Safeguarding in Luton

The Annual Report for Luton Safeguarding Adults Board

2019 – 2021 Annual Report

September 2021

CONTENTS

INDEPENDENT CHAIR - INTRODUCTION

I was appointed to take on the role of Luton Safeguarding Adult Board Independent Chair and attended my first board meeting virtually in September 2020. Therefore, although this report covers a two year period from April 2019 to March 2021, I am only able to comment as the incoming Independent Chair on the period from September 2020 onward. Since this time I have worked alongside the members of LSAB providing advice and objective challenge and also supporting its development.

There has been significant openness and engagement across the LSAB in developing how the board works and how it determines its priorities. During the period under review the LSAB has identified areas of strength and aspects of partnership working that need to improve. However, there is a strong LSAB culture which provides an important foundation for effective safeguarding. This includes hearing the range of voices of members and stakeholders, establishing and working together on co-produced priorities, connecting SAB sub-groups firmly into a shared vision and priorities, looking outwards and learning from the wider and local evidence base in adult safeguarding, and recognising challenge as positive and responding constructively.

The LSAB has drawn on national research and local practice development from its Safeguarding Adults Reviews (SARs). The LSAB demonstrates a continued commitment to developing its approach to how and when SARs are carried out and to a focus on the extent to which the learning impacts practice and outcomes including the use of rapid reviews and SARs in rapid time. A new approach to improvement and learning connects learning from SARs with information from data and other sources. This is important for accountability and assurance. It supports our evidence-based decision making on the LSAB priorities.

The LSAB has a well organised group of multi-agency professionals that oversees reviews and ensures there is a culture of learning and continuous improvement. This group works jointly across adults and children's reviews, learning and improvement to distil the cross cutting learning. Their focus is to ensure recommendations from reviews improve outcomes for vulnerable adults and that lessons learned are embedded into practice.

On examination of all reviews undertaken over the past eighteen months the partnership has highlighted some recurring themes, which include identifying that staff need the necessary knowledge and training to be able to understand the implications that culture, faith and transitions have for a family and the impact it may also have upon children. This has led to a review of diversity and faith data, training requirements and procedures for cultural competence.

Other areas identified in the reviews included, among other things, inconsistency of frontline practice, inconsistent information sharing, the need to improve management oversight along with a high turnover of staff. The themes from reviews also include care planning, mental health and discharge planning. I am pleased to see that these issues have been recognised by the safeguarding partners and are being addressed into 2021 to 2022.

There has been a necessary focus and positive progress on quality assurance this year. Further development, such as through greater use of case file audit, targeting areas highlighted through the LSAB Scrutiny and Performance Group will further support this going into 2021/2022. I would also expect the partners to continue to undertake an audit process which ensures that the learning is revisited and embedded. I will closely monitor the audit process to confirm that learning is indeed embedded, and practice is improved and also that more audit work is undertaken.

All this work and development has taken place in the challenging context presented by the Covid-19 pandemic and the LSAB has been alert to the impacts and risks for safeguarding adults presented by the pandemic. The effects of the pandemic will continue to be significant and we will need to continue to develop our Covid recovery plan.

The partnership in Luton is mature and well developed, partners do put energy into scrutinising and challenging practice in an appropriate and considered way. Scrutiny and challenge have led the partnership to identify some key areas for further development in relation to co-production,

engagement, feedback from frontline staff, ensuring thresholds are understood, improving information sharing and multi-agency decision making.

It is really important that the partnership is able to demonstrate that it is making a difference, that the learning from all reviews and audits is embedded into practice and that this learning leads to improved outcomes for vulnerable adults. This area needs to be further developed and ingrained across all partner agencies.

Conclusion

There are, in my view, many strengths to the Luton Safeguarding Adults Board arrangements. I have found a strong partnership that is open to scrutiny and challenge and one which strives to continually learn and improve practice. There is strong leadership and a clear sense of joint and equal responsibility from the safeguarding partners. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged. Attendance at meetings is good. There is excellent engagement from leaders across the partnership who set a culture which drives improvement activity.

In my dealings with senior leaders, I have found a strong desire to understand safeguarding, promote change and deliver safeguarding improvements, this was evident with the ongoing work to deliver effective services during the national pandemic.

Finally, may I take this opportunity to thank all of the organisations and individuals in the public, voluntary and private sectors who work tirelessly across Luton to improve the safety and quality of life of our citizens. I would also like to thanks the Business Unit for their continued efforts in supporting the work of the LSAB and myself as Independent Chair.

Alan Caton OBE

Independent Chair Luton Safeguarding Adults Board

1. THE ROLE OF THE SAFEGUARDING BOARD IN LUTON

LUTON SAFEGUARDING ADULT BOARD (LSAB)

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

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

BOARDS' PARTNERS

The Board has the following organisations as partners and lay members who are residents of Luton

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

WHAT MAKES AN EFFECTIVE SAFEGUARDING BOARD?

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

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

This report is structured around providing evidence about how the LSAB demonstrates those attributes over the last two years.

2. CONTEXT OF LUTON – DEMOGRAPHICS

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

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

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

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

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

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

ARE THERE EFFECTIVE GOVERNANCE ARRANGEMENTS AND OPERATING STRUCTURES IN PLACE?

PARTNERSHIP SELF EVALUATION

The LSAB requested that the Local Government Association undertake a Safeguarding Adults Peer Review of the Luton Safeguarding Adults Board (LSAB) in 2017. In Nov 2020 the Board took some time to review progress against the recommendations

The review noted that there were a number of issues for the Board:

> "*These focused on the respective roles and responsibilities by LSAB members and specifically on inconsistent attendance and a lack of appropriate seniority of some individuals representing organisations. This has also led to a questionable awareness of adult safeguarding, what it means and how it is delivered in each organisation. There is also a variable understanding of the Board's strategic priorities and an overall lack of clarity around what the priorities actually are and how these can be achieved. In the light of this there is significant room for improvement, especially as the Board is now a statutory body with increased oversight and responsibility.* "

[1] Luton Poverty Needs Assessment

It also noted the inconsistent implementation of Making Safeguarding Personal (MSP) by partner agencies, as well as a lack of clarity of what it meant for those involved. There was little collective accountability to the work of the LSAB. As a result the performance management of safeguarding in, and across, partner organisations needed to be significantly improved as well as the collection and analysis of data.

.

There was significant progress since the review with greater ownership and engagement by all Board partners. This has been evidenced in terms of audit activity, provision of performance data, utilising the increased training offer. The audits demonstrate progress in improving some of the basic safeguarding practice

It is also evidenced in all sub groups (bar service user group), where attendance has over the three years improved for the most part. Significantly there has been an increase in challenging and robust dialogue between partners.

The merging of the business units has also enabled greater resilience and resource to support developments. More importantly it has allowed for efficiencies and collaboration.

The pace of change is however slower at times than it should be, and this is perhaps best exemplified in relation to Pan Beds working. A key change since the review is the changing provider landscape across the county and move to a BLMK footprint. As a county, there are now one set of providers and that is an opportunity that needs to be more fully grasped. County wide providers are clearly supportive of that, but it has been challenging and been an uphill battle to increase the work undertaken at a Pan Beds level. It is a significant issue in comparison to LSCBs where there has been a significant and positive shift to Pan Beds working.

Making safeguarding personal is another example where as a system, it is hard to demonstrate impact. Audits show it is being considered, and whilst there has been some significant improvement in some services, it has been variable in others. A Pan Beds event was held in 2018, and again this is an issue which is likely to have more work required.

An update on the recommendations from the review are set out in Appendix B

COVID

The rapid changes as a result of COVID has put significant pressures on all the LSAB partners. It has meant for example a number of meetings / audits were put on hold during 2020/21 as especially for health partners' staff were redeployed.

However COVID did show the strength of the partnership working and also enabled some positive changes to practice. The SAR in Rapid Time identified a number of those changes with a number continuing to be maintained as they have enabled improved communication, understanding of and sharing risk.

However it is important to understand the ongoing impact that COVID has had. A paper to the Health and Wellbeing Board in March 2021, set out three challenges in the context of COVID.

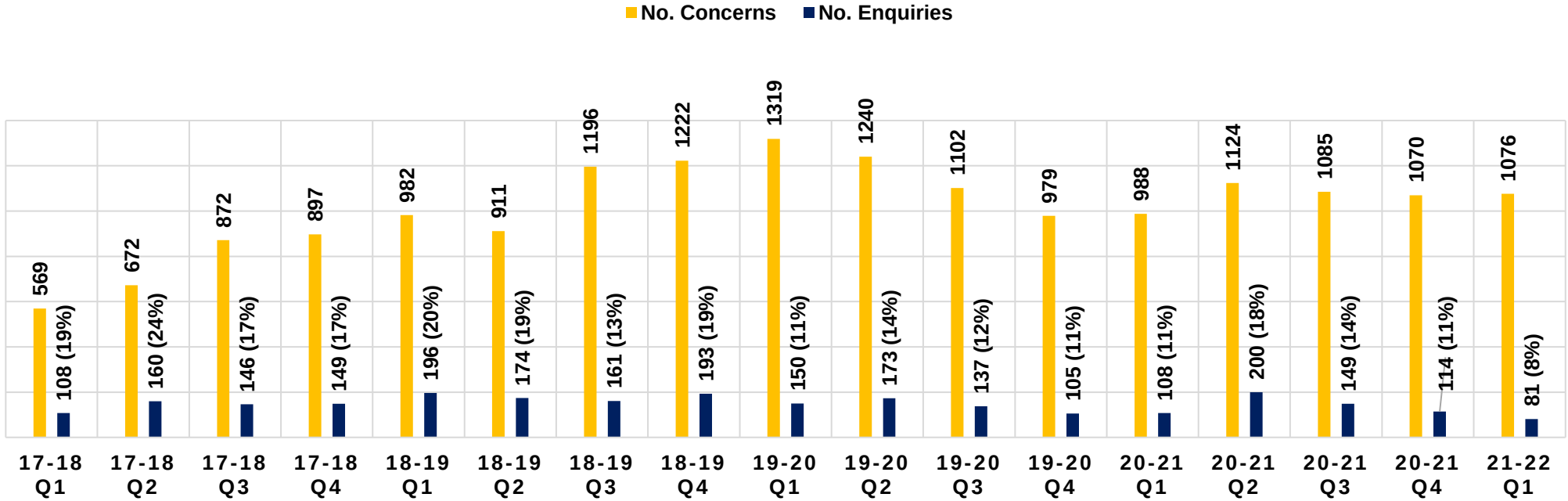
a) *Staff capacity and resilience*. This last year has been difficult, and a number of practitioners have had to deal with a lot of emotional stress either professionally, personally or both. The question therefore arises if they have the capacity to maintain

the quality in the context of tiredness and "*ceaseless demand".* A focus on staff welfare is therefore important, if standards of practice are to be maintained

b) *Likely increase in demand for all services*. This is already in evidence in relation to domestic abuse and mental health services.

c) *The cutting back of services due to budget cuts*. In a context of reduced income, how does the system as a whole try and adjust to those changes, in the face of increasing vulnerability and complexity?

