physical health.

In order to avoid duplication the findings and resulting recommendations and outcomes are detailed under the relevant priorities.

There was **one** SAR commissioned in 2024/25 which relates to a single individual:

- **Adult EMMA** which is around suicide, sexual exploitation, substance misuse and homelessness. This review is currently ongoing and due to be concluded October 2025 and will be published once family engagement is complete. Emerging learning from the rapid review undertaken is being taken forward against relevant priorities.

Within the Joint Case Review Group we also undertook a comparison of learning from the Second National Analysis of Safeguarding Adult Reviews: April 2019 - March 2023, gaining assurance that we were already sighted on key learning and development themes highlighted nationally.

Learning from SARs evaluation and development day

In March 2024, the Joint Quality Assurance and Learning (JQAL) held an in person Learning from SARs development and evaluation day. The aim of the event was for the LSAB to assess and review the impact of learning and evidence of change from SARS undertaken over the past 24 months. The event utilised the *Research in Practice* approach as outlined in "*Developing effective Safeguarding Adult Reviews learning events*" *Darlington Trust (2021)* research paper (www.researchinpractice.org.uk). In order to reduce duplication agencies were allocated SARs linked to one of the LSAB priorities for presentation back to the group.

The wider group reviewed the evidence of the impact from the implementation of learning from SAR action plans and recommendations from within a systematic, cultural and strategical viewpoint. It also examined the multi-agency impact of such learning on policies, procedures and practice to protect vulnerable individuals within the community.

The priorities and SARS were allocated as follows:

- Rough Sleeping – Adult Social Care - Adult ANNA and Adult Keira
- Modern Day Slavery and exploitation – Bedfordshire Police - Adult ANNA
- Emotional Health and Wellbeing – ELFT – Adult Keira and Adult C
- Domestic Abuse – BHNHST – Adult ANNA
- Self-neglect and Neglect – CCS and ICB – Self-Neglect Thematic and Family T

As part of the partnership discussions on the agency presentation the golden thread of agencies also considered the golden threads of:

- Cultural Competence
- Cybercrime
- Implementing learning from SARs and relevant CSPR's
- Legal Literacy
- Making Safeguarding Personal and responding to personal lived experiences
- Mental Capacity Act

The evidence of impact from this event has been reported against the priority below.

SELF-NEGLECT AND NEGLECT

The LSAB has undertaken significant work in 2024/25 in relation to Self-Neglect and Neglect. Much of this work has been linked to the learning, findings and recommendations from SARs. The work undertaken in relation to Family T is detailed above in the section on SAR learning. This section focuses on the evidence found within the SAR evaluation day on Self-neglect and Neglect (led by Cambridgeshire Community Services (CCS) and Bedfordshire, Luton, Milton Keynes Integrated Care Board (BLMK ICB)) considered the Self Neglect Thematic SAR and Family T Integrated Practice Review.

- The impact reported in relation to the Self-Neglect Thematic SAR, - CASPA has provided a risk assessment and management forum which has led to safer practice and risk reduction. This is a multi-agency approach and there has been positive buy in from all agencies in trying to find solutions to support the individual. As a result of the actions CCS have implemented, there is greater internal assurance in risk reduction. Developing the clear criteria has improved partnership working and improved confidence in resolving challenging cases/concerns.
- In relation to Family T, CCS report the impact of change to be improved recognition of young carers and improved think family focus.
- In addition, there has been improved partnership working with clear and active escalation routes. Referral outcomes are now being received in a more appropriate timeframe.
- Internal and multi-agency working has improved with regards to a think family approach. Supervision within early stages; this will be audited once fully rolled out.
- Improved working utilising the clutter scale has led to this being adapted within CCS children's services. There has been improved record keeping regarding the patient home environment.
- Staff are bringing more identified self-neglect cases for ad hoc supervision and recognising the wider family and feedback from training has been positive. Luton Adult Social Care staff are improving practice by considering the impact of self-neglect on children within the household and demonstrating better use of whole family approaches.

The Thematic SAR Self Neglect considered the response to cases of self-neglect and concomitant poor living conditions and hoarding as a key challenge in services for adults. Self-neglect results in individuals being unable to care for their basic needs and presents challenges including ethical and legal considerations, particularly where adults appear to have the mental capacity to refuse support. The thematic review considered agency interventions in each case and sought to raise awareness of the lived experience of the individuals involved in the review.

Key Findings from the Review

- Self-Neglect and hoarding were not appropriately identified as safeguarding matters and as a result the local adult safeguarding procedures were not followed.
- Intervention was not effective in the longer term and agencies tended to act in isolation. These were complex cases. There were some examples of good practice in intervening to support these two men. There were significant delays, stop-start interventions were not well coordinated.
- The local safeguarding system did not work effectively enough to ensure that timely and decisive action was taken to safeguard them. The intervention was not successful in the mid to longer term with significant outstanding problems such as unidentified mental health needs which are likely to have led to them making unwise decisions and to deteriorating still further. For the most part, agencies acted singly and when they tried to collaborate to address the needs, this was not accepted or insufficiently prioritised by other agencies.
- Overall, there was a lack of effective multiagency working so each case lacked a clear plan to safeguard these men and there was a lack of shared intervention and risk management. When the person concerned is determined that generally they do not want agencies to be involved or they are only willing to cooperate in a limited way, the question of risk and their lived experience is relevant to consider alongside and concerns about their cognitive and decision-making capacity.
- Self-neglect especially over a long period is associated with adverse outcomes and a deterioration in physical and mental well-being.
- The challenges presented by these two men made it difficult for professionals to work with them, but this should have been overcome with all professionals working together at pace with a shared agenda and remit to resolve the safeguarding concerns for them.
- There was inconsistency in the way these two cases were dealt with. In both cases, even when the self-neglect was recognised, it was not fully understood by all agencies and should have been fully explored as a safeguarding matter in line with the local interagency procedures.
- The mental health of these two men was of concern and there appears to have been a lack of access to appropriate support for other professionals to have the men's mental health and cognitive capacity assessed.
- Changes to practice and visiting during COVID lockdown limited the degree of intervention with both men as face-to-face interventions were stalled resulting in even more deterioration in their circumstances.
- There was some positive practice in these cases but there was also delay and indecision in one case and inaction in the other. In cases of serious chronic self-neglect, thorough and robust joint risk assessment and planning is required – including a clear shared safeguarding plan - with regular multiagency review to support effective collaboration between agencies.

The report summarised the findings into three recommendations with detailed actions, their specific outcomes and impact summarised below:

1. **Learning from this review should be shared locally and interactive workshops held to disseminate the findings**
   - Learning summary of the findings have been shared widely locally and placed on the LSAB website along with '7 minute briefings' linked to the factors in their case some of which are shown below:
     - Final LSAB Thematic SAR Self-Neglect
     - Executive Summary Thematic SAR Self Neglect
     - Self-neglect and hoarding policy
     - LSAB 7 minute briefing self-neglect
     - LSAB 7 minute briefing Executive Capacity
     - LSAB 7 minute briefings Hoarding protocol

- ❖ Multiagency workshops have been held face to face for 48 practitioners and online sessions for 81 individuals. These have included these cases as case studies for learning and improving practice around working with self-neglect and Mental Capacity Assessments. Further sessions will be run in Quarter 1 & 2 in 2025-26.

2. **New Safeguarding Procedures on self-neglect should be developed which identify chronic self-neglect as a safeguarding matter**
   - ❖ The multi-agency safeguarding procedures have been renewed by the LSAB to provide a clear framework across all agencies for the response to chronic self-neglect. These have been disseminated, included in webinars and in news items on the LSAB website and weekly update email.

- LSAB supporting adults who self-neglect multi agency practice guidance
- https://safeguardingbedfordshire.org.uk/p/latest-news/lsab-launch-new-guidance-for-supporting-adults-who-self-neglect
- https://safeguardingbedfordshire.org.uk/p/latest-news/luton-safeguarding-adults-board-publish-key-safeguarding-guidance-for-all-practice

3. **LSAB to produce a policy and relevant training for all those working with vulnerable adults on engaging "uncooperative" adults and on how to develop an effective assessment of cognitive functioning**

❖ The LSAB has produced and published guidance on engaging individuals with care and support needs that can who appear complex or unwilling to engage with services offered, this includes consideration of mental capacity and cultural needs. We have also made changes to the language used such as uncooperative or did not engage and reframed this to more positive language.

- Luton framework for multi-agency engagement of adults with care and support needs

Initial partner survey responses to whether the guidance is being utilised were:

❖ **77.8%** of practitioners surveyed knew about the guidance
❖ **33.3%** of practitioners surveyed had used the guidance in their practice
❖ **33.3%** of practitioners surveyed had examples of positive outcomes after using the guidance

The LSAB and its partners needs to further disseminate and test practitioners' knowledge and utilisation of these procedures. In order to assist in this evaluation the LSAB is seeking to gather and analyse website data drawn from website traffic in 2025/26.

DOMESTIC ABUSE

The Joint Quality Assurance and Learning group reviewed all SARs and rapid reviews undertaken in the last twenty four months linked to each of our priority areas. Under the domestic abuse workstream (led by BHNHST) and referencing the Adult ANNA SAR/DHR the following evidence of impact was found:

- In relation to Adult ANNA SAR, and the impact of change, Bedfordshire Hospital NHS Foundation Trust (BHNHSFT) reported staff have clear pathways and processes in place and more awareness of the CASPA process to safeguard vulnerable adults.
- The impact of this has been an increase in the number of referrals being made for support in each area from staff, which shows an increased awareness.
- Domestic Abuse was also included in the BHNHST data collection for Quarter 2, and a domestic abuse audit completed which demonstrated good options in relation to standards assessed. Lip Balms have been commissioned with domestic abuse helplines listed, mobile phones commissioned with credit and another year funded for the Emergency Department Navigators
- East London Foundation Trust (ELFT) mentioned that 1 in 4 patients have experienced domestic abuse, ELFT have started to make routine enquires with individuals to try to identify Domestic Abuse more and offer support regarding the impact of it. There is ongoing work for ELFT to become a Trauma Informed Organisation throughout its work.
- CCS have domestic abuse routine enquiry on Systems One, mandatory half a day training, and it is included in Level 3 safeguarding training.
- Gaps discussed where the learning has taken place but not shared / distributed widely enough to frontline staff. It was noted that there is always a focus on the victim leaving the situation and there is ongoing work by ELFT to collect measures on domestic abuse crimes, exploitation and abuse results in sanctions against the perpetrator.

The LSAB also shares domestic abuse as a joint priority with the Luton Safeguarding Children Partnership. Domestic Abuse work in Luton is led and governed by the Luton Community Safety Partnership and the **Luton Domestic Abuse Local Partnership Board** (DALPG) who have developed a Luton Domestic Abuse Strategy. Services, resources and training are delivered by the Bedfordshire Domestic Abuse Partnership (BDAP)

Domestic abuse can be a common feature in cases where there are other identified risk factors such as poverty, exploitation and poor mental health. Data within Safeguarding Adult Collection (SAC) - *SG2A: Concluded Enquiries by Abuse Type and Source of Risk* for domestic abuse show the number of enquiries has increased. The number of concerns for domestic abuse doubled from **9** in 2022/2023 to **18** in 2023/24 and increased again in 2024/25 to **20**. The continued increase for Domestic Abuse is positive as these are known to be under reported safeguarding concerns.

Alleged Abuse Type	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Domestic Abuse	14	22	10	9	18	20

The data below shows the number of domestic abuse crimes for Luton recorded by Bedfordshire Police.

DA Crimes (crimes where the DA keyword has been applied)

Aggravating Factor	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Domestic Abuse	264	282	262	291	255	268	249	249	301	269	265	260	**3,215**

This shows a drop in incidents during the summer with a spike in incidents recorded into October 2024 through to January 2025. These differences were explored within the LSCP Joint Quality Assurance and Leaning Group as a deep dive. This showed that the increase prior to the school closing for the holiday and other variances could be linked to school term times rather than any other significant events. It is already known that during the festive period into January of any year there are increases in reported incidents of domestic abuse nationally. There is a similar pattern in cases that are closed as a domestic incident.

