Safeguarding in Luton

The Annual Report for Luton Safeguarding Adults Board

2023 – 2024 Annual Report

September 2024

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INDEPENDENT CHAIR - INTRODUCTION

It is with great pleasure that I present Luton's Safeguarding Adults Board's Annual Report for 2023/24. I have held the role of independent chair since 2020 and was appointed not just to chair the Strategic Board but also to offer independent scrutiny of Luton's multi-agency safeguarding arrangements for adults. This introduction to the report is my assessment of how effective these arrangements have been in practice over the past 12 months. I will highlight where the arrangements are performing well and where I consider further development is required.

The report highlights the work carried out by the Board and its partners, reflecting their commitment to the safety and wellbeing of adults with care and support needs. All partners are working towards the vision that no one should have to tolerate, or be exposed to abuse, neglect, or exploitation.

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

Our Strategic plan and priority area of 'Making Safeguarding Personal' (MSP) has been our focus and there is clear evidence within this report that we are delivering, using the six principles of adult safeguarding: Empowerment, Protection, Prevention Partnership, Proportionality, and Accountability for the basis of that focus. In Luton we recognise that each adult suffering abuse or neglect is an individual and the safeguarding response will be about achieving the best possible outcome for that person. All safeguarding practice must ensure that the person at risk remains at the centre of all safeguarding activities and work to meet the expectations and wishes of the individual.

Going forward, I would like to see more focus on transitional safeguarding, ensuring a smooth and coherent journey for vulnerable young individuals. This continues to be complex and challenging work, particularly for those young people who have been experiencing abuse and exploitation. As they reach 18, the services available to them are limited.

Abuse and exploitation do not end at 18 years of age and yet many services for adults are designed only to support those people with ongoing care and support needs. This important work needs to continue to enable the partnership to develop effective 'Transitional Safeguarding' arrangements, this requires an effective partnership between both Children's and Adult Services to develop the necessary procedures to identify and protect those young people who are at risk of harm as they transition into adulthood.

This report highlights the Safeguarding Adult Review (SARs) that have been undertaken by the partnership during this reporting period. The purpose of a SAR is to identify improvements people as they navigate the complexities of adolescence and transition to adulthood. This requires effective collaboration between partners which will create a strong safety net for these to be made to prevent deaths or serious harm occurring again. Such reviews should seek to inform effective learning and reduce the recurrence of similar incidents. It is the responsibility of the SAB to identify such cases and to commission reviews as appropriate so that improvements

can be made. This report highlights the volume of SARs that have been undertaken by the Board.

Luton Safeguarding Adult Partners have a well organised group of multi-agency professionals that oversee reviews and ensure there is a culture of learning and continuous improvement. Learning from reviews is a Board priority. The report highlights the key themes that are emanating from these reviews. It is pleasing to see that the partnership is embedding the learning from SARs into frontline practice. I will continue to monitor the process of learning from reviews to ensure that it is embedded, and practice is improved.

This report outlines the funding required for the partnership to function effectively. The funding historically sits disproportionately with the local authority. In order to meet the increasing costs that the LSAB needs to fulfil its functions effectively, I would like to see the strategic partners review the current arrangements to ensure funding is shared equitably between the key partner agencies and can meet future needs.

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

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 vulnerable people.

Alan Caton OBE

Luton SAB Independent Chair

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 can be found on page 6.

CORE DUTIES

The LSAB has three core statutory duties. It must:

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

In meeting these core duties, this annual report is structured to demonstrate how the LSAB has addressed these requirements.

KEY FINDINGS

The information in this report demonstrates how the LSAB has progressed its work from its intentions last year through to its achievements in the current year. This annual report describes the work undertaken to seek assurance and evidence about the effectiveness of single agency and multi-agency adult safeguarding in Luton across its priorities and golden threads and to ensure evidence of practice development and sector-led improvement against its recommendations from last year.