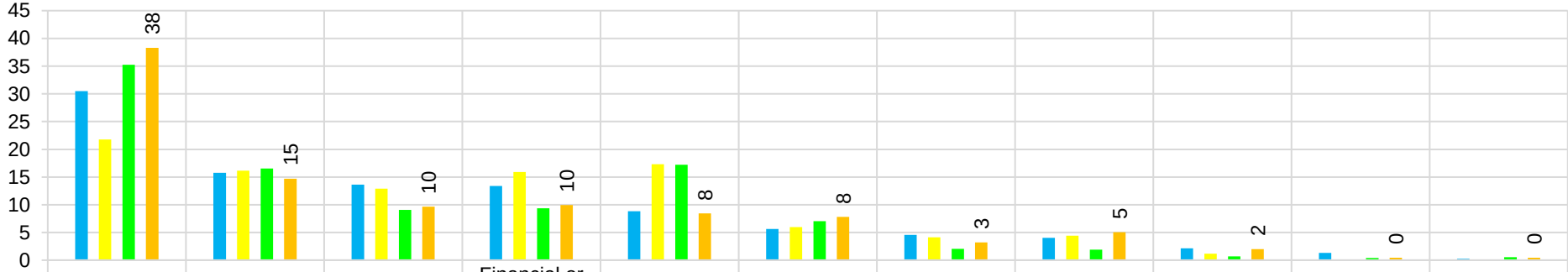
CHART 1A: CONCERNS AND ENQUIRIES 2017/18 - 2021/22 Q1



Commentary:

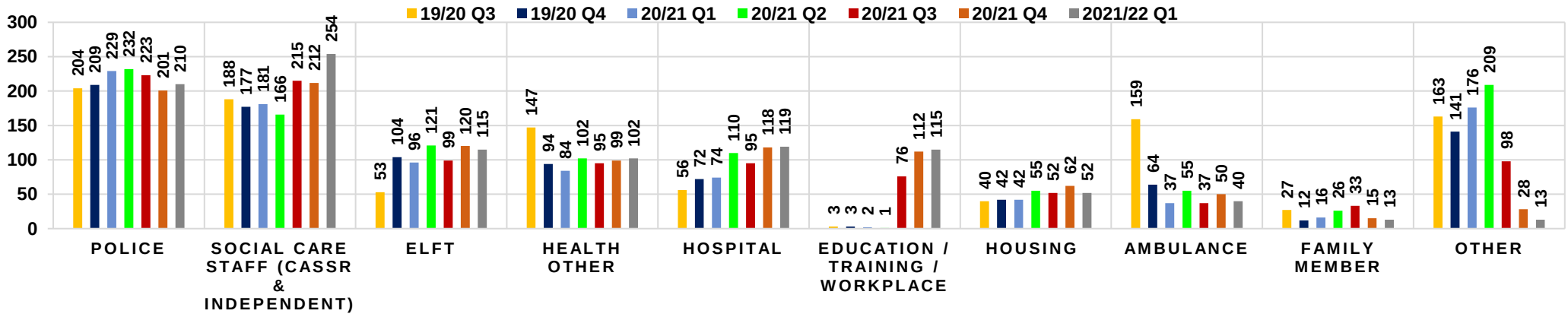
The number of concerns and enquiries raised, has increased every year, with a 43% increase in safeguarding concerns raised since 2017/18. The Board has regularly discussed how to manage the number of concerns coming in and monitors this through its LSAB Scrutiny and Performance Group

CHART 1B: S.42 ENQUIRIES BY TYPE OF ABUSE (%) 2017-21



	Neglect & Acts of Omission	Physical Abuse	Psychological Abuse	Financial or Material Abuse	Organisational Abuse	Self-Neglect	Sexual Abuse	Domestic Abuse	Sexual Exploitation	Modern Slavery	Discriminatory Abuse
17-18	30	16	14	13	9	6	5	4	2	1	0
18-19	22	16	13	16	17	6	4	4	1	0	0
19-20	35	17	9	9	17	7	2	2	1	0	1
20-21	38	15	10	10	8	8	3	5	2	0	0

CHART 2A SOURCE OF CONCERNS 19/20 Q3 TO 21/22 Q1 (TOTAL)



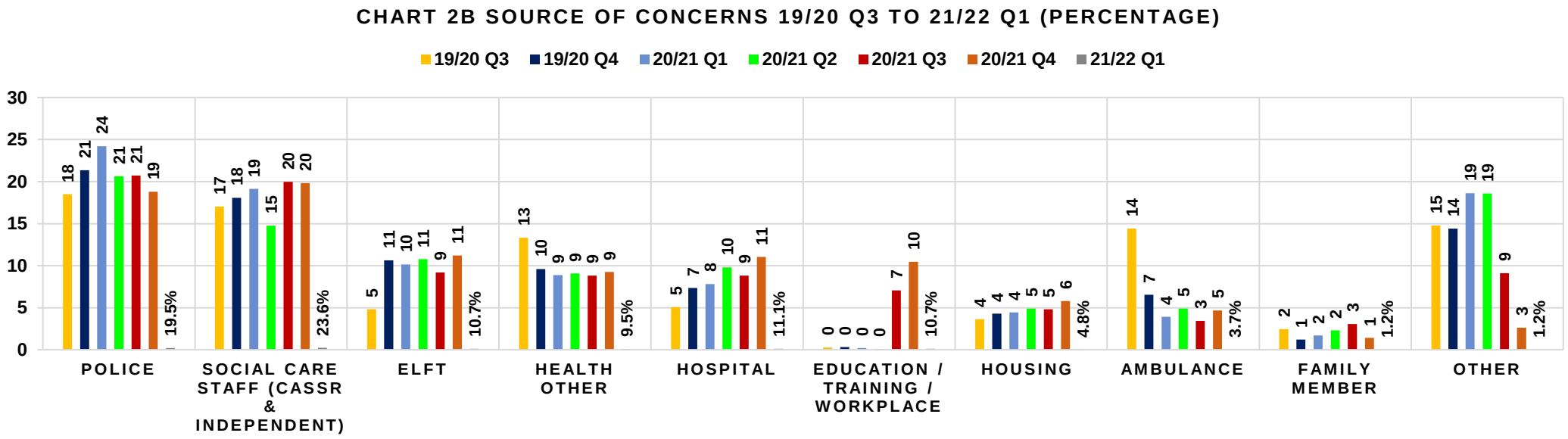
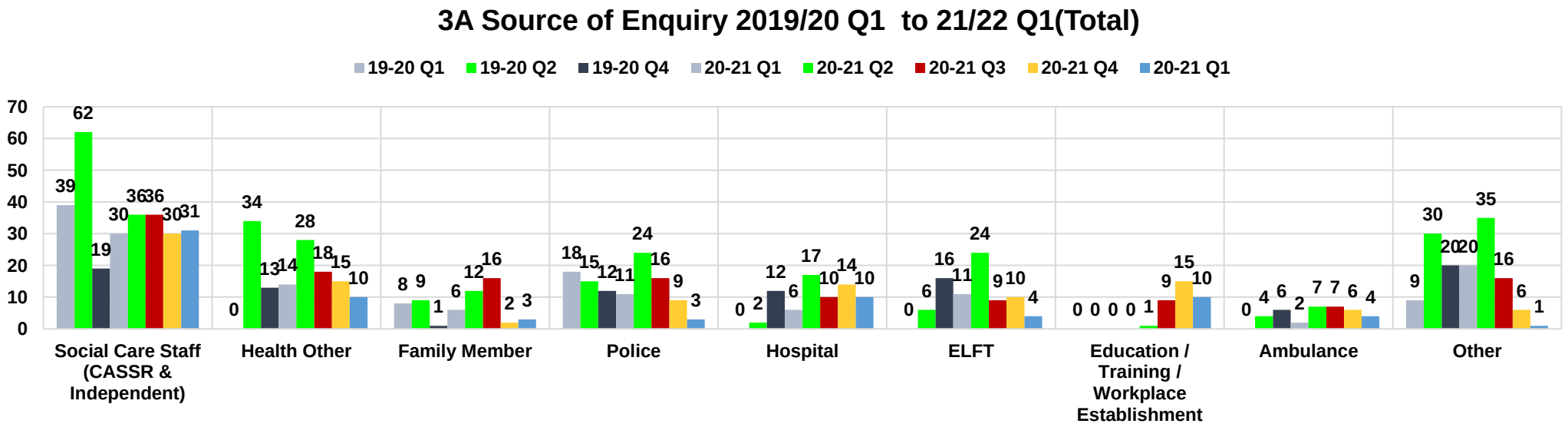


CHART 2B SOURCE OF CONCERNS 19/20 Q3 TO 21/22 Q1 (PERCENTAGE)
19/20 Q3
19/20 Q4
20/21 Q1
20/21 Q2
20/21 Q3
20/21 Q4
21/22 Q1
30
25
20
15
10
5
0
18 21 24 21 21 19 19.5%
17 18 19 15 20 20 23.6%
5 11 10 11 9 11 10.7%
13 10 9 9 9 9 9.5%
5 7 8 10 9 11 11.1%
0 0 0 0 7 10 10.7%
4 4 4 5 5 6 4.8%
14 7 4 5 3 5 3.7%
2 1 2 2 3 1 1.2%
15 14 19 19 9 3 1.2%
POLICE
SOCIAL CARE STAFF (CASSR & INDEPENDENT)
ELFT
HEALTH OTHER
HOSPITAL
EDUCATION / TRAINING / WORKPLACE
HOUSING
AMBULANCE
FAMILY MEMBER
OTHER