DA Incidents (incidents closed as a Domestic Incident) by Police 2024-25

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
182	**181**	**182**	**194**	**165**	**181**	**196**	**195**	**197**	**190**	**169**	**184**

Monthly place based Multi-Agency Risk Assessment Conference (MARAC) meetings consider safety planning for both adults and children who are victims of domestic abuse as well as looking at ways of addressing perpetrator behaviour to reduce incidents both in terms of severity and frequency. The LSAB also contributes to the Domestic Abuse Luton Programme Board and supports its priorities within the Luton Domestic Abuse Strategy 2023-2025:

- Prevention and early help
- Partnership:
- Provision and Improvement
- Protection

The strategy measures outcomes for participants using both quantitative and qualitative methods. The LSAB received an end of year report in June 2024 containing the following outputs and data:

Services Commissioned within Luton:

- **Impact Housing**: Support for victims fleeing domestic abuse, including those with complex needs.
- **Women's Aid General Refuges**: Three refuges, including one for Southern Asian women, with specialist workers and family support.
- **Women's Aid Refuge for Complex Health Needs**: A 5-bed refuge for women with mental health, drug/alcohol, and Black Minority Ethnicity (BME) women with complex needs.
- **Women's Aid Children Family Worker**: Support for children and families affected by domestic abuse.
- **Harmful Practices Support Advocacy**: Advocacy for victims of Female Genital Mutilation (FGM), including court and safeguarding support.
- **Ebonista Project**: A 3-day perpetrators program with victim support.
- **KIDVA-Embrace**: Two full-time IDVAs supporting child domestic abuse victims and child-to-parent violence cases.
- **Flexi Fund – Impakt**: Financial support for domestic abuse victims for urgent needs like travel, clothing, and accommodation.

Equalities Monitoring:

1. **Age Range**: Majority of participants aged 30–40.
2. **Relationship Status**: 36.5% married/cohabiting, 25.8% single.
3. **Religion**: 35.5% Muslim, 25.8% no religion.
4. **Disabilities**: 29% mental health concerns, 9.7% neurodiverse.
5. **Substance Misuse**: 9.7% drug addiction, 16.1% alcohol addiction.
6. **Ethnic Origin**: 32.3% Pakistani, 25.8% White British.

While this information provides some insight into the outputs and impact of domestic abuse work within Luton, the LSAB is seeking further metrics to include in its scorecard. This work will continue into 2025/26 with exploration of Power BI as a reporting tool.

Working together with partner agencies such as the Independent Domestic Violence Advocate Service (IDVA) and Bedfordshire Domestic Abuse Partnership (BDAP) has led to a change in process for Clare's Law. Since the implementation in February 2024 there has been significant increase in right to ask and right to know applications. Positive feedback has been received directly from individuals disclosed to, allowing them to make informed decisions regarding their relationship status. Further data will be included in the LSAB dataset in 2025/26.

The LSAB also participated in the 16 Days of Activism against Gender-Based Violence, which is an annual international campaign that began on 25 November, the International Day for the Elimination of Violence against Women, and which ran 10 December, Human Rights Day. The LSAB undertook to promote the daily activities taking place and for partners to participate in selected activities and to mark White Ribbon Day and the start of 16 Days of Action in a bid to end gender-based violence against women and girls.

Luton Council and several of its partners have been 'White Ribbon' accredited to demonstrate our commitment to preventing violence against women and girls and to help promote equality.

The White Ribbon Day theme was *'It starts with men*', in order to address the attitudes and behaviours that contribute to a fear of violence for women in their daily lives and to specifically encourage men to hold themselves accountable to women and to each other to affect positive change to transform harmful cultures. Monday 25 November was also the start of 16 Days of Action Against Gender-Based Violence, an international campaign to challenge violence and abuse against women and girls.

A number of events happened in Luton and across Bedfordshire during the 16 days, including the #TooManyNames event, on Friday 29 November at Luton Point where the women who have lost their lives due to male violence were honoured. This year, 118 names of women and girls who were killed, four of whom lived in Bedfordshire, were read aloud. This event serves as a tragic reminder of the devastating impact of gender-based violence not just in Bedfordshire, but across the UK and the rest of the world. This event was organised by the Bedfordshire Domestic Abuse Partnership. The campaign also demonstrates the raw emotions survivors face when going through and rebuilding from domestic abuse, sexual assault and other crimes.

In February 2025, information about Stalking Protection Orders was added to Section 3, of the *Pan Beds Multi-Agency Safeguarding* procedures *Specialist Domestic Abuse Services* and Support. Information about the timeframe for introduction of Domestic Abuse Protection Orders and Domestic Abuse Protection Notices was also updated. The LSAB will seek data regarding the use of these procedures by practitioners in 2025/26.

MODERN SLAVERY AND SEXUAL EXPLOITATION

The Joint Quality Assurance and Learning group reviewed all SARs and rapid reviews undertaken in the last twenty four months linked to each of our priority areas. Under the Modern Day Slavery and Exploitation (led by Beds Police) and referencing the Adult ANNA SAR/DHR the following evidence of impact was found:

- In relation to the Police response, there has been continuing operations within the High Town area of the town, targeted meetings by the Police with Community Safety Partnership involvement and the identification of a cohort of victims and perpetrators.
- It was discussed there had been a marked improvement within Working Together, especially with Health and an IDVA based in the control room to speak to professionals and a Mate Crime policy. However, it was noted that "Safe Spaces" are not clearly known to professionals.
- It was not known if the marked improvements had directly come as an outcome of the Adult ANNA SAR however, it was clear there had been a drive in last twenty four months to

increase the number of safe spaces in Luton. Safe spaces are available through the Luton Council, Mind BLMK, Women's Aid in Luton, and a Bright Space at the police station for children. There are also safe spaces at libraries and other community locations to access support for a variety of issues, including domestic abuse, mental health, and exploitation.

- The Partnership Boards have a shared protocol and procedures for multi-agency involvement and legal powers to disrupt sexual exploitation and hold to account perpetrators are routinely utilised.
- The LSAB and DALPB dataset includes measures for relevant partner agencies to demonstrate domestic abuse crimes, and sexual exploitation and abuse, results in sanctions against the perpetrator and safety for the victim survivor. The police are developing a bespoke dataset in Power BI to evidence the impact of these measures.

However, the LSAB is aware from its dataset that safeguarding concerns raised for modern slavery and exploitation remain low in 2024/25. The LSAB has a priority to support vulnerable adults who are at risk of modern slavery and sexual exploitation ensuring they are identified, engaged, kept safe and offered effective support. The LSAB partners therefore work closely with the On Street Sexual Exploitation Steering Group led by Public Health under the auspices of the Community Safety Partnership who also sit on our LSAB Strategic Board.

Much of this work is linked to the findings and recommendations from the Adult ANNA Integrated SAR/DHR Sept 2023. ANNA who died by suicide in September 2022 was a previously Looked After Child, victim of sexual abuse and exploitation, who experienced threats of physical violence, she was known to mental health services had housing and homelessness issues and was often reluctant to engage with services.

The activity undertaken by partners in 2024-25 as part of the Luton On-Street Sexual Exploitation Strategy activities aim to reduce harm, support exploited individuals, and address community concerns effectively including safeguarding those at risk of harm. It includes:

1. **Review of National Guidance**: The National Police Chief Council's (NPCC) *National Policing and Sex Work Guidance* is undergoing a consultation process starting April 1, 2024, with revised guidance expected by August 1, 2025.
2. **Operation OCTANS**: Continued police operation to tackle on-street sexual exploitation, focusing on disrupting sex buyers, exploiters, antisocial behaviour, and drug activity. Efforts include ensuring cameras and lights are operational to enhance safety and create a hostile environment for criminal activity.
3. **Community Engagement**: Increased consultation with High Town residents to build confidence in reporting incidents and address community concerns. Regular communication sessions are planned to foster trust and encourage reporting.
4. **Support Services Expansion**: Azalea reported an increase in new clients from 6 in March 2023 to 17 in March 2024, indicating expanded outreach and support for exploited women. Azalea is a key member of the LSAB Strategic Board as the VCSE representative and chair of the LSAB VCSE Coproduction group.
5. **Multiagency Collaboration**: A steering group chaired by Bedfordshire Police and Luton Borough Council Public Health continues to provide strategic direction, involving various stakeholders to address exploitation comprehensively.
6. **Draft Strategic Objectives Implementation 2024/25**:
    - Recruitment of a council analyst to develop a live profile and evaluate the impact of actions.
    - Efforts to provide crisis accommodation and wraparound support for exploited women.
    - Development of trauma-informed health services to improve health outcomes.
    - Prevention initiatives targeting vulnerable individuals, including care plans for at-risk care leavers.
    - Increased police presence at Azalea sessions to build trust and encourage reporting.

The LSAB Scrutiny & Performance Task and Finish Group also received single agency highlight reports with a theme on modern slavery and adult exploitation at its meeting in May 2024 and the partners provided the following assurance:

- **Beds Police:** have an in-depth response to modern day slavery and exploitation, they have designated desks for vulnerability, exploitation, modern day slavery and immigration crime to look to try to tackle the problem with police and multi-agency interventions. There have been ongoing police operations where there were arrests and victims identified. The police were involved in setting up the reception centre and completing onward National Referral Mechanism (NRM) referrals. It was discussed that, with consent, a NRM referral can be completed and this can support with ongoing communication with the individual.
- **BHT:** Bedfordshire Hospitals NHS Trust arrange specialist Exploitation Awareness days for staff and they represent the Trust at the Modern-Day Slavery group.
- **CCS**: the number of referrals is low, and CCS need to build more awareness around this subject. Training is provided around modern-day slavery and exploitation to staff within CCS (420 staff currently). Staff regularly ask for advice - this is not always followed up by a referral, but staff are asking for advice. All concerns are referred into MASH, however, some would go back to the involved agency or worker involved for advice. There is also a statement regarding this on the website and there is an Adult safeguarding helpline. However, there have been no calls to the helpline regarding modern day slavery. There are not any current cases with regards to exploitation and modern day slavery known to CCS.
- **ELFT:** within Quarter 4 there is only one person open to ELFT for a Section 42 enquiry. All Band 5 nurses have Level 3 safeguarding training which includes a modern-day slavery module. One query raised was why in mental health we are not seeing modern day slavery in referrals and identifying this more often or why they are not being referred to mental health services.
- **ResoLUTiONs CGL**: as part of the multi-agency team at the reception centres, offered support and that this is a good opportunity for onward referrals if moved out of area. They also work with individuals who may have dual diagnosis and be exploited through the on-street sex trade and other forms of exploitation such as cuckooing.

LSAB published A Luton framework for shared understanding of adult safeguarding concerns in September 2024-25. This established a pathway for sexual exploitation to automatically undergo enquiries in MASH under section 42, Care Act 2014. This guidance supports development of an understanding and concerns received and local system intelligence. It is expected therefore this will be an area of reportable growth in 2025-26.

The LSAB has also revised its multi-agency safeguarding procedures to include guidance on working with adult concerns and whether it requires single agency support, signposting, or a referral for a Care Act assessment to a section 42 safeguarding enquiry to be opened. Working with experts by experience and partner agencies, the two Partnership Boards have revised the local policy framework for responding to adult sexual exploitation to incorporate good practice and integrate it into the multi-agency risks management processes.
sexual exploitation and modern slavery

Supporting agencies with specialist skills or opportunities for engagement with women involved in sex work (police, housing, mental health, substance misuse services and Azalea) have adopted revised procedures to identify those at risk of trafficking and experiencing sexual exploitation and violence and agreed operational delivery groups.

Azalea has provided training and awareness agencies working with this vulnerable group of women - agencies include Resolutions, Noah and Stepping Stones. They are linked in with the high intensity women's Team at Resolutions, and there is co-working in place. There is also case working with Leavale GP surgery. The surgery provides condoms for the women who need

them. The vulnerable women's group brings professionals together for collaboration and joint working.

The CASPA process has been further implemented to ensure the most appropriate risk management process is used depending on the level of risk, so that robust plans can be agreed and agencies own actions to mitigate abuse.

- CASPA TOR - CASPA TOR August 2024
- CASPA Pathway - CASAP Pathway April 2024

The Partnership Boards have agreed reporting arrangements so that they are able to monitor how effective agencies work together to reduce risk.

There is an on-street sexual exploitation (OSSE) Steering Group who manage the OSSE Strategy and Action Plan as well as Operational Delivery Groups who take forward the individual workstreams around Prevent, Protect, Pursue and Prepare. This has been developed in conjunction with the University of Bedfordshire and incorporates best practice nationally and locally.

The findings from the workshop and the research have been developed into the Luton on-street sexual exploitation 10-year strategy (2024-34). This is supported by an action plan setting out how the partners can make real change, along with a charter of agreement for partner organisations to sign up to. The strategy includes six strategic objectives:

- identifying the problem
- developing routes out
- improving health outcomes
- prevention and early intervention
- community intelligence
- tackling demand and disruption.