RECOMMENDATIONS OUTCOMES 2023-24

The LSAB Annual Report 2022-2023 set out that, while the Board had made progress in improving governance and is using data and audit to assure itself of the quality of practice the LSAB needed to undertake further work in 2023/24 including:

- **the LSAB Strategic Board and Statutory Partners Chair and Safeguarding Assurance group to set strategic vision and direction** holding partners to account for their contribution to safeguarding effectiveness and to receive assurance reports and provide challenge and scrutiny to ensure safeguarding effectiveness. Also to ensure the LSAB **has sufficient resources to meet its statutory requirements and core duties**
- **review of the effectiveness of established priorities** with consideration of emerging themes and new priorities to **develop a revised** Strategic Business Plan 2024-2026 and in year **delivery plan, revised structure and governance arrangements**
- **use its Scrutiny and Performance space** to learn more about themes and develop new metrics within its scorecard and extend its work on data analysis, audit and measuring impact
- **extending its work in the Voluntary, Community and Social Enterprise Sector** (VCSE)

- **ensuring those with lived experience are able to offer their view** on the LSAB Priorities and can communicate how well the LSAB are meeting the six safeguarding principles and embedding the principles of Making Safeguarding Personal (MSP)
- **oversee delivery** of the planned new accessible safeguarding website and online multi-agency safeguarding procedures which includes escalation pathways
- **development of audit schedule for whole of 2023/24** to include an Audit of section 42 enquiries conducted for mental health reasons under provider arrangements in Q1. To undertake a Multi-Agency Drug and Alcohol audit in Q2 and to link with the Adult D SAR action plan evaluation. **Undertake a SAR Learning Development Day** to evaluate the impact of the activity undertaken against SARs over past two years in Q3, **to review the action plans from rapid reviews** held in previous years and
- **disseminate learning from audits and reviews** including escalation and deliver training on themes emerging from reviews and performance information as well as to **conclude and publish the ongoing SARs and other learning reviews.**
- As part of its communication work **to develop the role of the LSAB Coproduction group** around participation and engagement with the VCSE sector and pathways for those with lived experience, providing support and advocacy to enable vulnerable adults to disclose the harm or abuse they are experiencing or have experienced in the past.
- exploring better means of communicating its work and the learning from reviews

The summary below sets out what each LSAB group set out to achieve and what it actually did against its agreed activity and work plan.

JOINT CASE REVIEW GROUP

- SAR Learning Development Day to be held in Quarter 3 to evaluate the impact of the activity undertaken against SARs over past two years
- Review the impact from action plans from rapid reviews held in previous two years
- Conclude and publish the ongoing Safeguarding Adult Reviews

The Joint Case Review Group, which is chaired by the Independent Chair, is responsible for completing SARs, when the criteria in section 44 Care Act 2014 are met for either mandatory or discretionary reviews. The annual report therefore provides details of the SARs undertaken and published during 2023/24, including implementation of their action plans, and the themes arising from previous SAR referrals, rapid reviews and SARs themselves. The impact of the learning of SARs was reviewed in an evaluation day which provided the LSAB with evidence of its effectiveness against the themes from previously SARs undertaken and the rapid reviews held in the previous two years. This showed the progress we had made against the themes:

- Lack of professional curiosity and questioning – *the single agency highlight reports showed evidence of staff questioning outcomes and more evidence of their professional curiosity around causality especially in high risk and complex cases, as well as in supervision discussions, changes in both single agency and multi-agency policies, and training delivery.*
- Lack of multi-agency working – *there was evidence of less silo working, with more use of multiagency multi-disciplinary meetings, including through the High Risk Complex Case Panel, more use of whole family approaches and good multi-agency attendance at operational groups to discuss cases and the Luton Drug and Alcohol Board.*
- Self-neglect and hoarding were not recognised as safeguarding issues – *there was evidence in the data of more concerns raised and safeguarding referrals for self-neglect.*

Cases were being reviewed in a multiagency setting through the hoarding panel. The revised Hoarding guidance and Falls Guidance was published alongside a multiagency procedure for identifying and working with self-neglect.

- No clear safeguarding plans, no shared effective intervention plans and risk management, often in isolation – *the single agency highlight reports provided evidence of more joined up working between agencies, with better clarity about the concerns, risks and intervention plans, more joined up working between adults and children's safeguarding depts and better understanding of the need for carers assessments*
- Lack of trained staff in Mental Capacity assessments - *Mental capacity and executive capacity training is an ongoing thread within LSAB subgroups and their training plan. Single agencies have provided evidence of their training delivery to staff around these issues, joined up working between Resolutions CGL, ELFT and Luton Council Public Health and Adult Social Care to deliver sessions on mental capacity as part of the LSAB training plan. However, there is more work to be done to ensure all staff are aware of the need to conduct mental capacity assessments for adults in specific circumstances*.