3A Source of Enquiry 2019/20 Q1 to 21/22 Q1(Total)
19-20 Q1
19-20 Q2
19-20 Q4
20-21 Q1
20-21 Q2
20-21 Q3
20-21 Q4
20-21 Q1
70
60
50
40
30
20
10
0
39 62 19 30 36 36 30 31
0 34 13 14 28 18 15 10
8 9 1 6 12 16 2 3
18 15 12 11 24 16 9 3
0 2 12 6 17 10 14 10
0 6 16 11 24 9 10 4
0 0 0 0 1 9 15 10
0 4 6 2 7 7 6 4
9 30 20 20 35 16 6 1
Social Care Staff (CASSR & Independent)
Health Other
Family Member
Police
Hospital
ELFT
Education / Training / Workplace Establishment
Ambulance
Other

3B Source of Enquiry 19/20 Q1 to 21/22 Q1 (Percentage)

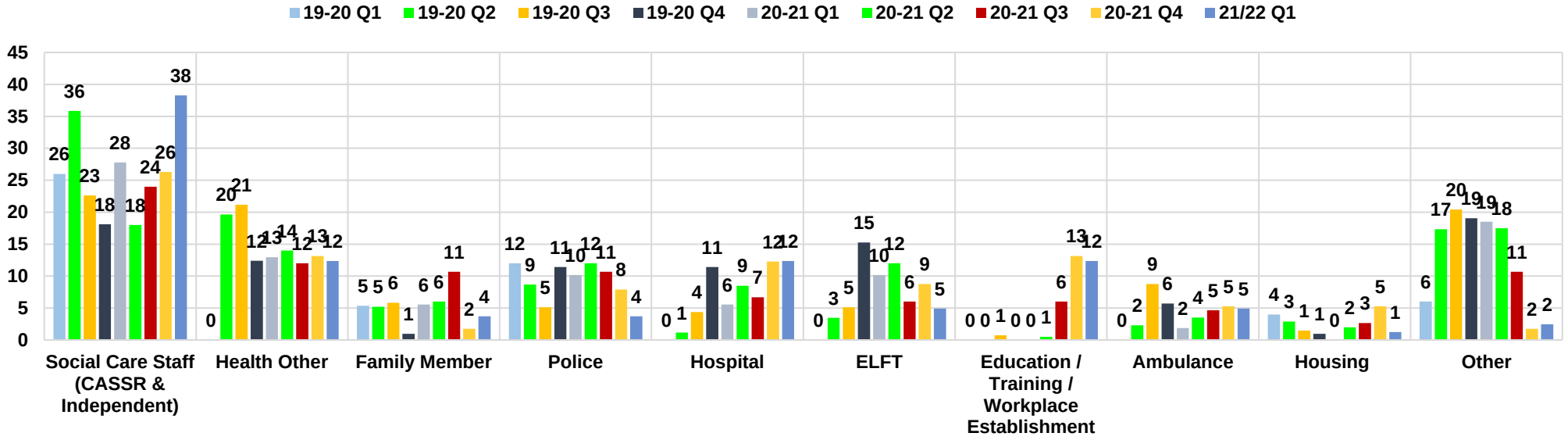


CHART 3C - COMPARISON
ENQUIRIES BY PRIMARY SUPPORT REASON (TOTAL)

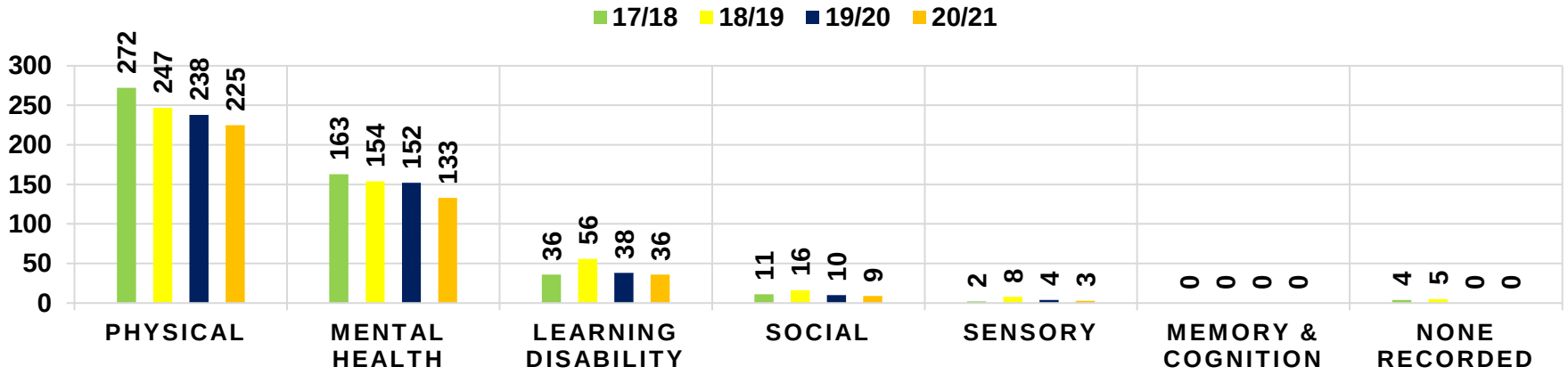
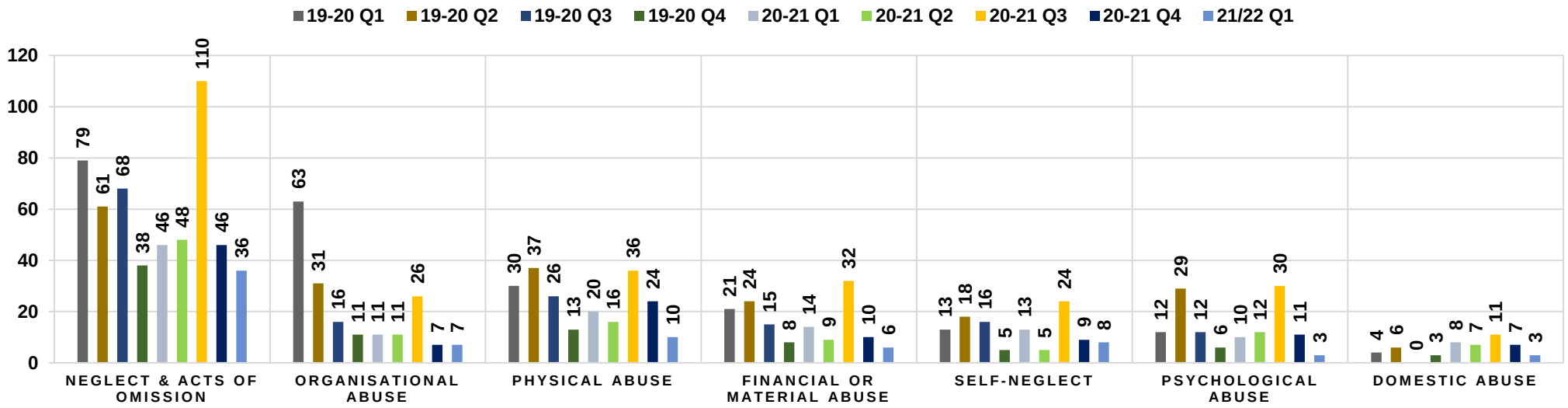


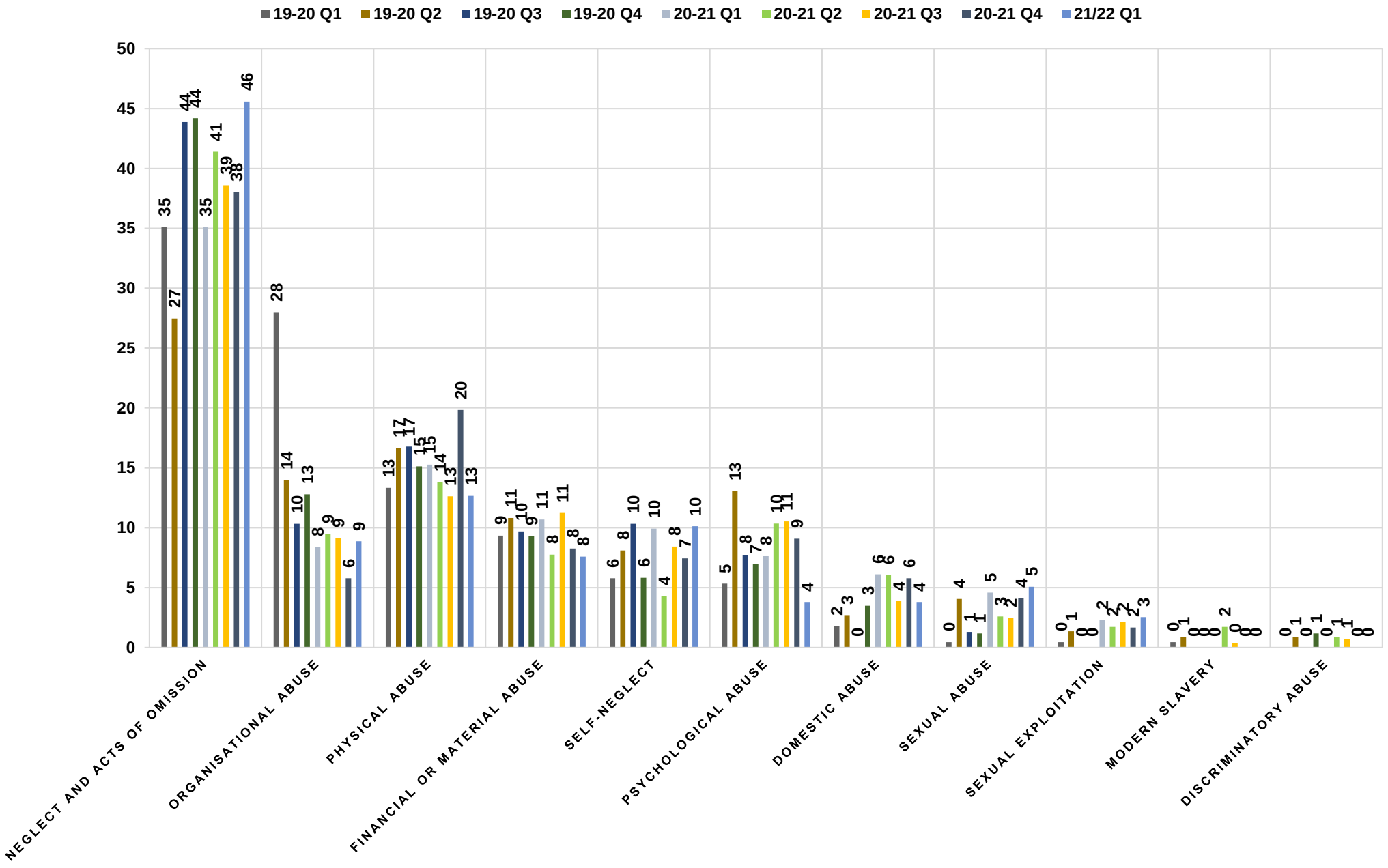
CHART 4A: ENQUIRIES BYTYPE OF ABUSE (TOTAL)