The ambition of more than 60 actions includes better wrap-around support to help women to exit (including, in an ideal world, crisis accommodation); more trauma-informed accessible health services for women; better funding for Azalea to enable more outreach work; and stepped-up police patrols to address the issue of sex buyers. The biggest challenge is to now identify funding for the action plan.

The partners have formed five organisational delivery groups which will work to deliver the actions. A multiagency steering group has been created to provide strategic direction, chaired by public health and Bedfordshire Police. The Community Safety Partnership has oversight of the work and will receive regular updates. This will ensure a good governance structure and a framework for evaluating impact and outcomes on a regular basis.

Luton's strategy and action plan were agreed in the summer of 2024, so this work is still at an early stage. The partners regularly attend community meetings to hear people's concerns and keep them updated on progress. Recent feedback from residents is that they can see action is being taken and the situation is already beginning to improve.

Blended Triage Teams consisting of ELFT and professionals from partner agencies such as Primary Care Link Workers, Talking Therapy's, ResoLUTiONs, Community Prescribers screen all referrals made for mental health support to ensure that the person's needs can be swiftly identified and that there is engagement with the appropriate service to meet their identified needs.

There has been an increase in the number of Section 42s completed and reviewed over the last 42 months and timeliness is up by 7%. There have been improvements regarding supported living license arrangements, and improvements within MASH regarding mental health issues.

Cases of modern-day slavery often involve exploitation, sex work, drugs and alcohol and are often difficult to manage, the risk often remains, patients are often presented at the point of crisis, this can lead to repeat referrals into the MASH. Vulnerable women especially around sex working are identified as high risk of exploitation and are well known to partner agencies however, the risk remains. As a result of the highlight report the LSAB agreed that it needed to continue to receive feedback on the numbers of referrals and safeguarding enquiries made in relation to modern day slavery and exploitation. Modern day slavery will continue to be on the LSAB risk register due to the low number of referrals received and the improvements to be made to identify modern day slavery within the care sector.

EMOTIONAL HEALTH AND WELLBEING

The LSAB Strategic Board received a report on suicide prevention for older people in December 2024. This set out that suicide among older adults is a significant concern, with rates increasing in later life, particularly for men aged 85+. Older adults may experience unique risk factors such as physical health deterioration, social isolation, and cognitive impairment, which can increase suicide risk. Self-harm in older adults is less common but often associated with higher suicidal intent and fatal outcomes. Care homes lack specific resources for suicide prevention, intervention, and postvention. The report made the following findings.

1. **Suicide in Later Life:**
   - Suicide rates rise in older age, especially for men aged 85+.
   - Self-harm in older adults is linked to higher suicidal intent and fatality.
   - Risk factors include psychiatric illness, physical health deterioration, pain, social isolation, bereavement, and cognitive impairment.
2. **Suicide Prevention Strategy for England:**
   - Aims to reduce suicide rates, improve support for self-harm and bereavement, and address common risk factors like financial difficulty, substance misuse, and loneliness.
   - Priority groups include middle-aged men, people who self-harm, and those in contact with mental health services.
3. **Care Homes:**
   - Care homes lack tailored resources for suicide prevention.
   - Risk factors in care homes include loss, bereavement, declining functional capacity, and elder abuse.
   - Staff training and a designated Suicide Prevention Lead are recommended.

<u>Recommendations:</u>

Universal Interventions:

- Promote positive mental wellbeing through education, awareness, and better recognition/treatment of mental disorders.
- Restrict access to means of suicide.

Targeted Interventions:

- Develop community support programs to address social risk factors.
- Improve management of physical health conditions, including pain.
- Ensure services are accessible and acceptable to older adults.

Care Home-Specific Actions:

- Implement whole-population approaches to promote protective factors and support transitions for new residents.
- Train staff in suicide prevention and self-harm competence frameworks.
- Develop safety plans for at-risk residents and provide postvention support after a death by suicide.

Practical Tools:

- Use the Care Home Suicide Prevention Checklist and Crisis Response Plan to guide prevention, intervention, and postvention activities.

Addressing suicide among older adults requires a multifaceted approach, including universal and targeted interventions, tailored strategies for care homes, and improved staff training and resources. Promoting mental wellbeing and addressing risk factors are critical to reducing suicide rates and supporting vulnerable populations. These are areas that the LSAB needs to consider when planning activity against this priority in 2025/26.

Under the Modern Emotional Health and Wellbeing priority review of SARs (led by ELFT) and referencing Adult Keira and Adult C the following evidence of impact was found:

- There is ongoing work highlighting the importance of medication and encouraging the use of Shared records. A gap was highlighted and there was discussion about where cases go when not referred for a SAR as they do not meet the criteria and how the agencies respond to any learning including service users who are unhappy with outcomes
- Good practice was highlighted in a case study utilising the escalation protocol where multi-agencies had worked together to ensure the safety of a vulnerable women with poor mental health and her unborn baby, across several boroughs.
- Further evidence of training undertaken was collated and this is listed below on trauma informed care.

Adult Kiara: This SAR focuses on the case of Kiara, examining her experiences with mental health, abuse, and agency involvement within the context of safeguarding practices. Following a significant suicide attempt in 2022, Kiara has been in hospital receiving medical and social care support. She is now recovering and looking forward to her future, expressing a desire for the SAR to help others in similar situations.
The report will be published in May 2025 but in the meantime the LSAB have been working on the following areas of practice as part of the **recommendations and agreed actions:**

1. **Enhance Multi-Agency Collaboration**:
   - Establish forums for professionals to share information and analyse patterns of risk for adults with complex vulnerabilities.
   - Conduct regular multi-agency audits to evaluate the effectiveness of safeguarding practices and ensure systemic improvements.

2. **Embed Cultural Competence:**
   - Provide training for all front-facing staff on cultural competence, diversity, and intersectionality.
   - Ensure assessments, care planning, and interventions consistently address cultural and systemic factors influencing vulnerable adults.

3. **Improve Suicide Prevention and Risk Assessment:**
   - Develop a joined-up approach to suicide ideation and prevention across the partnership.
   - Train professionals to assess suicide ideation and self-harm risks beyond episodic responses, focusing on safeguarding adults between high-risk episodes.

4. **Strengthen Advocacy Support:**
   - Employ advocates to represent adults experiencing high levels of risk and mental health episodes, ensuring their needs, risks, and wishes are voiced effectively.

5. **Review Policies and Procedures:**
   - Update training, policies, and procedures related to suicide ideation, Post Traumatic Stress Disorder (PTSD), forced marriage, and honour-based violence.

- Ensure professionals are confident in using the Mental Capacity Act to assess decision-making capacity in vulnerable adults.

6. **Improve Housing and Medication Access:**
   - Develop systems to ensure vulnerable adults can access safe housing and medication without unnecessary delays.
   - Provide support to families navigating these processes during crisis situations.

7. **Promote Trauma-Informed Practice:**
   - Train professionals to adopt trauma-informed approaches when working with adults who have experienced abuse, neglect, and complex PTSD.
   - Ensure interventions are holistic and address underlying patterns of need rather than isolated incidents.

8. **Create Opportunities for Professional Reflection:**
   - Facilitate regular opportunities for professionals to collaborate, reflect, and learn from cases involving adults with multiple vulnerabilities.
   - Encourage courageous conversations about cultural competence and intersectionality in safeguarding practices.

9. **Monitor Progress and Impact:**
   - LSAB should oversee the implementation of these actions and monitor their impact through annual audits and reviews.
   - Agencies should report back to LSAB on how they are progressing with the learning from this review.

These actions aim to improve safeguarding practices, address systemic gaps, and ensure vulnerable adults like Kiara receive the support they need. The outcomes and impact of these actions will be formally reported on in the next annual report for 2025/26.

Trauma Informed Care - The Joint Quality Assurance & Learning Group received presentations in June 2024 on approaches to Trauma Informed Care. This gave evidence of agencies progress in relation to trauma informed activities. Bedfordshire Hospitals, Bedfordshire Police, Cambridgeshire Community Services, East London Foundation Trust and LBC Adult Social Care provided assurances that over 4,000 members of their staff have received access to support and trauma informed approaches and attended:

- Oliver McGowan Training package.
- Formal Trauma Informed Care training
- First contact engagement training
- De-escalation training including sessions on:
- Communicating with Empathy
- Communication in End of Life Care
- Communication – Care Certificate
- Communicating with patients, parents and carers
- Disability Matters –Communication in health
- Communication Support Tools
- Effective Communication and presentation.

Right Care Right Person (RCRP)

The LSAB Strategic Board has received regular reports regarding RCCP and has provided focus and challenge on the response to welfare calls. At the Strategic Board in March 2025 the changes to governance related to the transition of the RCRP from project monitoring to business-as-usual processes, including performance monitoring and addressing identified gaps in mental health and safeguarding services in Bedfordshire were presented.

The key changes in RCRP governance structures aim to streamline operations, improve coordination among partners, and enhance monitoring and escalation processes and include:

1. **Transition to Business as Usual (BAU)**: Current project arrangements will cease, and new BAU processes will commence from 6th May 2025.
2. **RCRP Partnership Steering Group**: A central steering group will oversee governance, including policy requirements, training, communications, legal implications, data monitoring for performance, and lessons learned.
3. **Multi-Agency Partnership Escalations**: A new escalation process will be implemented, with reviewed and approved Terms of Reference and MS Forms.
4. **Closure of Non-Essential Meetings**: Partnership meetings not required under the new governance structure will be closed.
5. **Integration with Local Governance**: Local governance structures for Bedford Borough Council, Luton Borough Council, Central Bedfordshire Council, East of England Ambulance Service (EEAS), ELFT, and Acute Trusts will be incorporated into the RCRP framework.
6. **Streamlined Oversight**: The governance structure will include oversight from various boards and groups, such as the Chief Exec Forum, Adult Mental Health Practitioners (AMHP) Governance Group, BLMK Integrated Care Board, and the Local Safeguarding Boards.

The reported outputs from the three stage initiative were cited as:

Reduction in Concern for Welfare Calls: Police attendance for concern for welfare calls dropped from 80% to 51%, potentially indicating better allocation of resources and reliance on appropriate agencies for non-urgent welfare concerns and indicating improved processes for managing these incidents. Around 300-400 calls per week are made to the mental health crisis line, showing active engagement with mental health services.

Improved Crisis Response: The establishment of the Healthcare Professionals Line and new processes was established in October 2024 to ensure rapid advice and guidance for urgent face-to-face assessments by crisis teams (East London NHS Foundation Trust). A new process was introduced in November 2024 for patients seen by police and requiring urgent face-to-face assessments by crisis teams. suggest faster and more effective responses to mental health crises. Referral numbers to Bedford and Luton crisis teams have remained steady, indicating consistent support for individuals in need.

Enhanced Multiagency Coordination: The implementation of RCRP governance structures, including multiagency escalation processes and streamlined oversight, are seen to improve service delivery and support for vulnerable individuals. EEAST reports a reduction in mental health demand, which could be attributed to seasonal averages or the implementation of RCRP. This is being monitored to determine the exact impact.

Training and Pathway Development: EEAST has provided bespoke training for ambulance staff and developed mental health pathways, which may enhance care for vulnerable individuals requiring emergency or non-emergency assistance.

While these changes suggest positive impacts, the LSAB has not been provided with specific data setting out the outcomes directly related to vulnerable individuals. This means that while the report demonstrated the differences made to the inputs to the system is did not provide data on the impact of RCRP on mental health demand and what happened to vulnerable adults signposted out of the police response system.

The LSAB is therefore keen to ensure that vulnerable adults have access to support services when required, and that the police have attended incidents where there is evidence that a crime

may have been committed, or there is a need for crime prevention. It will retain RCRP as a risk register item in 2025/26 and seek assurance data regarding those vulnerable adults.

Mental Health Bill

The LSAB also received a report from Adult Social Care in March 2025 on the implications for practice of the **Mental Health Bill** and its progress through parliament. The key points were:

- The bar for detention will be higher; there must be evidence that 'serious harm may be caused to the health or safety of the patient or of another person'.
- People with a learning disability and autistic people without a co-occurring mental health issue will only be able to be detained for a maximum of 28 days, however this will only be enacted when the government is confident sufficient community services are in place.
- Integrated care boards (ICBs) and local authorities will need to ensure they meet the needs of people with learning disabilities and autistic people without having to detain them, which means by 'increasing community provision for this group'. They will also have to maintain a dynamic list of people with learning disabilities and autistic people who are at risk of detention.
- Community treatment orders (CTOs) will remain but will have stricter criteria.
- Patients will be able to choose their nominated person, with safeguards in place.