Commentary:

The highest category for abuse was neglect and acts of omission (38%) which has doubled since 2018/19, followed by Organisation abuse (28%) and Physical Abuse at (13%). Financial and material abuse has reduced from (17%) to (9%)

CHART 4B - ENQUIRIES BY TYPES OF ABUSE (PERCENTAGE)



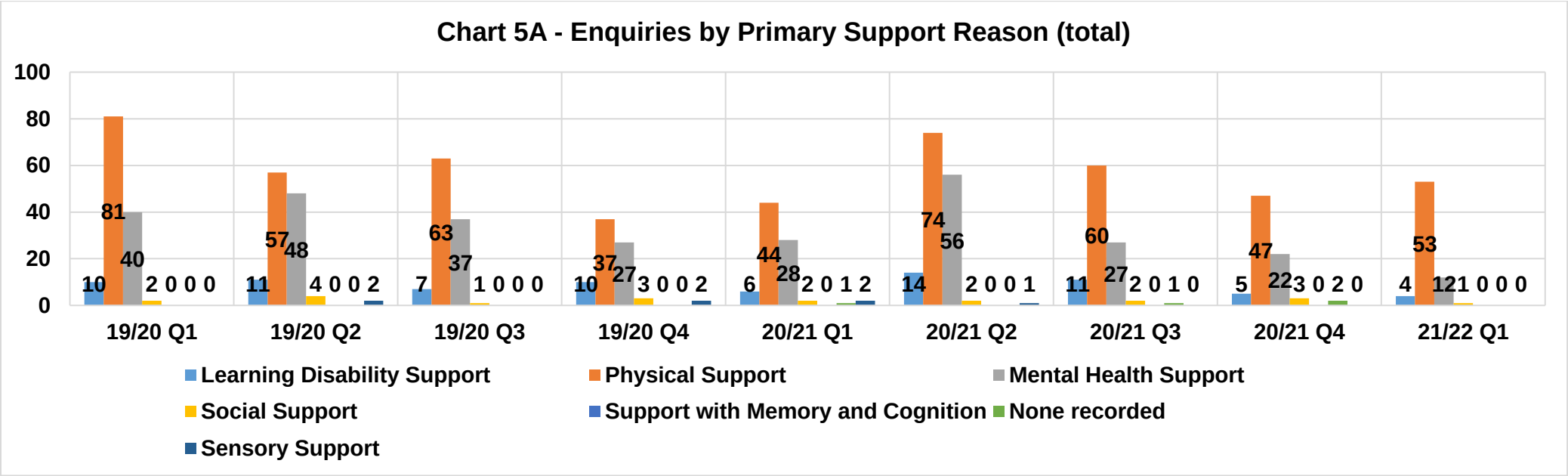


Chart 5A - Enquiries by Primary Support Reason (total)
100
80
60
40
20
0
10 81 40 2 0 0 0
11 57 48 4 0 0 2
7 63 37 1 0 0 0
10 37 27 3 0 0 2
6 44 28 2 0 1 2
14 74 56 2 0 0 1
11 60 27 2 0 1 0
5 47 22 3 0 2 0
4 53 12 1 0 0 0
19/20 Q1
19/20 Q2
19/20 Q3
19/20 Q4
20/21 Q1
20/21 Q2
20/21 Q3
20/21 Q4
21/22 Q1
Learning Disability Support
Physical Support
Mental Health Support
Social Support
Support with Memory and Cognition
None recorded
Sensory Support

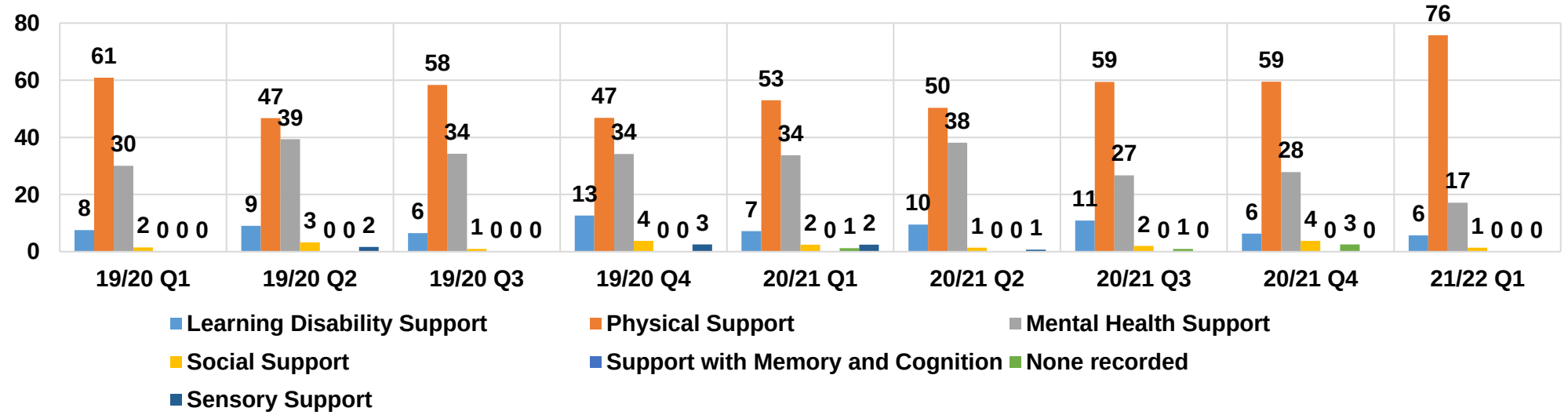


Chart 5B - Enquiries by Primary Support Reason (percentage)
80
60
40
20
0
8 61 30 2 0 0 0
9 47 39 3 0 0 2
6 58 34 1 0 0 0
13 47 34 4 0 0 3
7 53 34 2 0 1 2
10 50 38 1 0 0 1
11 59 27 2 0 1 0
6 59 28 4 0 3 0
6 76 17 1 0 0 0
19/20 Q1
19/20 Q2
19/20 Q3
19/20 Q4
20/21 Q1
20/21 Q2
20/21 Q3
20/21 Q4
21/22 Q1
Learning Disability Support
Physical Support
Mental Health Support
Social Support
Support with Memory and Cognition
None recorded
Sensory Support

CHART 6A - ENQUIRIES BY AGE GROUP (TOTAL)

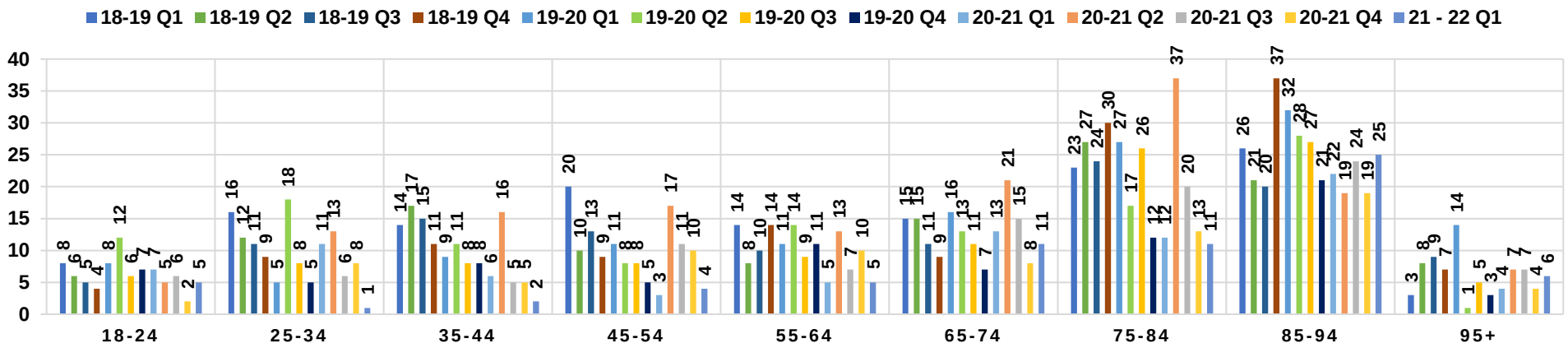
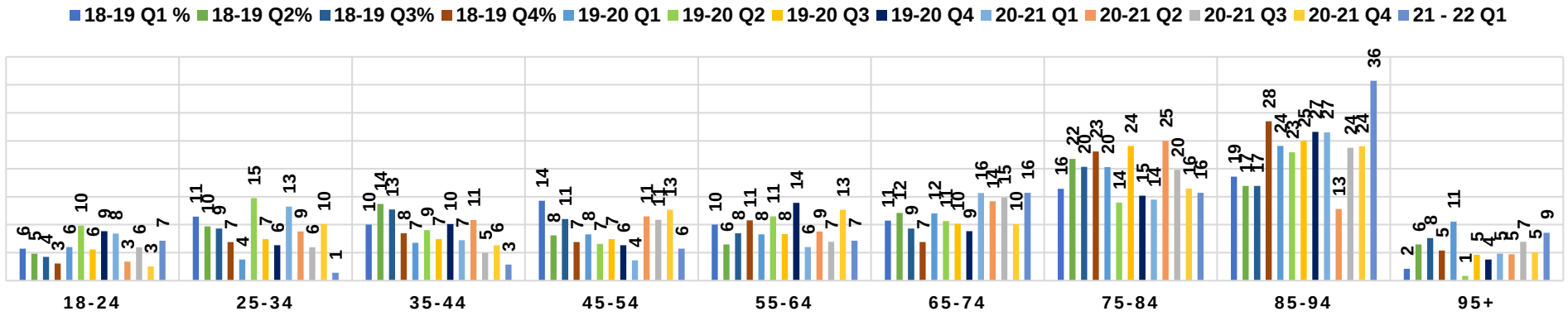


CHART 6B - ENQUIRIES BY AGE GROUP (PERCENTAGE)



Commentary:

(48%) of the enquiries related to the 65+ age groups and are primarily presenting with care and support needs, and this would be in line with national norms. The Board has considered whether the number of referrals for people aged 25-34 is low at given that Luton has quite a young adult population and the rate has ranged from (4%) to (11%) over the year.