Successful implementation of the Act will depend on ensuring that the workplace is aware of the revised Act through training, education and that resources are available to all practitioners. The LSAB intends to monitor progress of the bill through parliament and agree appropriate workstreams as required in 2025/26.

ROUGH SLEEPING

LSAB added Rough Sleeping to its governance structure and workstreams, in line with the mandate from the government in the Ministerial Letter in May 2024. The LSAB has had oversight of a response plan to the mandatory requirements.

	Recommendation	Safeguarding Adults Boards Evidence/Action
1.	**Governance structure, accountability, and system-wide change.**	
1A.	SABs should ensure their governance structure has the necessary mechanisms to hold partners working with people rough sleeping accountable.	The LSAB has added Rough Sleeping to its governance structure and workstreams including in its delivery plan and procedures. It has held a rough sleeping workshop for partners to understand both the risk but also the approaches available to rough sleeping in Luton
1B.	SABs should act as an active presence in system-wide governance discussions. These discussions should seek outcomes which promote the integration of experience informed practice into service standards.	The LSAB has sought assurance on the numbers of rough sleepers in Luton and how many of them are utilising drug and alcohol services, on street sexual exploitation services and homelessness charities.
2.	**Named Board Member for rough sleeping**	
	SABs should designate a member of the Board to lead and update on complex or stalled cases within the local authority's Target Priority Group (TPG) of people rough sleeping.	The Interim Service Director Housing is a member of LSAB Strategic Board and the designated member who leads and updates on complex or stalled cases within the local authority's TPD is the LBC Rough Sleeping Coordination Manager and outputs are to be reported to the LSAB on a quarterly basis.
3.	**Strategic plans, annual reports and procedures**	
	SABs should actively reference rough sleeping and homelessness in annual reports and strategic plans.	Rough sleeping is featured in the LSAB Strategic Business Plan 2024-26 and Delivery Plan 2024/25. Rough sleeping is also referenced on the LSAB Risk Register as an area of focus and amelioration.

	Recommendation	Safeguarding Adults Boards Evidence/Action
	Promoting workforce safeguarding and legal literacy is also strongly recommended.	Awareness raising within the workforce of safeguarding those involved rough sleeping and legal literacy is on the LSAB Training Plan as part of its blended learning delivery.
4.	**Safeguarding Adult Reviews**	
	In compliance with the Care Act 2014 ("Section 44"), SABs should proactively commission Safeguarding Adult Reviews in cases of deaths involving rough sleeping whether they meet the mandatory requirements. There should also be a clear focus on implementing learnings from the reviews.	The LSAB has a robust approach to referring cases for consideration of a SAR and decision making around the section 44 Care Act 2014 criteria. This includes cases where there are concerns about recent or non-recent rough sleeping.

The Joint Quality Assurance and Learning (JQAL) group reviewed all SARs and rapid reviews undertaken in the last twenty four months linked to each of our priority areas. Under the Rough Sleeping priority (led by LBC ASC and Housing) and referencing SARs on Adult ANNA and the unpublished Adult Keira, Adult EMMA and Adult Leah SAR the following evidence of impact was found:

- There have been rough sleeping workshops, to aid the partnership, and the Service Director of Housing is now a member of the Board. In addition, there is an LBC Rough Sleeping Co-ordination manager and outputs reported to the Board quarterly. There are several new initiatives including commissioning specialist services, street outreach and a more multi-disciplinary response.
- In relation to the SAR's, and in Adult Keira's case the author of the review has been assured that many of the issues raised in her report have already been understood and agencies separately and together have acted upon some of the issues raised in her report.
- The impact of this SAR has been increased awareness, increased problem-solving awareness, and improvements in assessments. Further impact has been as follows: Safeguarding information sharing huddle has been introduced including appropriate escalations brought to this huddle improving accountability, more accountability to the LSAB Board, and Housing now being represented at Board level. In addition, there has been more information sharing with key agencies, and regular updates at Board level.
- Impact and learning from the Adult Leah / MR's SAR has been as follows. Due to the introduction of accommodation-based support, there has been a decline in numbers of new rough sleepers per quarter. In addition, there is a strong partnership early intervention approach, including mental health support. Although auditing data shows that there appears to be a small improvement in the quality of Mental Capacity Assessments (MCA), application of thresholds is still an area of development and there will be ongoing training to support this need.
- The impact of Adult Anna's SAR has been an improvement in collaborative working, improved support pathways for clients, agencies now more familiar with their responsibilities, and more staff seeking advice. In addition, there has been more trauma awareness from staff, also in relation to more awareness to prevent re-traumatising service users.
- The Complex Case Pathway has also been introduced and guidance on a shared understanding of safeguarding concerns has been shared widely. The social care workforce is more equipped in dealing with victims of sexual exploitation and domestic abuse and able to respond quickly. There is progress in having a domestic abuse pathway, and a Public Health vulnerable women's pathway. OSSE strategy was completed, and a Complex Case co-ordinator will be employed – this will improve the co-ordination of support.

CARE MARKETS

The LSAB also received six monthly reports on Care Markets. This highlighted that market pressure continues around shortage of residential or nursing beds, demands on our hospitals, and lack of placement activity due to providers demanding costs above LBC rates. There is also a challenge around budget changes and the rise in employers National Insurance affecting providers sustainability to remain in market in 2025. Ongoing issues with Care Quality Commission (CQC) approaches have been seen to be damaging providers trust in the regulator.

Residential and Nursing bed capacity

TOTAL BED CAPACITY	**812**
TOTAL VOIDS	38
VOIDS CAPACITY WE CAN UTILISE	27 = 3.32%

Providers under Provider Performance Review

One supported living provider under provider performance due to receiving requires improvement in their PAMMS service review

Two residential care homes under provider performance- One due to CQC breaches and one due to receiving requires improvement in PAMMS service review

One nursing care home which has recently been de-escalated from serious concerns due to demonstrating significant improvements. Provider performance is now monitoring for sustainability and continuation of improvements.

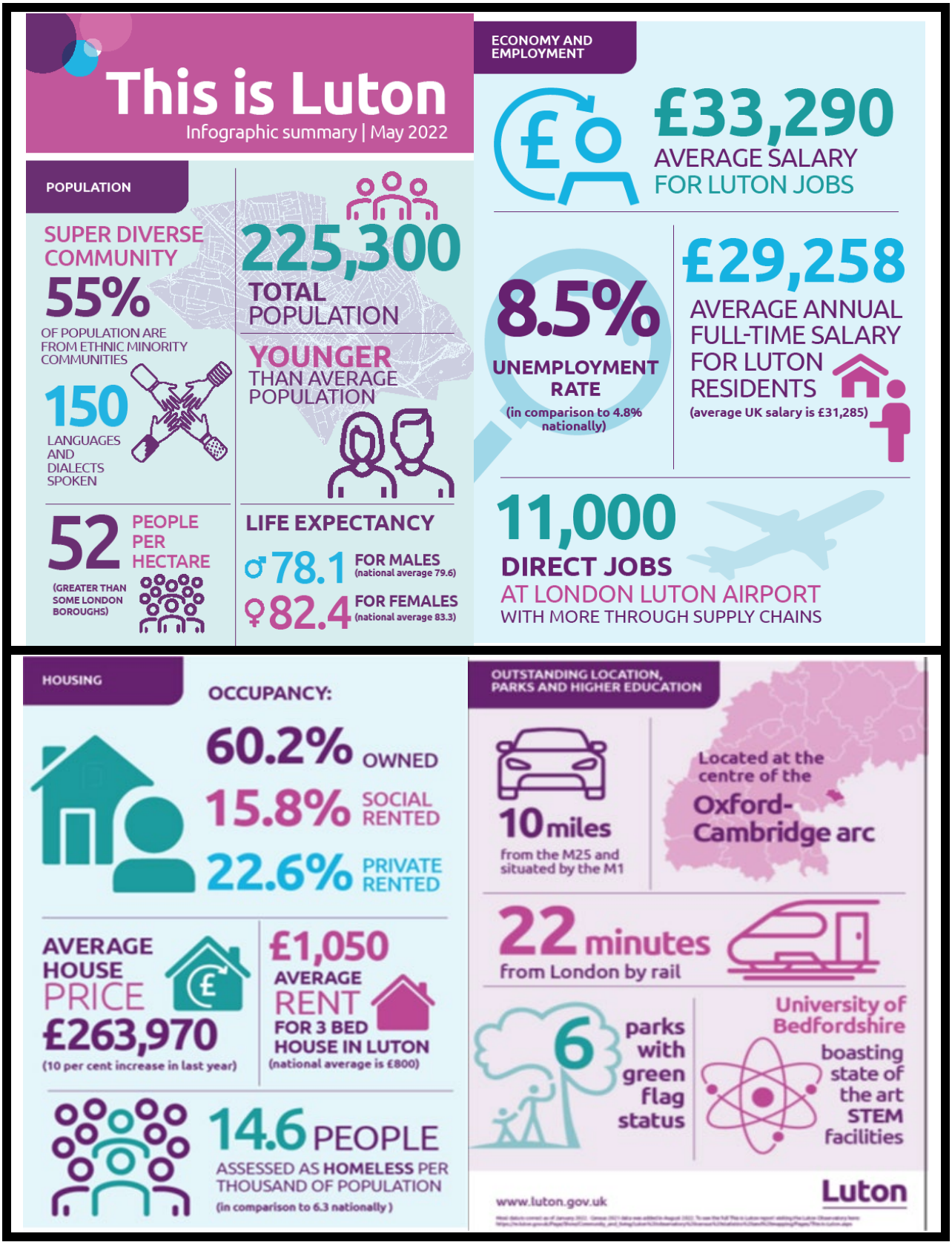
One homecare provider under provider performance due to receiving requires improvement in their recent PAMMS service review.

Measures being taken

- Weekly updates are provided to the Senior Leadership Team (SLT), and the provider quality team works closely with providers to address challenges, share information, and hold timely meetings.
- CQC meetings occur every six weeks to ensure mutual expectations and robust discussions.
- Annual deep dive assessments are conducted for care homes, and the provider forum gathers intelligence to address concerns.
- Issues have arisen with non-commissioned providers in Luton, including safeguarding concerns like Modern-Day Slavery.
- Collaborative forums are available to address these concerns, and key staff are attending these meetings for better outcomes. Resources are focused on commissioned care but also consider other elements.

3. 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 LSAB dataset has predominantly used data from adult social care to consider the throughput of safeguarding concerns to safeguarding enquiries from partners.

The single agency thematic highlight reports which began in 2023-24 are providing assurance on the effectiveness of safeguarding across a range of practice areas. Highlight reports have been produced on outcomes of provider led section 42 enquiries, safeguarding training compliance, modern day slavery, right care right person and domestic abuse.

LSAB SCRUTINY AND PERFORMANCE TASK & FINISH GROUP

The LSAB Scrutiny and Performance Task & Finish Group was tasked in April 2024 with taking forward the scorecard and narratives to ensure the provision of high-quality multi-agency core data and narrative. This is to provide the LSAB with evidence of impact, patterns and trends and emerging issues, and barriers to effective safeguarding across a range of measures. The focus being that measures tell us how well we are safeguarding adults in Luton. The group met regularly throughout 2024-25 and sought to drive forward on a multi-agency core dataset and provision of narratives and highlight reports. The group achieved the following across the year:

- partner agencies reviewed their existing single agency safeguarding data and narratives and confirmed what is available that can be provided by all agencies as core data
- committed to provide date to be collated into a simplified scorecard to give a multi-agency perspective on safeguarding themes.
- worked with business intelligence leads to agree a data cycle for collection of data and narrative to ensure the group has data available to scrutinise in a fully populated scorecard

- formulated a highlight report to the Joint Quality Assurance Leads Group and a high level report to the LSAB Strategic Board.
- produced thematic single agency highlight reports that provided an overview of their contribution to the LSAB priorities including impact data and narratives as well as identifying and gaps, challenges or barriers to multiagency safeguarding effectiveness.
- agreed a safeguarding effectiveness evaluation tool to be produced annually against agreed standards to support the evidence of impact within the annual report

The following challenges remain:

- The scorecard data returns from single agency have been problematic and did not provide a validated end of year position for the LSAB to review its impact against priorities and development of emerging themes.
- The single agency partners are not always collecting or providing ethnicity data in referrals which means that figures for 'Ethnic background not known' is too high, and remains a consistent area for improvement.
- The LSAB is reliant on use of an Excel spreadsheet collection template which requires manual collation and completion, however, there is appetite to utilise other reporting tools and to be able to overlay data into a multi-agency Power BI report.
- The LSAB continued to utilise the ASC Safeguarding Adult Collection (SAC) 2024-25 as a proxy measure of multi-agency input into the safeguarding system, some key highlights are shown below.