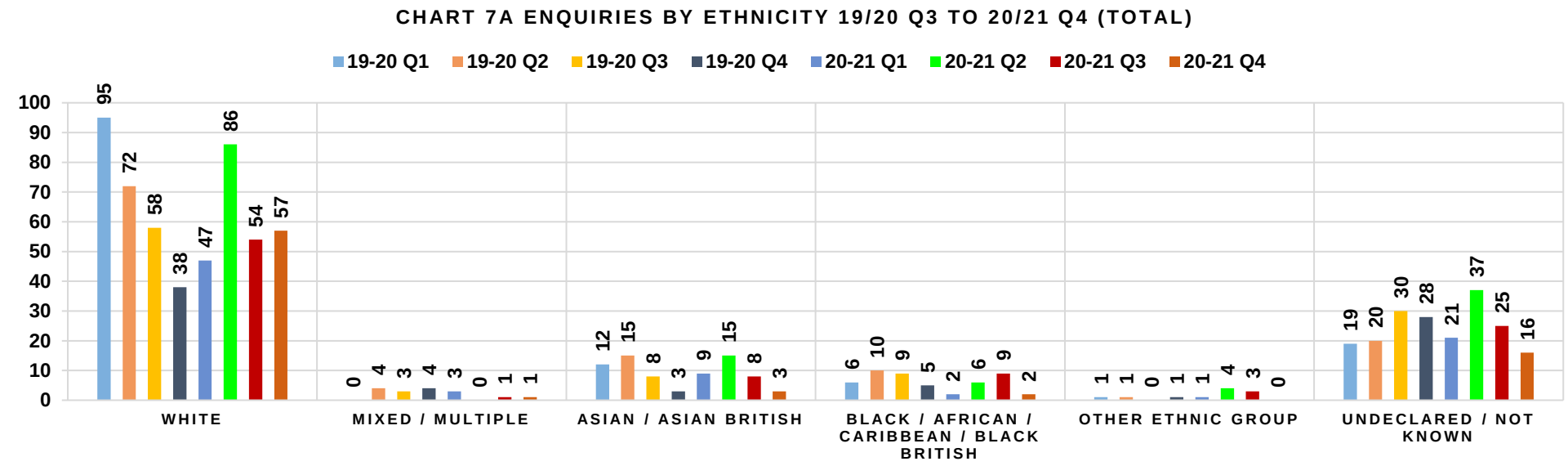


CHART 7A ENQUIRIES BY ETHNICITY 19/20 Q3 TO 20/21 Q4 (TOTAL)
19-20 Q1
19-20 Q2
19-20 Q3
19-20 Q4
20-21 Q1
20-21 Q2
20-21 Q3
20-21 Q4
100
90
80
70
60
50
40
30
20
10
0
95
72
58
38
47
86
54
57
0
4
3
4
3
0
1
1
12
15
8
3
9
15
8
3
6
10
9
5
2
6
9
2
1
1
0
1
1
4
3
0
19
20
30
28
21
37
25
16
WHITE
MIXED / MULTIPLE
ASIAN / ASIAN BRITISH
BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
OTHER ETHNIC GROUP
UNDECLARED / NOT KNOWN

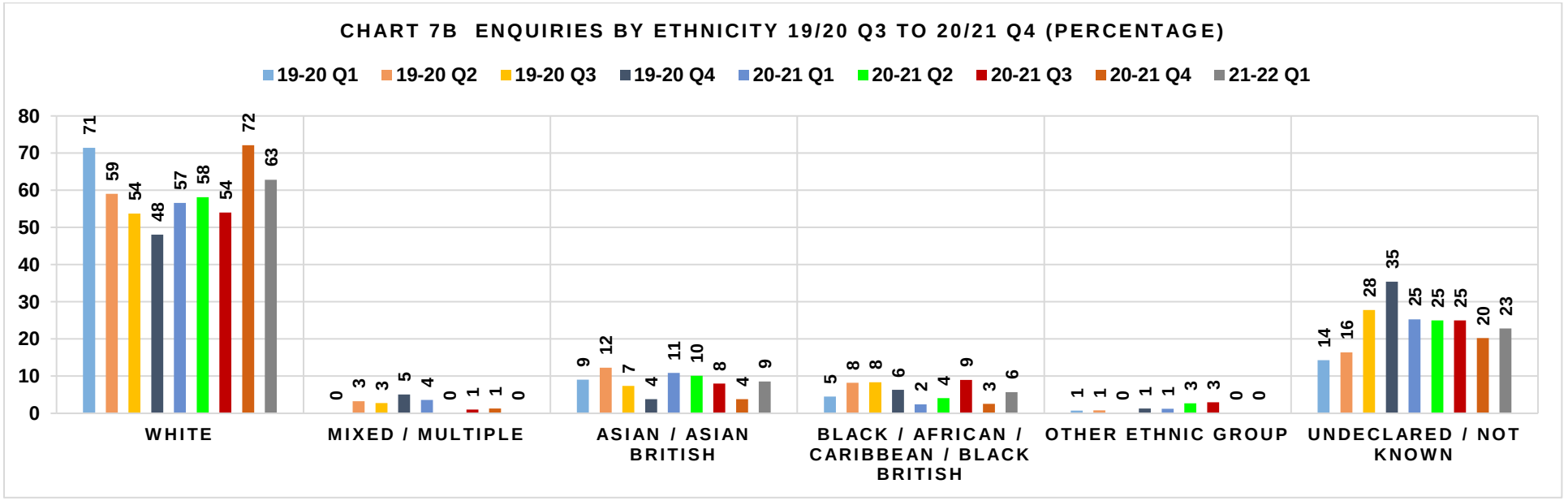


CHART 7B ENQUIRIES BY ETHNICITY 19/20 Q3 TO 20/21 Q4 (PERCENTAGE)
19-20 Q1
19-20 Q2
19-20 Q3
19-20 Q4
20-21 Q1
20-21 Q2
20-21 Q3
20-21 Q4
21-22 Q1
80
70
60
50
40
30
20
10
0
71
59
54
48
57
58
54
72
63
0
3
3
5
4
0
1
1
0
9
12
7
4
11
10
8
4
9
5
8
8
6
2
4
9
3
6
1
1
0
1
1
3
3
0
0
14
16
28
35
25
25
25
20
23
WHITE
MIXED / MULTIPLE
ASIAN / ASIAN BRITISH
BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
OTHER ETHNIC GROUP
UNDECLARED / NOT KNOWN

CHART 8A ENQUIRIES BY SETTING 19/20 TO 21/22 Q1 (TOTAL)

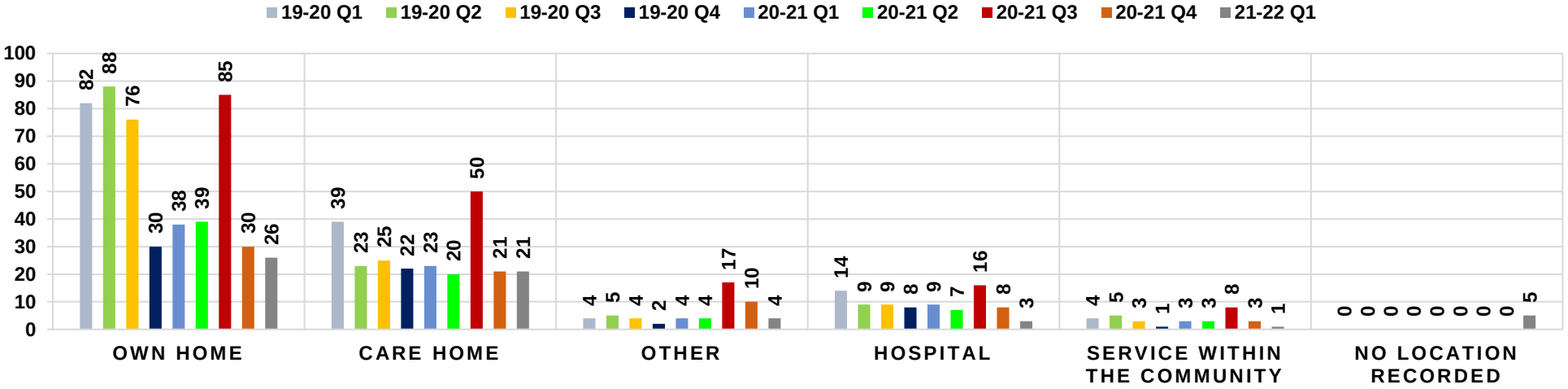


CHART 8B ENQUIRIES BY SETTING 19/21 TO 21/22 Q1 (PERCENTAGE)