FIGURE 3: TOTAL NUMBER OF CONCERNS, ENQUIRIES AND CONVERSION RATE - APRIL 2019 – MARCH 2025

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Total number of concerns	4640	4266	4578	3967	3656	3749
Concerns raised for individuals	3031	2744	2907	2976	2790	2851
Total number of enquires	509	473	341	355	406	411
Enquiries commenced for individuals	442	411	314	329	350	389
Conversion Rate %	11%	11%	7%	9%	11%	11%

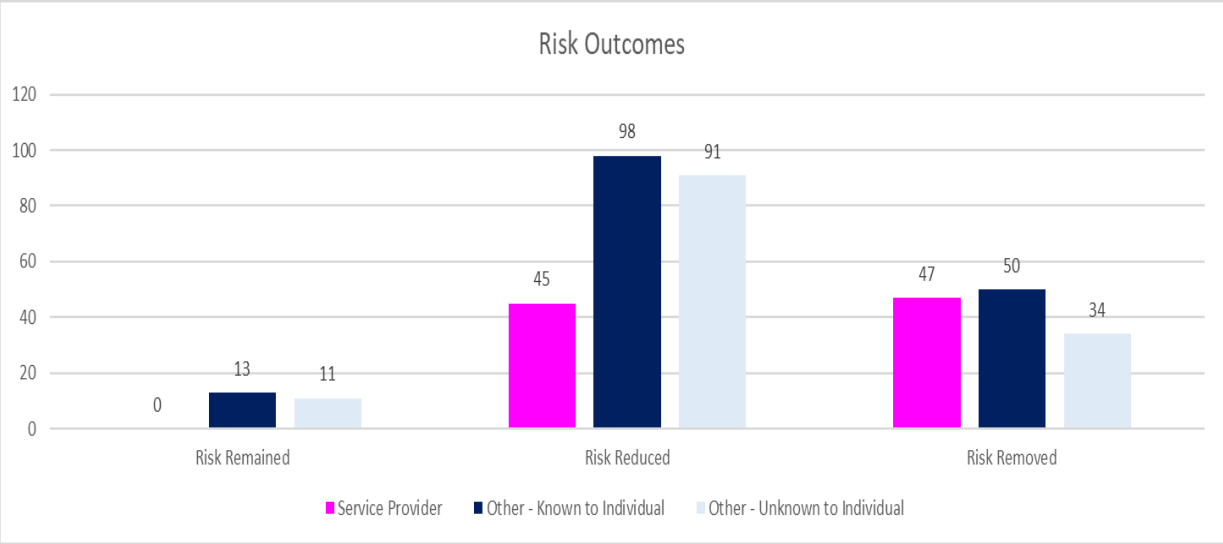
In 2024/25, Adult Social Care recorded a total of **3749** safeguarding concerns received into the Adults MASH. In comparison to the **3656** concerns received in 2023–24 and **4578** in 2022-23, there was a noticeable drop in the total number of concerns received into the MASH.

The reduction in concerns is seen a positive and has been explained by a robust screening process which has managed successfully to redirect non-safeguarding concerns to other adult social care pathways.

Redirecting queries that are not safeguarding concerns has effectively improved accuracy of data and reduced the overall number of concerns reported under safeguarding, whilst also ensuring that people that need other types of support can access appropriate services without delay.

In 2024-25 a total of **411** safeguarding concerns progressed to section 42 enquiries which is similar to the total number of enquiries in 2023-24. This represents a conversion rate of **11%** from concern to enquiry. Measured against the national average conversion rate of 34%, Luton's conversion rate is much lower. However, there is no national standard for the level of concerns or enquiries expected per 100,000 residents and no standard agreed way of reporting. Luton's rates are more similar to rates in the Eastern Region. There has also been changes made mid-year to how concerns and enquiries are recorded in the MASH.

FIGURE 4: RISK OUTCOMES APRIL 2024 – MARCH 2025



Of the number of enquires completed in 2024-25, **94%** are recorded as risk reduced or removed. From the **385** Section 42 enquiries the safeguarding outcomes were recorded as:

- Risk removed following safeguarding interventions in **131** cases (34%), reduced in **234** cases (60%) and remaining in **24** cases (6%).

This builds on last year's improvement. Reduction of risk is fundamental to the work of safeguarding. There will be situations where it is not possible to reduce risk for example domestic abuse and/or multiple vulnerabilities such as mental health, drug and alcohol abuse and homelessness can be an area of challenge in reducing risks.

There are several strands of work to support a cycle of continual improvement. This includes specialist safeguarding training across partners with a focus on interventions and strategies for the reduction of risk, targeted audit activity and professional development across Adult Social Care to support understanding and professional confidence when assessing safeguarding outcomes and associated risks.

The partnership continues to update its safeguarding documentation and processes by way of audit and recommendations on a routine basis. A revised version of the pan-Bedfordshire referral form, with this information marked as mandatory, has been socialised. The partnership training plan includes this as an area for targeted development for delivery this financial year.

The Safeguarding Adult Collection (SAC) 2024-25 Overview Summary which shows how contacts have been made and safeguarding enquiries addressed is attached as Appendix A.

MULTI-AGENCY AUDITS

The LSAB Multi-agency Audit Group had an established rolling programme of audits and highlight reports throughout 2024/25 which included themes linked to learning from reviews. The audits undertaken in 2024/25 are summarised below, many of the findings in the audits were similar in terms of general practice that needed to be improved.

Transitions Audit April 2024

The transitions audit was agreed primarily to ensure young people and adults are dealt with in accordance with the Luton safeguarding policies and procedures to ensure transitioning to

children and adult social care was being appropriately applied. The audit was conducted as a joint audit with the Luton Safeguarding Children Partnership.

The audit sample size was 10 cases randomly selected on the following criteria.

- Individuals aged between 17½ - 25
- Individuals who have been involved in a safeguarding enquiry section 42
- Enquiries must have been closed/completed in the last 12 months
- There must have been multi-agency involvement with the individual at the time of the concern and or enquiry

Single agencies assessed their involvement with the individuals and graded the cases. This information was collated into an audit scoring matrix which was moderated in a multi-agency audit meeting where partners considered the quality of the multi-agency interventions in a face-to-face event, to enable the involved agencies to evaluate, reflect and learn from the effectiveness of multi-agency working.

Overview of key Findings:

- Children with a diagnosed disability and those who were Looked After Children were more likely to have a robust planned and successful transition into adult services. Children and young people subject to Child in Need plans, contextual safeguarding, transitioning to adult social care under safeguarding were not automatically considered or robustly transitioned.
- Learning disability was recorded in case work, often without a clear diagnosis and discussed in relation to Global developmental delay and when this moves into a specific diagnosis.
- There were barriers linked to neurodiversity especially where there was coexisting mental health, alcohol, and substance abuse. In some cases there appeared to be a lack of skills to manage diagnosis, behaviours, and physical conditions.
- There is a need for a Luton Adult safeguarding framework document and staff training in relation to Autism, ASD, and learning disabilities.
- There were sometimes gaps in the information provided to adult social care and they refused to accept referrals for safeguarding plans due to the lack of previous knowledge or assessment by children's social care.
- The awareness of transition needs to be addressed from the age of 14 – 18 with children and young people who are looked after children, child in need. The risk of sexual exploitation in adulthood did not always lead to a referral to Adult Social care while they were still a child.
- There are different transitional pathways within health. A Luton Multi agency Safeguarding transitions pathway has been identified as a clear theme for all agencies to access.
- The awareness of transition needs to be addressed by practitioners from the age of 14 – 18 with children and young people who are looked after children, child in need. Transitional plans need to be discussed in supervision.

Transitions work is being led by the Director of Adult Social Services and the Service Director Children's Operations and includes children and young adults in a range of circumstances. The systems learning has been fed into this work and the LSAB / LSCP are developing a joint safeguarding transitioning pathway for vulnerable young people and adults when transitioning in safeguarding processes.

- A lead professional was not always identified to act as a key conduit and contact point with regards to the delivery and co-ordination of services.
- Historical information was not shared between agencies, particularly at the point of referral to Adult Social care or information such as perpetrator organised rings to the Police. However, individual cases noted good information sharing to Bedfordshire Hospital Trust and Adult Social Care from Children Social care. Also good practice

from Paediatric Team at the Bedfordshire Hospital Trust with regards to their involvement and recording secondary diagnoses such as allergies.
- The risk of sexual exploitation did not always lead to a referral to Adult Social care.
- Parents were often assumed to be the protective factor for children and young people.
- Think Family approaches were often not applied.
- When undertaking a Mental Capacity Assessment, the risk of sexual harm to individuals or others were not always assessed properly.
- Legal literacy was not always applied to connect legal legislation with Mental Capacity Assessment and professionally curious practice.
- A lack of professional curiosity around patterns of interest/sexual harm. Also, around DARVO (deny, attack, reverse victim, and offender)
- The Pan Bedfordshire Children's Policy WAS NOT BROUGHT could be applied to working with vulnerable adults and is not as clear cut for adults than in children's processes. Adults who have capacity do not have to attend appointments if they do not want to.
- Gender based abuse was not always identified, assessed, and considered as a high risk.
- Professionals did not always consider complexity within individual cases and whether such cases should have been referred to the Luton CASPA.
- The use of multi-disciplinary team (MDT) meetings can vary within the partnership. Different models of joint working and barriers and facilitating of these meetings can become blurred with so many approaches.
- When escalating a case to adult social care, agencies are not always sure of the escalation processes.

The policy and procedures requiring work identified within this audit has been reviewed and overseen by the Joint Quality Assurance and Learning group and Pan Beds SAB Steering Group. As a result the systems learning from this audit has fed into the work developing policy, procedures and practice. This is detailed in the section on the work of the Joint Quality Assurance and Learning Group and Pan Beds Steering Group.

Good practice

- Good Practice was evidenced from The Paediatric Team at the Bedfordshire Hospital Trust with regards to involvement, recording diagnosis such as allergies.
- The voice of the child/young person and Making Safeguarding personal were noted as clear and concise in most cases but could be improved in a few. In eight cases there was clear evidence of young people being spoken to alone and in two cases there was no evidence this did not happen, in nine cases there was some consideration of complex needs.

Audit of 'What a good referral looks like?' June 2024

The purpose of the audit was to establish the quality of referral received into the Adults Multi-Agency Safeguarding Hub and to identify if the referral that contained all the relevant information required to make a threshold decision. The results of the audit were fed back to the Joint Quality Assurance and Learning group to consider what has worked well, where improvements or changes could be made and agree upon recommendations or actions to ensure the quality of referrals received. The audit sample was ten safeguarding referrals sent to the MASH between December 2023 – June 2024.

Overview of key Findings:

The main findings of the audit were:

- **Insufficient Information in Referrals**: 50% of referrals lacked adequate information, impacting decision-making and outcomes. 80% were missing ethnicity and other identity information, sometimes including who they lived with.
- **Poor Risk and Safety Assessment**: 40% of referrals showed a lack of planning and assessment around risk and safety.

- **Overuse of Safeguarding Referrals**: A culture of submitting safeguarding referrals to MASH without evaluating if they met the criteria was identified. Referrers often failed to explore other support options or signposting to other services.
- **Passing Responsibilities**: Some referrals reflected a tendency to shift responsibility to adult social care instead of collaborating with others to reduce risk or prevent harm. Concerns were raised too early in 40% of cases alluding to some professional anxiety within the system. There was few interim protection plans put in place as some agencies did not take steps to make subjects safe before sending referrals, expecting the referral to generate an urgent safety plan and advice.
- **Limited Information from Partner Agencies**: Referrals from agencies like Bedfordshire Trust Hospital, East of England Ambulance Service, and Bedfordshire Police often contained limited information, affecting the referral quality. Also, it was not always easy to identify how to contact the referrer to confirm or clarify information.
- **Quality of Information Sharing**: Poor information sharing between agencies impacted the quality of referrals and decision-making and there was limited overlay or collation of what agencies knew. Police, Bedfordshire Trust, and East Herts Ambulance use individual safeguarding templates.
- **Failure to Engage Adults at Risk**: Referrers did not consistently discuss referrals with the adult at risk or consider their lived experience and diversity. The consideration of Mental Capacity Assessment and consent could have been improved in some cases.
- **Underutilisation of Tools**: Tools like the clutter rating scale, self-neglect tool, falls guidance and Domestic Abuse Risk Assessment (DARA) were not consistently used or included in the referral, which could have improved referral quality.
- **Delays in Support**: Submissions to MASH sometimes delayed support processes as early intervention or long-term support could have been initiated instead of waiting for referrals to be screened and triaged by the MASH.
- **Adequate Contact Details**: All referrals audited included sufficient contact details to contact the person who was the subject of the referral.