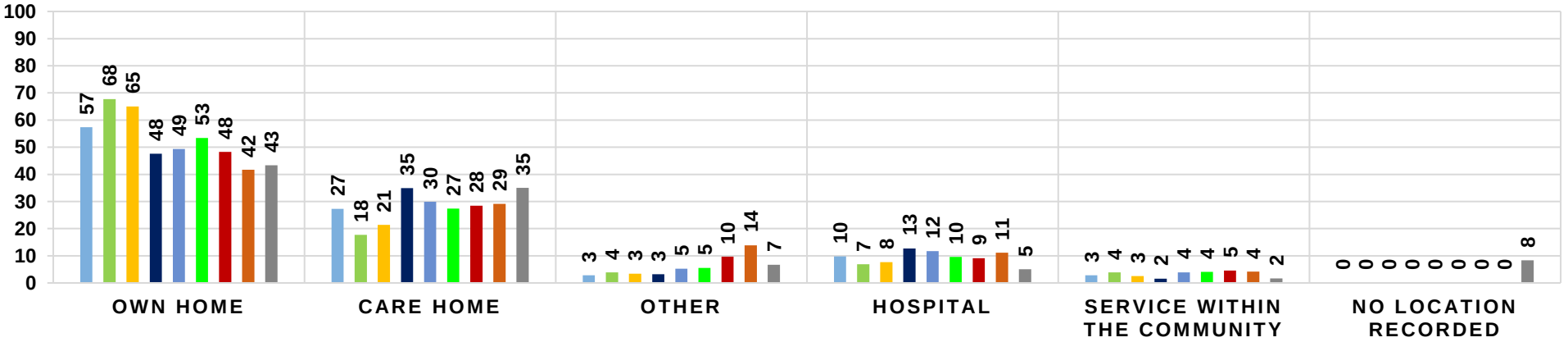


CHART 9 2018/19 - 2020/21 OUTCOMES COMPARISON (PERCENTAGE)

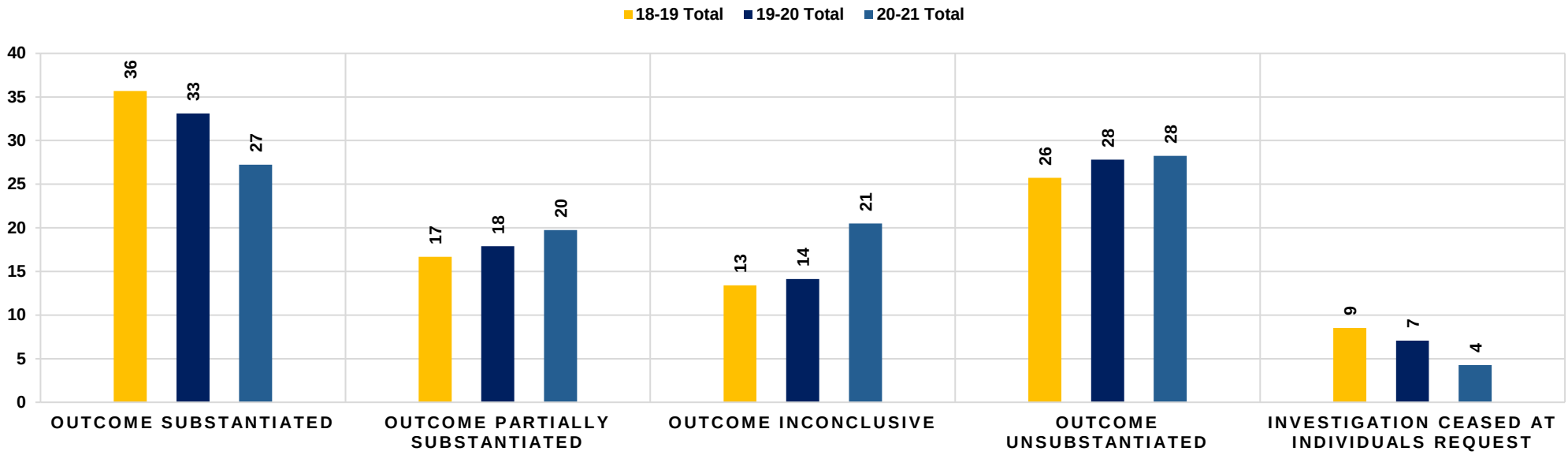
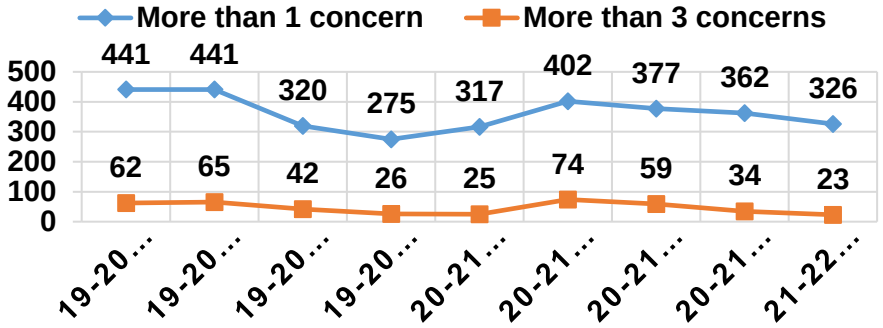


CHART 10: REPEATS PER QUARTER (TOTAL)



ENSURE LEARNING FROM AUDITS AND CASE REVIEWS IS IDENTIFIED AND IS USED TO DEVELOP PRACTICE AND SERVICE PROVISION.

AUDITS

Luton is involved in two sets of multi-agency audit activity to monitor practice:

a) At a Pan Beds level it supports 2-3 multi-agency audits a year. The themes are based on discussion with partners and the priority areas. A short report setting out learning and actions is tabled at the Pan Bedfordshire Learning and Improvement Group. Actions are monitored by that group.
b) Local multi agency audits are undertaken by agreement of the Executive. The report is fed into the Luton Learning and improvement group, and it has responsibility for monitoring actions.

Partners also undertake their own audits and these are shared either at a Pan Beds or Luton level.

The aim of this group is to ensure continuous improvement in the safeguarding practice across partner organisations. Other partners such as Housing, Fire and Rescue, Ambulance services are invited to take part in audits as required.

This paper provides a highlight of the Multi-agency Audit Group's activity, from February 2018 to January 2020. The Board is asked to consider this report and to agree the audit programme for the coming year.

The Process

The group has met eight times since 2017/18 Q4, with 68 cases audited to date.

Concerns reported to the MASH were randomly selected by the LBC Business Intelligence Unit (BI) for audit. In 2018/19 Q4, the group started to look at themes either originating from the Board or identified from previous audits.

All partner organisations were asked to ensure that identified learning (good practice and areas for improvement) was fed back to staff through supervisions, floor meetings and training.

The audit programme has enabled partners to work together to assess the quality of safeguarding work, capture best practice and recommend improvement actions in Luton and Pan Beds.

Governance

Quarterly reports from this group were presented to the LSAB Audit and Assurance Subgroup for scrutiny. The Audit and Assurance subgroup was asked to scrutinise the actions generated from the audits, to hold partners to account and provide an assurance report to the LSAB. In addition, recommendations from the audits which require a multi-agency response were reported in the quarterly LSAB Safeguarding Performance report.

Learning

In the first few audits some clear areas for learning and improvement were identified. Organisations were asked to put monitoring in place and whilst monitoring continues, audits have highlighted considerable improvement over the last year concerning the following issues:

- Lack of evidence of mental capacity assessments
- Completion of S42 enquiries within 28 days
- Failure to review protection plans within 3 months
- Inconsistent completion and review of risk assessments
- Poor record keeping
- To ensure the outcome of the S42 Enquiry is communicated to the referring agency and the Quality team.

ASC provided assurance that they are ensuring all relevant parties receive details of outcomes. This is being reinforced by SP at BIA forums.

Maintaining up to date risk assessments: The audit identified a reliance on old assessments rather than reviewing them afresh. LDUH changed its processes to incorporate the risk assessment and MASH staff are monitoring.

Managing Allegations against Staff: There was inconsistency across partners in managing allegations against staff. A working group was convened and agreed a way for consultancy advice to be offered by the LADO service as required.

Managing Perpetrators: Section 42s, currently focus on the person being assessed. This may be a gap in terms of suspected perpetrators and the risk they may pose to others, the public or themselves. Audit identified a gap in understanding civil and criminal matters and this has been addressed in the Working Together Module.

Themed Audit - No Further Action: Evidenced improvement in recording and practice by individual organisations. Areas of where improvement was needed related to;

- Engagement with Young Adults: There is a challenge in engaging some young adults. Partner agencies identifying who has the best relationship, needs to be considered in order to improve engagement and increase the chances of effective safeguarding. Assurance was sought from partners that the new Working Together module features in single agency training. The audit suggested poor engagement and hard to engage.
    - An audit will be undertaken by Samantha Parker looking at how we work with difficult to engage people and the means to engage them.
- Inappropriate referrals: The audit identified that in some cases the complaints procedure, was a better pathway than an s.42 enquiry.
    - Some referrals would have been better placed signposted to other agencies, including third sector, who may be able to dedicate more time to an individual than the statutory agencies. This was already identified by the police and work is ongoing to improve referral practice.
    - A new referral pathway into mental health for the police was put in place. In Q3 we have seen some changes which may be an early indication of the impact of this change.

- Knowledge of Pathways: Further awareness is needed on the variety of pathways for vulnerable people especially if they do not meet the safeguarding criteria. There will be a half day event to map pathways in summer.

Themed Audit - Females 30-45: This group was audited for assurance, due to the low referral rates. The audit identified a number of positive findings of practice, with one standing out in terms of the work undertaken to ensure the persons voice was sought. All of which was communicated back to staff and managers.

Themed Audit – Multiple Safeguarding Concerns:

- Information Sharing: It is generally accepted that whilst information is being collated in different places, information sharing is disjointed. It was agreed that partners should be reminded of that MDTs can and should be used to escalate a concern when there are gaps in the information needed to support the person.

  The police asked partners to ensure that they are involved much earlier in the process when it has been identified that a case may have a criminal element.

  LDUH safeguarding were not aware of the issues surrounding one of the cases. Vijay Patel is leading on a small group to draft a template for a multi-agency protection plan which can be shared with partner agencies and to determine how that will work with the MASH system and parameters.