These findings highlighted the need for better multi-agency collaboration, improved referral processes, and the use of appropriate tools for assessment to enhance outcomes as follows:

LSAB Guidance on Mental Capacity and Consent:
- References the need to ensure a person's capacity (including mental capacity) is considered during safeguarding referrals when appropriate.
- Mental Capacity Act and consent is recorded on safeguarding referrals.

Framework for Risk Response:
- Created an Adult Safeguarding Threshold guidance document and a framework for responding to low, medium, and high-risk safeguarding needs to promote early and consistent identification of needs and reduce professional anxiety in the system
- Provided a single point of contact for escalation and further inquiry.
- Developed LSAB 7 minute briefing - good safeguarding referral

Collaborative Working:
- Critical risk cases are referred to CASPA for multi-agency response.
- Improved use the Think Family approach and Multi-Agency Intelligence forms.
- Increased use of Multi-Disciplinary Team meeting and information-sharing processes, identifying lead professionals

Mental Health Drug and Alcohol Misuse Dual Diagnosis – November 2024

The LSAB Multi Agency Audit Group conducted a dual diagnosis audit focusing on the effectiveness of multi-agency responses to adults with care support needs who also have mental health and substance misuse issues. The purpose of the audit was to test the effectiveness of the multi-agency response to adults with care and support needs and who also

have a dual diagnosis of mental health problems and drug and alcohol misuse. The audit reviewed what has worked well, where improvements or changes could be made from a systems perspective. The main findings of the Dual Diagnosis audit were:

1. **Joint Appointments**: Joint appointments between CGL ResoLUTiONs and ELFT could have been explored for difficult-to-engage cases.
2. **Dispute Resolution**: The professional dispute resolution and escalation process was not effectively used to consider the voice and wishes of individuals wanting to attend rehab groups.
3. **Information Sharing**: Limited evidence of information sharing between ELFT and CGL ResoLUTIONS, with no recorded outcomes of escalations. No evidence of use of Multi-Agency Intelligence Forms by any agency for identifying criminal, victim, or perpetrator behaviour and sharing this intelligence with the police
4. **CASPA Outcomes**: Cases referred to the CASPA forum lacked recorded outcomes.
5. **Police Referrals**: Police referrals often did not raise mental health or safeguarding concerns due to process, and practice issues, with cases not meeting the threshold for pathways.
6. **Multi-Disciplinary Teams (MDTs)**: Internal MDT meetings were recorded, but MDTs excluded external agencies in most cases. There were multiagency MDTs in a limited number of cases.
7. **Mental Capacity Assessments**: Evidence of Mental Capacity Assessments (MCAs) was recorded in some cases. Given the audit theme of mental health with drug and alcohol misuse as a dual diagnosis it might be expected that more MCAs might have been undertaken. Mental capacity can deteriorate when individuals do not engage in mental health or substance misuse treatment.
8. **Joint Assessment and Management Plans**: Lack of evidence for adequate joint assessment and management plans in some cases.
9. **Relapse Risk**: Identified gaps in support for clients at risk of relapsing across multiple services.
10. **Housing Refusals**: High-risk clients were often refused housing by providers as there was no suitable accommodation.
11. **Inconsistent Records**: Inconsistencies in timelines when clients were identified as intoxicated but recorded as abstaining by another agency.

Good practice

- **Non-Engagement Challenges**: Non-engagement is complex, but efforts to encourage clients were evidenced by ResoLUTiONs.
- **Communication**: Good communication between primary care, Bedfordshire Hospital Trust, and ResoLUTIONS was noted, but challenges remain in delivering care to non-engaging clients.
- **Reduction in Police Involvement**: Since January 2024, under the right care right person initiative there has been a reduction in police involvement in mental health issues unless a crime was involved, with better agency signposting.
- **Housing Support**: Good housing input was noted, with support for tenancy management.
- **Advocacy and Support**: Advocacy and other support were considered and recorded in several cases.

These findings highlight areas of strength, such as housing support and communication, as well as areas needing improvement, such as joint working, information sharing, and addressing non-engagement challenges. In order to prevent duplication of effort, recommendations and actions resulting from the three audits across the year, as well as consolidation of the findings from the Learning from SARS Evaluation and Development Day in March 2025, have been triangulated into a single action plan. This have been taken forward into the JQAL workplan for 2025/26 and the single action plan will continue to be overseen by the JQAL.

TRAINING

The LSAB provides multi-agency safeguarding adults training through a blended approach including webinars, face to face training and eLearning formats. There has been a real challenge for the partnership to provide accessibility for its practitioners and to achieve value for money within a very limited budget.

- Mental capacity assessments – delivered to 32 delegates
- Awareness of safeguarding adults – delivered to 171 delegates
- Trauma informed approaches – delivered to 24 delegates
- Learning from reviews – three sessions to 62 delegates
- Multi-agency procedures – three sessions to 89 delegates
- Safeguarding Bedfordshire – webinar accessed by 104 people

The LSAB has been working collaboratively with BLMK Public Health in implementing the BLMK Suicide Prevention Action plan and suicide prevention training. Here is the link to the Suicide Prevention Hub it which is a web based resource for frontline professionals to support their work in suicide prevention. It is not designed for the general public but a tool to support professionals in suicide prevention Homepage - Suicide Prevention Hub . Professionals can also join the local suicide prevention network here BLMK suicide prevention network - Suicide Prevention Hub.

Public Health commission general awareness and gate keeper training and a small number of targeted training programmes related to themes and risk factors within local data and audits and action plan for example training for primary care, bereavement by suicide training. The LSAB works closely with BLMK ICB, Public Health and ELFT to promote and deliver additional skill based training for practitioners. These courses cover more in depth skills to support suicidal individuals and safety planning. Examples of these courses include Assist, 4Mental Health, Storm.

The general awareness sessions below support the overarching themes of the multi-agency suicide prevention action plan to make suicide prevention everyone's business. Training - Suicide Prevention Hub

See the Signs (STS) - General Awareness
MIND BLMK deliver STS training across BLMK, a 2.5 hour basic suicide awareness course delivered mainly online and is suitable for all practitioners as an introduction to suicide prevention.

See the Signs & Domestic Abuse - is a general introduction to the links between suicide and domestic abuse. This training was developed due to emerging evidence related to the links between suicide and Domestic Abuse such as research by Vulnerability Knowledge and Practice Programme (VKPP).

Training is integral to the LSAB's improvement cycle and the LSAB continues to explore alternative ways of working and new technology to support the delivery of adult safeguarding training. Following delegate feedback we have continued to offer a hybrid training programme with both classroom-based and virtual trainer-led training in 2024-25 and intend to extend a hybrid delivery model into 2025-26 whilst also exploring AI functionality. Practitioners across Bedfordshire can also access e-learning through Safeguarding Bedfordshire much of which is free at point of delivery. Practitioners from adult facing services can attend classroom training provided by Safeguarding Bedfordshire although some courses are chargeable to their organisation. The LSAB also wishes to be able to collect data on both single agency and multi-agency training delivery and impact in 2025/26.

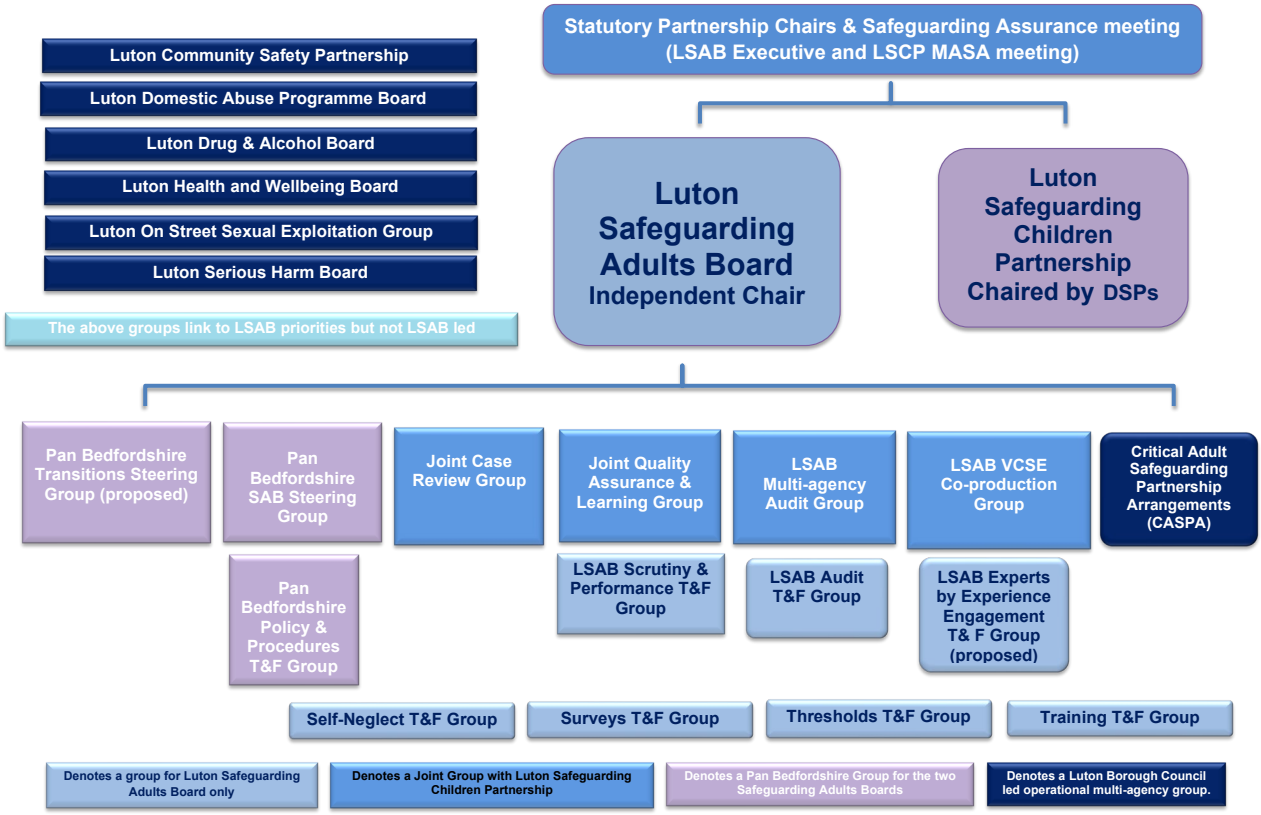
4. BOARD FUNCTIONING AND GOVERNANCE

The Care Act 2014 mandates under section 43 that every local authority must establish a Safeguarding Adults Board for its area. The responsibility for convening the LSAB is delegated to the Director Adult Social Services and the Chief Executive of the Local Authority is accountable for the effectiveness of the SAB.

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 Independent Chair who has been in post since June 2020 retired at the end of March 2025 and the new Independent Chair commenced in post in April 2025.

LSAB Structures to support delivery
• Luton Joint Statutory Partners Chairs Safeguarding Assurance
• LSAB Strategic Board
• Luton Joint Quality Assurance & Learning Group (joint with LSCP)
• Luton Joint Case Review Group (joint with LSCP)
• LSAB Coproduction VCSE Group
• Pan Beds Steering Group (joint with CBBB SAB to review cross cutting themes)
• Themed Task & Finish Groups to take forward identified themes

The LSAB governance flow chart as of April 2024 is shown below:



An accessible LSAB structure chart as updated in June 2024 is available here.

SECTOR LED PEER REVIEW OF GOVERNANCE

In September 2024, the LSAB Strategic Board commissioned a review of its governance, effectiveness and structure through Partners in Care and Health. This review was brought about in light of the retirement of the LSAB Independent Chair, changes being brought about by the updated Working Together for Children (2023) and the subsequent plan to dissolve the Luton joint children and adults business unit. The review was concluded on 23 December 2024.