Themed Audit – Self Neglect:

- Findings were reported in the Q3 Safeguarding Performance Report
- No Further Action: Similar to previous audits when safeguarding alerts are raised and they are "no further action". A further short audit of NFA was agreed, for assurance that actions given to agencies subsequent to NFA, are followed up.

For Discussion

- For single agencies; ensuring actions are completed
- All partners to ensure that all practitioners are sharing vital information in line with the requirements of the Care Act 2014 and the GDPR (2018)
- GPs lack of response
- Inconsistent follow through on taking on board actions from the audit. Partners are asked to review the latest audit to ensure they provide an appropriate response
- Agree the audit programme for next year

LEARNING FROM SAFEGUARDING ADULT REVIEWS (SAR)

The Board has had a number of SARs or rapid reviews (initial scoping of the review in a timely way) underway or completed over the year.

Year	SAR referrals / rapid reviews	SARs commissioned
2019-20	**3**	**1**
2020-21	**6**	**3**

Rapid reviews

Prior to April 2020, organisations submitted a referral for cases they considered may meet the criteria for a Safeguarding Adult Review and ASC conducted a section 42 review before the partnership considered whether a review was required. Since April 2020 the board has been conducting rapid reviews which are similar to those conducted within the children's safeguarding board to get to the learning quicker.

Reviews Published	**Issues/potential learning**
LSAB Mr B	End of life pathways
LSAB Castletroy	COVID support for care homes

IMPLEMENTING LEARNING

The number of reviews has led to some thematic analysis, which not surprisingly, are in

The learning is being disseminated through:

a) Feeding into Pan Beds LSAB workshops and events
b) LBC practice weeks
c) One page summaries of each SAR

Impact is being checked through the analysis of data and theme based audits as highlighted earlier.

PARTNERSHIP SELF EVALUATION

A paper to the Health and Wellbeing Board in March 2021, set out three challenges in the context of COVID.

d) *Staff capacity and resilience*. This last year has been difficult, and a number of practitioners have had to deal with a lot of emotional stress either professionally, personally or both. The question therefore arises if they have the capacity to maintain the quality in the context of tiredness and "*ceaseless demand".* A focus on staff welfare is therefore important, if standards of practice are to be maintained

e) *Likely increase in demand for all services*. This is already in evidence in relation to domestic abuse and mental health services.

f) *The cutting back of services due to budget cuts*. In a context of reduced income, how does the system as a whole try and adjust to those changes, in the face of increasing vulnerability and complexity?

BOARD FUNCTIONING

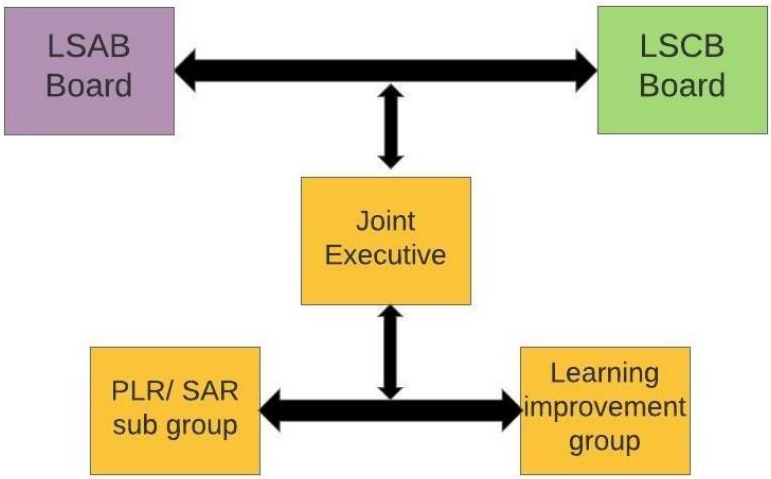
The Board and sub groups have looked at the demographic analysis in relation to ethnicity, as Luton has a "super diverse" population. The highest number of enquiries remains the white ethnic group accounting for 63% of all enquiries. There were slight increases in the number of enquiries relating to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

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

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

There has been significant progress with the effectiveness of performance monitoring for the LSAB. The LSAB Board has discussed performance regularly, and partners have worked on identifying and resolving a range of issues, which have impinged on the system. Multi-agency audits now take place on a quarterly basis, and have focused on how well practitioners are assessing safeguarding concerns. The sub groups were rationalised over the year following discussions with partners on reducing the number of meetings. We have continued to work closely between LSAB and LSCB with one set of joint sub groups which feed into the respective Boards

BOARD AND SUB GROUP STRUCTURES IN LUTON



LSAB Priorities 2019-2021

The Board's Strategic Plan sets out its three years ambitions and how it aims to make progress each year. The full plan is available here:

The Boards have agreed to continue work on these priorities for 2020/21.

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

The Board is supporting the work of engaging with the faith and community sectors alongside the LCB. One of the tasks identified is the need for better communication on what

safeguarding is, and the role that all people can play in providing support and advocacy to enable a person/child to disclose the harm or abuse they are experiencing.

3. PRIORITIES

The LSAB is are required to agree and undertake work on a set of priorities. The table below sets out the priorities the Boards' agreed to for 2019/21.

KEY THEMES/PRIORITIES:

The Board has also identified three key areas to focus its work upon:

- Domestic abuse (joint with LSCB)
- Implementing learning from SARs
- Emotional wellbeing and mental health (work on 16-25yrs is also part of the LSCB priority on emotional wellbeing and mental health)
- Cybercrime

Consideration of the Making Safeguarding Personal, the wishes and feelings of the person and their lived experience should be a part of everything we do.

The board's mission is reflected in seven strategically identified work streams, delivered through the operations of its subgroups – this is to ensure that the business of the board is effectively managed and progressed, to ensure that partner agencies are fulfilling their statutory obligations in accordance with the Care Act 2014.

The LSAB delegates power to its subgroups to carry out work related to the Boards business plan; undertake consultation as appropriate; make decisions on work related to the Board where authority has been specifically delegated by the Board; investigate a particular issue; publish material on behalf of the Board; prepare a response to consultation matters on behalf of the Board, discharge any functions delegated to it from the Board.

The Board therefore decided to continue with the priorities set in 2019 through to 2023. As noted earlier, there had been significant improvement in governance, with sub groups meeting actively and being able to complete various activities such as multi agency auditing and shaping the content of new LSAB training.

Partners and other organisations contributed to the initial development of a risk profile for Luton. This was important as it identified some new areas of risk such as the implementation of Universal Credit and the Homelessness legislation which would impact on vulnerable adults.

During 2019-2021 the focus has been on using performance and audits, to review the quality of practice.

Future priorities

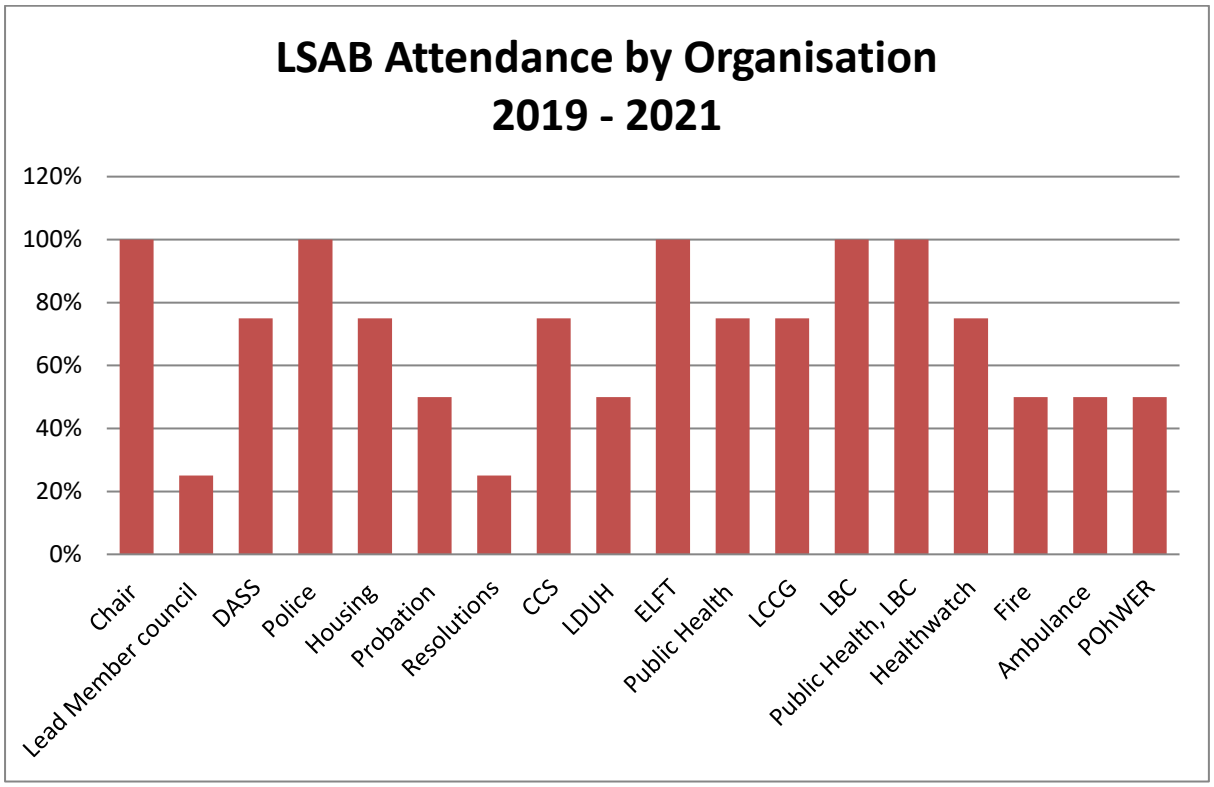
The Boards have agreed to continue work on these priorities for 2021/22.

The Board has made progress in improving governance and is using data and audit to assure itself of the quality of practice. The Board recognises that it has only made partial progress in

embedding the principles of Making Safeguarding Personal; hence it agreed it needed to maintain the priorities. One of the tasks identified is the need for better communication on what safeguarding is, and the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing.