The review evaluated the current SAB arrangements and processes (including the Business Unit structure). The outcome of the evaluation was to help identify what is required of the LSAB to ensure effective governance and assurance arrangements. The review intended to support in the context of sector led improvement and inform future work planning for Luton SAB and help focus the safeguarding adult arrangements in line with the forthcoming CQC inspections.

Review Objectives

- To ensure colleagues / agencies are clear on their roles and accountability to Luton SAB and have capacity to support and work effectively ensuring the SAB discharges its functions; this will include reviewing the Board's structure and how the new business unit can support this
- The ensure the SAB partners understand the relevant element of CQC inspection framework
- Highlight areas of assurance
- Seek assurance on Board members understanding of what MSP is and what measures are in place to demonstrate achieving this
- Highlight areas for improvement / development.

Impact:

- understanding of what is working well and less well. Including consideration of new governance arrangements, capacity, SAB structure and delivery of statutory duties.
- help to clarify future areas of development for the new arrangement.
- highlight the ability to demonstrate effective assurance (particular focus on the experience of the person and their involvement from MSP and on CQC inspection framework preparedness.
- understanding our capacity for improvement.
- The review will consider the capacity of the business unit to support the SAB arrangement.

The review of Luton Safeguarding Adults Board (LSAB) arrangements highlighted several findings across governance, structure, functioning, and areas for improvement:

Governance and Structure:

- LSAB's structure is complex compared to other boards, requiring significant commitment from partners and the Business Unit. Some sub-groups and task-and-finish groups are not functioning well, raising concerns about sustainability.
- Decision-making clarity is needed, as confusion exists between LSAB and the Statutory Partnership Chairs Safeguarding Assurance Meeting.
- Membership gaps were identified, including the absence of Public Health, Carers, and advocacy providers. Lay member representation was suggested to bring citizens' voices to the board.

Functioning and Culture:

- Positive outcomes were noted, including preventative work, emergency navigators in hospitals, modern slavery initiatives, and the Hoarding Panel.

- Concerns were raised about the lack of multi-agency data, partner agency participation, and the perception that adults' safeguarding has taken a back seat compared to children's safeguarding.
- Some members were unclear about governance arrangements, statutory functions, and their roles on the board. Members also need to ensure they provide agreed reports to the Business Unit in a timely manner.

Business Unit:

- The Business Unit is perceived as knowledgeable and supportive but overstretched, servicing both adults and children's safeguarding structures. As a result of this, some concerns were raised about efficiency, workload distribution, and timeliness of board papers at times.
- Some partners felt the Business Unit spends more time on children's agendas, with adults receiving less focus.

Statutory Requirements:

- Strategic priorities are clearly set out, but not all members can articulate them. Prevention work needs more focus, and the interface with community safety is not well embedded.
- SAR processes are in place, but concerns exist about repeated learning points and timeliness of actions.
- MSP is a golden thread but not consistently embedded across agencies.

Budget:

- The majority of the budget is allocated to staffing, with concerns about SAR funding pressures and funding for development and the need for future funding agreements that address this and consider equitability across funding partners.

The review provided several key recommendations and opportunities to improve LSAB functioning:

1. **Ensure the LSAB Governance document (MoU) is finalised and signed off**
    - LSAB needs to clarify where decision making lies – it is the Reviewer's view this is the LSAB with the group chaired by the LA Chief Executive should discuss reserved matters such as budget, barriers to improve safeguarding arrangements which require escalation and also issues coming over the horizon. There is a clear place for informal discussions and sharing information regarding children and adult issues but be specific on decision making matters
    - Review membership and ensure carers and voice of the person are represented.
    - Ensure clear timescales for papers to be disseminated are included and monitored.

2. **Put in place more formal arrangements for inducting new members**
    - Not all members were clear on their role and responsibilities in relation to the Board or with the detail of the Strategic Plan and Board functions; by doing this everyone will be clearer in their leadership responsibilities.

3. **Take the opportunity to review the SAB structure**
    - Start by looking at what is essential first (be helpful to have the new Chair in post to help with the structure review) as part of this review the joint sub-groups could this be managed differently; review the function of each sub-group.
    - Board members (particularly Police and ICB) consider chairing sub-groups.
    - Consider how sub-groups report into LSAB if new chairing arrangements are put in place

- Confirm that strategic priorities / delivery actions are located within the sub-group structure so there is clear read across – need very clear work plans and any diversion needs to be escalated to the Board.
- Enhance the joint working with community safety, potentially use a development day to do the work.

4. **Review the BU structure required to support the LSAB and be clear on the expectation of the role and function of Unit members;**
   - in the meantime put in place joint line management meetings for Business Unit Manager. Ensure the BU drive forward partnership engagement and Board business.

5. **Increase the pace on developing a MA dashboard and put in place for April 2025**
   - if possible include Equality Diversity and Inclusion information available (put requests out to other areas who have developed these).

6. **Hearing the voice of the person and MSP**
   - Strengthen arrangements for the participation of people with lived experience to support the work of the Board – this can be done in a variety of ways – speak with other areas about this
   - Set out the Boards position on MSP - the expectations from partners and what will be reported at Board to demonstrate how partners are implementing MSP – work on this at pace

7. **Set time aside to consider EDI –**
   - why is it important for the Board, when reviewing EDI information? Does it make a difference to how you work with the community?
   - Seek assurance from partners about their work in relation to this; ensure its running through all elements of work? (Note this is an issue raised in many areas and you could start leading the way with this).

8. **Prevention**
   - partners are doing some proactive work however the Board would benefit from articulating its position and ensure a more cohesive approach is taken;
   - consider developing a Prevention Strategy which sets out what partners are doing and contributing (again many SABs do not have this in place but it is important to develop).

9. **PIPOT**
   - provide annual update reports to LSAB; ensure all partners are contributing to this.

10. **Consider developing the following:**
    - Training and Development Strategy this will help be clearer on the offer and what is available from partner agencies
    - Quality Assurance Framework – by having this in place the SAB will have assurance it is focusing on key reports and will also prevent all reports needing to come to the LSAB as they can be overseen by the quality assurance group.

11. **Independent Chair Role**
    - In the event that the Independent Chair and the Scrutineer role are filled by the same person ensure the LSAB has a clear Job Description as these are very different roles with different responsibilities

The review identified positive outcomes and collaborative culture but highlighted areas for improvement in governance, structure, partner engagement, and strategic focus to ensure LSAB's effectiveness and sustainability. The recommendations aim to streamline LSAB's structure, enhance governance, improve partner engagement, and ensure the board focuses

on impactful safeguarding priorities. While several actions have already been taken forward under our current Independent Chair the remaining recommendations particularly around structure and governance will be taken forward with the new Independent Chair in 2025/26.

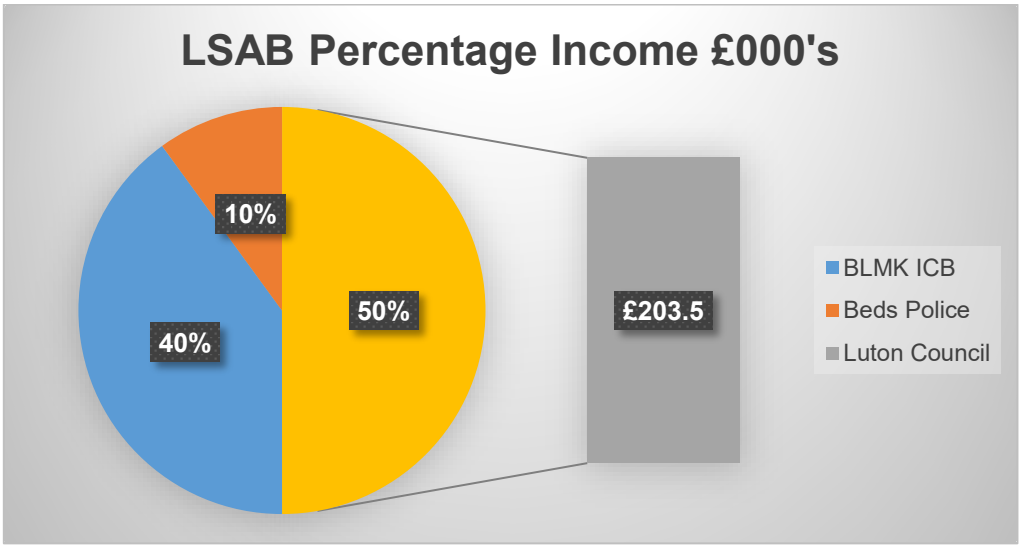
AGENCY ATTENDANCE AT STRATEGIC BOARD 2024 – 2025

LSAB Strategic Board meetings have continued to be held via Teams with an annual Development Day held in person. Attendance across all meetings and subgroups has continued to be good with the three statutory partners attendance all at **100%**. The Ambulance Service, and Herts Urgent care have not attended any board meetings although they have contributed fully to audits, rapid reviews and Safeguarding Adults Reviews. Partners also attended the in person '*learning from SARs evaluation and development day'* in March 2025. Attendance for Age Concern UK ended as their CEO retired. LBC Housing attended in a 'Rough Sleeping' capacity in 2024/25. They have an agreed strategic lead in place for attendance moving forward. Our new Lead Member is well engaged and has met with both our outgoing and incoming Independent Chair.

BOARD BUDGETS 2024/2025

The LSAB budget has been set each year based on historical contributions. It has historically excluded the costs of SARs and any additional fixed costs. Final invoices have been charged retrospectively at financial year end. However, in 2023/24 the ICB and Police advised they were unable to meet any additional LSAB costs at year end. The LSAB budget for 2024/25 was set in April 2024 at **£203,500**, based on historical funding agreements that did not take account of financial commitments. It was also set without a SAR contingency in place to cover the costs for any new SARS. However, there was a clear agreement for all funding partners to meet SAR costs at year end in equal proportions. The LSAB budget contributions had shown no growth since 2020 and Luton Borough Council ASC had picked up additional costs for SARs at year end due to the other funding partners working to a committal accounting basis and being invoiced at the start of year. In April 2024, the agreed financial contributions were BLMK ICB £81,300, Bedfordshire Police £20,390, and the Local Authority £101,591 shown below.

FIGURE 5: LSAB INCOME & CONTRIBUTIONS AS % APRIL 2024 – MARCH 2025



However, as the total costs exceeded the profiled budget in 2024/25 statutory funding partners were asked for additional contributions as below:

FIGURE 6: LSAB PARTNERS CONTRIBUTIONS APRIL 2022 – MARCH 2025

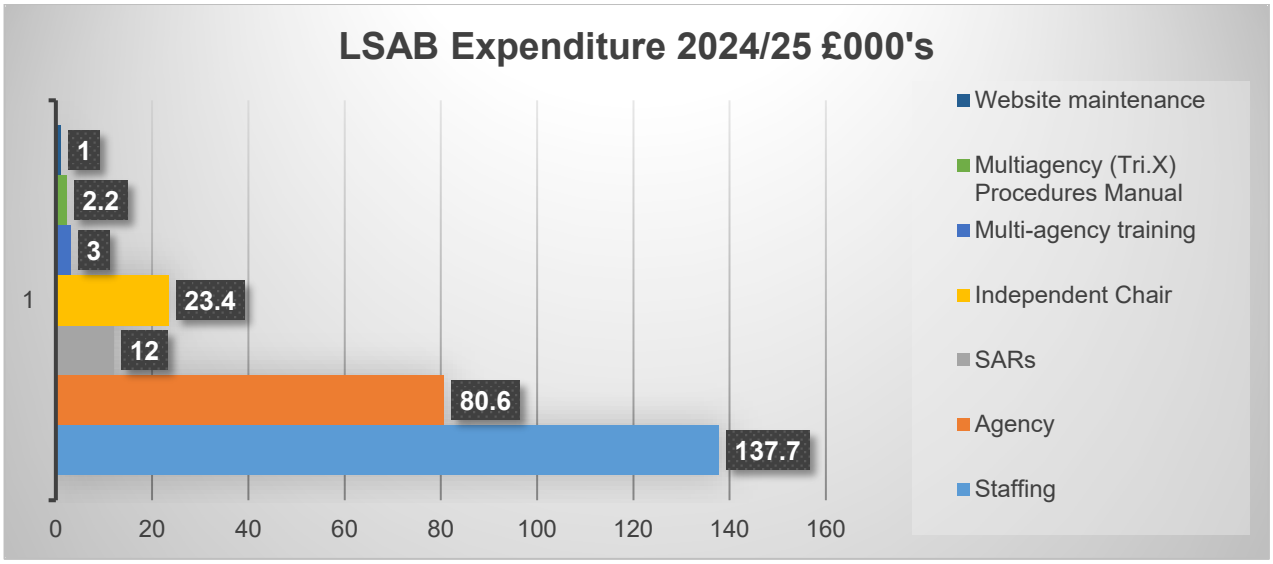
Budget and Contributions	2022/2023 £000's	2023/2024 £000's	2024/2025 £000's	2025/26 Proposed 000's
Budget Set	**£182,424**	**£197,900**	**£203,500**	**£282,800**
BLMK ICB Baseline	£72,984	£75,305	£81,305	£113,350
BLMK ICB Additional	£21,812	£13,713	£29,760	0
Beds Police Baseline	£18,240	£19,790	£20,390	£28,300
Beds Police Additional	£5,451	£3,428	£10,440	0
Luton Council Baseline	91,200	£98,950	£101,591	£141,150
Luton Additional	£48,231	£27,624	£36,414	**0**
Total	**£257,918**	**£240,800**	**£279,700**	**£282,800**

NB: The budget for 2025/26 has been set as full committal cost recovery budget at £282,800.
Expenditure has increased year on year since 2018 from £240,000 to **£279,700** in 2024/25. The biggest LSAB Expenditure is on staffing costs which took up **78%** of its budget as the total cost of staffing in 2024/25 was **£218,300**. This increase in costa in 2024/25 was due to two factors.

The costs of the LSAB/LSCP Strategic Business Manager post had previously not been profiled in the LSAB budget. Due to a vacancy in a key post that has significant responsibility for strategic safeguarding integration there was a need to retain agency staff. The value of this has been clearly demonstrated in the evidence of impact throughout this report.

The spend on SARs reduced to £12,000 and accounted for **5%** of total spend in 2024/25. Expenditure on reviews has decreased by £6,000 since last year due to less reviews being undertaken. The spend on Independent Chair costs is a fixed cost and has been static over the last three years. Spend on training has remained low at £3,000 due to budget limitations. Figure 12 below shows the actual expenditure during 2024/25.

FIGURE 7: LSAB EXPENDITURE APRIL 2024 – MARCH 202



6.SUMMARY OF OUR ACHIEVEMENTS AND FUTURE PLANS 2024/25

The LSABs three core objective are outlined above and it is clear much work has been done to coordinate and hold partners to account to make sure they are promoting the welfare and safeguarding vulnerable adults as defined under section 42 Care Act 2014. There has been timely learning from SARs and rapid reviews which have been implemented through dissemination, briefings and training.

The LSAB Strategic Business Plan 2024-26 sets out the LSAB priorities and how it measures impact through audit, performance data and making safeguarding personal.

This model has worked well with actions delegated to the appropriate subgroup and monitored via action plans with regular highlight reports, and progress reported back to the LSAB Strategic Board. This modelling has ensured the LSAB have:

- **Set the strategic direction, vision, and culture** of the local safeguarding arrangements, including agreeing and reviewing shared priorities and the resource required to deliver services effectively.
- **Lead their organisation's individual contribution** to the shared priorities, ensuring strong governance, accountability, and reporting mechanisms to hold their delegates to account for the delivery of agency commitments.
- **Review and sign off key partnership documents**: published multi-agency safeguarding arrangements, including plans for independent scrutiny, shared annual budget, yearly report, and local threshold document.
- **Provide shared oversight of learning** from independent scrutiny, serious incidents, local child safeguarding practice reviews, and national reviews, ensuring recommendations are implemented and have a demonstrable impact on practice (as set out in the yearly report).
- **Ensure multi-agency arrangements** have the necessary level of business support, including intelligence and analytical functions, such as an agreed data set providing oversight and a robust understanding of practice.
- **Ensure all relevant agencies, including the VCSE,** are clear on their role and contribution to safeguarding arrangements."

In order to reduce pressures and demand in the system for partners there are joint arrangements with the Luton Safeguarding Children's Partnership. The joint work is overseen by the Joint Executive Group who reports into each Strategic Board and ensures that their vision and strategic direction takes account of cross cutting priorities and a shared Risk Register ensures that each Board is alert to system risks. There has been significant joint work including a cross cutting section on development day and examples within operational practice where the relationships established at strategic level have supported innovative joint practice.

Having a shared Joint Quality Assurance and Learning Group has supported the connectivity across services and helped LSAB to identify possible gaps in domestic abuse, drug and alcohol use, legal literacy, preparing for adulthood - transitional safeguarding and cultural competence to name a few of the themes it has worked on together with the LSCP.

The LSAB has continued to work collaboratively with our neighbouring safeguarding adults and children boards to ensure there is a more joined up approach to safeguarding. This has been particularly important where agencies deliver services across areas and are represented on several different partnerships. A positive step has been agreeing a common approach and response to specific safeguarding issues such as hoarding, exploitation, and self-neglect as seen within the Pan Bedfordshire safeguarding procedures. There has been much work done in the individual organisations and single agency safeguarding reports are also attached as Appendix B.

The partnership has made notable progress in several areas this year, as highlighted throughout the report: Key Achievements included:

- **Strengthened governance structures:** Changes to the LSAB structure to reduce duplication and improve governance oversight, fewer focussed priorities and adapting to government initiatives including adding rough sleeping as a priority.
- **New Initiatives**: Establishment of **CASPA** (Critical Adult Safeguarding Partnership Arrangements) and progress in the **Hoarding Panel**, which has been further developed.
- **Improved Practices**: through a reduction in **unnecessary Section 42 inquiries**, with partners working to refine safeguarding processes. Evidence of enhanced **multi-agency collaboration**, including better ownership of safeguarding responsibilities.
- **Increased Training and Awareness Raising**: including delivery of **domestic abuse training** for social workers, housing staff, and other frontline professionals. Introduction of **trauma-informed practice training**, with plans to roll it out more widely. Public Health commissioning **KIDVAs** (Children's Independent Domestic Violence Advocates) to raise awareness and improve safeguarding effectiveness.
- **Improved Data and Insights**: Increased focus on **data sharing and collection**, including the development and of the LSAB Scorecard to measure impact of safeguarding against priorities. Recognition of gaps in data and narratives and plans to address these and secure population of the scorecard on a multi-agency basis.
- **Reduction in number of SARs**: There was a significant reduction in **Safeguarding Adult Reviews (SARs)** and rapid reviews from 2022/23 due to improved partnership understanding of the criteria and these reduced from **five** in 2022/23 to **one** in 2024/25.
- **Focus on Vulnerable Groups**: Greater emphasis on **elderly victims** of domestic abuse and self-neglect, as well as initiatives to support **rough sleepers**, including training for housing staff and addressing barriers to accessing services. The LSAB also received assurance reports from the National Probation Service regarding the National Probation Reset as well as UK Border Force progress with implementation of safeguarding recommendations from its Inspection.
- **Collaborated with neighbouring boards:** the LSAB continued to work on cross-cutting themes together with the Children's Safeguarding Partnerships and the Central Bedfordshire, Bedford Council Safeguarding Adults Board (CBBC SAB) on shared multi-agency procedures, joint initiatives and training. This is particularly important where agencies deliver services across and are represented on several Partnerships. It also agreed a common approach and response to specific safeguarding issues such as hoarding, exploitation, and self-neglect as seen within the Pan Bedfordshire safeguarding procedures.

In regard to the six safeguarding principles:

- **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 CASPA to bring together partners to discuss cases which cause concern. Alongside that, it is working with the Local Safeguarding Children Board on preparing for adulthood and how they improve their practice in working with vulnerable young people transitioning into services for adults.
- **Proportionality:** The Board uses data on referrals for safeguarding and the outcomes to scrutinise the quality of services. There is some evidence that people are supported and redirected to more appropriate services rather than being directed to 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:** There is strong partnership working with a shared responsibility for learning and practice improvement that extends across services for children 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.

The LSAB have worked hard to better communicate 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. It recognises that everyone has a vital contribution to make to improve quality of life for adults and communities. This can be evidenced in the work of the refreshed LSAB Coproduction VCSE subgroup with a new Chair, extended membership and revised terms of reference. However, the board has not achieved sufficient progress in moving this from stakeholder engagement to actual coproduction with those with lived experience of services.

Within the budget section the LSAB expenditure has increased and the majority of the costs have been picked up the local authority in 2024/25. There has been less SARs undertaken with the SAR expenditure reduced by a third. There has been some funding available for delivery of training and development activity which has been utilised to best effect to ensure that training is delivered at low cost or through reciprocal arrangements. The LSAB remains mindful that it needs to ensure it provides more focus on delivering against its specific priority areas and that it cannot spread its limited resources too wide.

As seen in the section on attendance the LSAB as a strong and supportive partnership who are able to hold challenging conversations and scrutinise practice and support each other to improve the outcomes for vulnerable adults in Luton. The LSAB will be implementing the recommendations of the Sector Led Peer Review under the direction of its new Independent Chair and will set a new Strategic Business Plan and Delivery Plan for 2025/26. This will assist in setting a key focus for the key deliverables, leads, activities, impact measures and timescales.

1. **Strengthen Governance and Structure:**
    - Implement the recommendations from the sector-led peer review under the new LSAB Independent Chair, at pace, as detailed on page 42 prioritising:
        - Finalising and implement the revised governance document (MoU) to clarify decision-making processes.
        - Review and streamline the LSAB structure, ensuring subgroups are aligned with strategic priorities and functioning effectively.
        - Enhance LSAB membership by including Public Health, carers, advocacy providers, and lay members to represent the community voice.
        - Secure sustainable funding and address budgetary gaps.

2. **Improve Data Collection and Analysis:**
    - Develop a multi-agency dashboard using tools like Power BI to provide validated data on safeguarding effectiveness.
    - Ensure ethnicity and diversity data are consistently collected and reported in safeguarding referrals.
    - Monitor outcomes for vulnerable adults signposted through initiatives like Right Care Right Person (RCRP).

3. **Enhance Community Engagement:**
    - Strengthen arrangements for participation of individuals with lived experiences to inform safeguarding priorities.

- Promote awareness campaigns and training to improve understanding of safeguarding issues among the community and professionals.

4. **Focus on Prevention:**
   - Develop a Prevention Strategy to articulate partner contributions and ensure a cohesive approach to early intervention.
   - Increase focus on preventative measures in areas like domestic abuse, exploitation, rough sleeping, mental health and self-neglect.

5. **Expand Training and Workforce Development:**
   - Create a Training and Development Strategy to clarify the safeguarding training offer and ensure accessibility for practitioners.
   - Deliver targeted training on themes like trauma-informed care, cultural competence, and legal literacy.

6. **Improve Multi-Agency Collaboration:**
   - Strengthen joint working arrangements with community safety and other local boards.
   - Ensure effective use of CASPA for complex cases and improve multi-agency responses to safeguarding concerns.

7. **Monitor and Implement Learning:**
   - Implement a local SAR Framework and conduct SARS using a range of robust methodologies
   - Implement an LSAB Audit Toolkit and undertake thematic audits linked to gaps
   - Continue to evaluate the impact of SARs and audits, ensuring recommendations are implemented and tracked.
   - Develop a Quality Assurance Framework to oversee safeguarding effectiveness and reduce duplication of efforts.

8. **Embed Making Safeguarding Personal (MSP):**
   - Strengthen lived experience engagement and coproduction.
   - Set clear expectations for MSP implementation across partner agencies.
   - Monitor and report on how MSP principles are being embedded in safeguarding practices.

9. **Focus on Emerging Themes:**
   - Address gaps in safeguarding concerns related to modern slavery, exploitation, and mental health.
   - Monitor the impact of the Mental Health Bill and adapt safeguarding practices accordingly.

10. **Further embed safeguarding guidance and tools across agencies.**
    - Strengthen whole-family approaches and carers assessments.
    - Seek assurance around trauma informed approaches and wraparound services
    - Monitor the use and effectiveness of LSAB escalation protocols
    - Seek assurance regarding whole family approaches and safeguarding transitions.

This will enable us to monitor progress and secure assurance that our actions are making a positive difference to the lived experience of adults with care and support needs. The Luton Safeguarding Adults Board will continue to work to meet its statutory responsibilities and to develop its approach to learning and improving to ensure early intervention in the safeguarding of vulnerable adults and ensure effective safeguarding arrangements in 2025/26. The LSAB at its Development Day in 2025/26 agreed its priorities for 2026/28 as *Transitional Safeguarding, Mental Capacity Assessments, Domestic Abuse* and *Multiple Vulnerabilities* (as a working title).