BOARD FUNCTIONING

Agency attendance at Board 2019- 2021



BOARDS' BUDGETS 2021/22

Income	£000's	Expenditure	£000's
Health	71.6	Staff	141
LBC	105.5	Provision of LSAB Training	8
Police	17.9	SAR	9
		Independent Chair / scrutineer	18
		Comms / developments	9
		Office costs	10
Total	**195**	**Total**	**195**

Board Members 2019 - 2021

2019/20	2020/21
Fran Pearson (Independent Chair)	Alan Caton (Independent Chair)
Vijay Patel (LSCB/LSAB Business Unit Manager)	Vijay Patel (LSCB/LSAB Business Unit Manager)
Julia Sirett (Cambridge Community Services NHS Trust)	Dawn Andrews (Cambridge Community Services NHS Trust)
Anne Murray (Luton Clinical Commissioning Group	Anne Murray (Luton Clinical Commissioning Group)
Liz Lees (Chief Nurse Luton & Dunstable Hospital)	Liz Lees (Chief Nurse Luton & Dunstable Hospital)
Michelle Bradley (East London Foundation Trust)	Michelle Bradley (East London Foundation Trust)
Claire McKenna (East London Foundation Trust)	Claire McKenna (East London Foundation Trust)
Julie Hall (LCCG Safeguarding Lead and Named Nurse Adults)	Julie Hall (LCCG Safeguarding Lead and Named Nurse Adults)
David Tamarro (East of England Ambulance Service, NHS Trust)	David Tamarro (East of England Ambulance Service, NHS Trust)
Emma Sullivan (Lay Member)	Emma Sullivan (Lay Member)
Kausar Ahmad (Lay Member)	Kausar Ahmad (Lay Member)
Cllr Javed Hussain (LBC Portfolio Holder for Adult Social Care)	Cllr Javed Hussain (LBC Portfolio Holder for Adult Social Care)
Vicky Sowah (LBC Legal Advisor Adults)	Vicky Sowah (LBC Legal Advisor Adults)
Glen Denham (LBC Quality Assurance & Performance Improvement Lead)	Amanda Lewis (LBC Director Children Families & Education)
Gerry Taylor (LBC Corporate Director Public Health)	Gerry Taylor (LBC Corporate Director Public Health)
Maud O'Leary (LBC Head of Adult Social Care)	Maud O'Leary (LBC Head of Adult Social Care)
Patrick Odling-Smee (LBC Head of Service, Housing & Community Living)	Patrick Odling-Smee (LBC Head of Service, Housing & Community Living)
Samantha Parker (LBC Service Manager Strategic Adult Safeguarding)	Samantha Parker (LBC Service Manager Strategic Adult Safeguarding)
Vicky Hawkes (LBC Neighbourhood	Vicky Hawkes (LBC Neighbourhood)
Stuart Auger (Bedfordshire Fire Service)	Stuart Auger (Bedfordshire Fire Service)
Mohammed Aziz (Bedfordshire Police Service)	Mohammed Aziz (Bedfordshire Police Service)
Alison Harding (Bedfordshire Probation)	Alison Harding (Bedfordshire Probation)
Lucy Nicholson (Healthwatch Chief Executive)	Lucy Nicholson (Healthwatch Chief Executive)
Asimah Naseem (POhWER)	Asimah Naseem (POhWER)

APPENDIX B - LGA PEER REVIEW- RECOMMENDATIONS

Recommendation	Actions	Impact	Next steps
Development of system leadership that includes greater transparency and accountability	Workshops for Board and sub group members in 2018 and 2019	Improved collaboration across partners (especially evident during COVID19) Improved communication between partners egg Business manager attends LDUH Board and that has facilitated greater connectivity between acute, community services and wider partners	
Develop consistent attendance by partners	Partners such as housing and fire service have significantly improved in their engagement at operational and strategic levels	Decisions on SARS etc., are made timeously. Improved partnership learning and collaboration especially since the onset of the COVID pandemic	
Ensure sufficient seniority of partners attending	Organisations have ensured the person attending is of sufficient seniority. However, most organisations have had a turnover and so there has been a lack of consistency	The lack of continuity of membership has meant on occasion some issues have dragged on rather than be dealt with in a timely manner.	
Create a detailed Strategic Plan outlining key priorities and actions to deliver outcomes within agreed timescales	Bringing Adult Social Care (ASC) into the MASH	The joining in MASH was a positive step. However, recent changes within CSC have meant a regression.	Clarity about joining up adults and children's services to ensure both are able to recognise risks for children and vulnerable adults

Recommendation	Actions	Impact	Next steps
			What is sought cooperation/collaboration or integration?
	Domestic Abuse	There have been improvements in relation to ASC involvement in MARAC. Wider issues of DA governance are being resolved, but lay out with the provenance of the LSAB	Should the LSAB have greater scrutiny on DA?
	Training	A wider LSAB training offer has been developed through the Pan Beds LSCB training unit. Bespoke multi agency training is now available and being used. The offer is continuing to be developed	There is great value if we can move to a Pan beds training offer. However, this is challenging because of the current set up within CBC and BBC
	Communications	Campaigns have been run for safeguarding and sexual exploitation. A guide on adult exploitation has been published. More work is underway on adult safeguarding targeting communities.	Ongoing outreach work to Luton's community is needed and is a feature of the faith and community safeguarding work underway Is there a need for focused communications on what adult safeguarding is?
	Housing	There has been a significant improvement in housing engagement demonstrated in the	Expanding reach of safeguarding into

Recommendation	Actions	Impact	Next steps
		SARs, but also in uptake on safeguarding training and raising concerns	housing associations and other providers
Review the role of the Board (Tore) and responsibilities of LSAB members	The Board structures have been modified. An induction guide has been written and circulated to new members	There is greater communication, collaboration and challenge across partners within meetings and also out with	
Clarify what cultural change means for the LSAB	Recruitment of two new lay members. Board representation has increased to include Resolutions. A service user group was initiated	The Service user group has not really established itself The Board needs to consider how we use lay members to best effect in order to make good use of their experiences and skills	Consider how to capture the service user experience and bring it to LSAB - this has been a weakness
	An increased budget for the Board has been secured	Enabled increased activity in terms of training provision Enabled increased staffing which has enabled business objectives to be achieved. The merging of business units for LSCB and LSAB have also allowed for greater resilience and continuity, as well as increased connectivity across adults and children's services	What does the Board and Business unit need to do increase visibility of key issues/practice?
Create fit for purpose sub-groups that deliver outcomes	The LSAB has moved from seven sub groups to three sub groups which are run jointly with the LSCB, alongside a performance and audit group	Multi agency audits take place and have demonstrated some impact.	

Recommendation	Actions	Impact	Next steps
		SAR sub group has been working well and decisions re SARs are being made in a timely manner. A new method for decision making on SARs (rapid review) has been tested and well received by partners	
	Use insightful data to drive performance management - this is provided quarterly and has been regularly scrutinised and used to shape audit and further scrutiny	Performance data has become more multi agency. We have seen better data and better application in improving practice. The Board have had initial discussion on how well safeguarding protects all of Luton's communities. A risk profile has been developed but this needs further development from a community/care provider perspective. SARs are being completed in a timely manner Multi agency audits have been undertaken regularly	Need to demonstrate sustained positive changes. We need to be able to demonstrate that learning from SARs is having a positive impact.

APPENDIX C BUSINESS PLAN

Luton Safeguarding Adults BUSINESS PLAN 2021 – 2023

INTRODUCTION:
The Luton Safeguarding Adults Board represents a statutory partnership of multi-agency partner organisations with the responsibility for safeguarding adults from abuse and neglect in accordance with the requirements of Section 6(7) of the Care Act 2014. To meet its responsibility it is required to:

- Develop policies and procedures for safeguarding and promoting the welfare of vulnerable adults in the area of the authority;
- Communicate to persons and bodies in the area of the authority the need to safeguard and promote the welfare of vulnerable adults, raising their awareness of how this can best be done and encouraging them to do so;
- Monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve;

OBJECTIVES:
The LSAB should support and / or seek assurance

a) Organisations and Board compliance on the legal duties under the Care Act through an informed understanding of safeguarding arrangements and performance in single agencies and an authoritative oversight of the quality of front-line multi-agency practice.
b) Support operational practice through the provision of relevant multi-agency policy or practice guidance.
c) Ensure learning from audits, significant Incidents and Safeguarding Adult Reviews is identified and is used to develop practice and service provision.
d) Ensure the provision of high quality multi-agency safeguarding training and evaluate the impact on practice of such training

KEY THEMES/PRIORITIES:
The Board has also identified three key areas to focus its work upon:

- Domestic abuse (joint with LSCB)
- Implementing learning from SARs and relevant CSPR's
- Emotional wellbeing and mental health (work on 16-25yrs is also part of the LSCB priority on emotional wellbeing and mental health)
- Cybercrime

Consideration of the Making Safeguarding Personal, the wishes and feelings of the person and their lived experience should be a part of everything we do.

Outcomes	Actions	Evidence of Impact
Domestic Abuse – vulnerable adults are kept safe and are effectively supported	• Multi agency Audits • Performance Monitoring • Assurance reports from DA forum	• Audit findings • Analysis of MARAC data • Feedback from victims
Implementing learning from SARs: Practitioners and managers actively apply learning from SARS/SI's in their daily practice	• Multi-agency Audit (To be defined) • Single Agency Audits • Performance Monitoring • Assurance reports from relevant sub-groups • Provision of learning opportunities including webinars on thematic issues • Review of learning from national analysis	• Evidence from audits (multi and single agency) • Feedback from practitioners • Uptake of learning and development opportunities
Emotional Wellbeing and Mental Health: Adults are able to access appropriate advice and have good support to manage issues of poor emotional wellbeing and / or mental health.	• Single Agency Audits • Performance Monitoring • Assurance reports and updates from partners • Training • Evidence of suicide	• Audit Findings • ELFT Performance Measures • Healthwatch data • Feedback from service users
Cybercrime: Adults are able to access appropriate advice support to deal with financial scams online	• Agree pan beds multi agency approach • Develop a comms campaign • Develop performance data to monitor • Develop Training strategy for all staff/ volunteers	• Number of staff accessing training • Number of crime reports reduced over 3 year period • No of mentions on social media • Feedback from service users