The Board has also been working on an action plan for a thematic SAR on Self-Neglect which will be published in due course. An integrated SAR/Domestic Homicide Review (DHR) 'Anna' is awaiting evaluation by the Home Office before publication. However, seven minute briefings have been published on these Reviews and the learning has been disseminated through key events and is being overseen by Joint Case Review Group

The LSAB published one SAR in November 2023 with themes of historical safeguarding concerns and neurodiversity, they are completing the resulting action plan and receiving evidence of impact.

The Board has benefited from contributions from family members and SAR subjects in their efforts to understand how practice for agencies working with them can be improved to achieve agreed outcomes. Further information on SAR activity can be found on page 8.

JOINT EXECUTIVE GROUP (RENAMED JOINT DELIVERY GROUP)

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

The Joint Executive Group which is chaired by the Independent Chair has overseen delivery of the evaluation of the LSAB Strategic Plan 2021-23 and evaluated its effectiveness. It has implemented the outcomes of the LSAB review of governance and accountability which has resulted in an updated Strategic Business Plan and delivery plan for 2024/25 and held partners to account as system leaders.

The group has also overseen the change from to a Joint Quality Assurance and Learning Group with a focus on ensuring we get the learning from SARs and other reviews out as soon as possible to continue with the thematic approach in terms of demonstrating impact and evidence of what difference the LSAB activity has made. The group has received partnership performance data from the LSAB Scrutiny and Performance Group to keep us on the front foot about emerging issues to the system.

The Board together with the Pan Beds Steering Group has made significant progress with the development and launch of the *Bedfordshire Safeguarding Adults Policy and Procedures,* [*Bedfordshire Safeguarding Adults Policy and Procedures*] alongside its neighbouring SAB. This has now replaced our outdated procedures documents. The launch and promotion of the procedures has included delivering regular webinars to practitioners to advise them of their use.

The LSAB has also written, revised and digitised a number of policies and practice guidance including which includes new escalation pathways to resolve professional disputes on outcomes for vulnerable adults. The LSAB has published new Falls Guidance and a *Management of Allegations against people in position of Trust (PiPoT)* protocol. The LSAB also took a significant step in implementing the *Critical Adult Safeguarding Partnership Arrangements (CASPA)* process to ensure effective practice for working with vulnerable adults with complex needs, challenging presentations and in high risk situations. It has also ensured delivery of the new joint Pan Bedfordshire website which includes a range of resources and is where our SARS are published https://safeguardingbedfordshire.org.uk/about-us/luton-safeguarding-adults-board

JOINT LEARNING AND IMPROVEMENT GROUP

- Audit of section 42 enquiries where the primary need of the individual was mental health reasons under partner arrangements in Q1.
- Multi-Agency Drug and Alcohol audit in September 2023/24 findings from which will be linked to the Adult D action plan and evaluation.
- Disseminate learning from audits and reviews and escalation of learning when it is deemed critical
- Deliver training on themes emerging from reviews and performance information

The Joint Learning and Improvement Group has been fundamental in ensuring the Board has been actively monitoring the implementation of the recommendations from learning from its multi-agency audit of safeguarding linked to drug and alcohol use and mental health. An ongoing theme across this year has been a continuation of our work on developing guidance of the application of thresholds from early help to making referrals for section 42 enquiries and use of the LSAB policy and procedures. Further information on this is on page 23 onwards.

The LSAB has increased its communication of what safeguarding is through planned campaigns, and provided training around the role that all organisations play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing. The LSAB and its partners has continued its work in embedding the principles of Making Safeguarding Personal and maintaining this as an overarching theme weaved through all aspects of its work plans and activity.

LSAB SCRUTINY AND PERFORMANCE SUBGROUP

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

- Cultural Competence
- Cybercrime and mate crime
- Drug and alcohol use
- Exploitation
- People subject to safeguarding enquiries MSP requirements.
- Person Centred Engagement
- SAR and rapid reviews
- Self-Neglect and Hoarding

- Suicides following discharge to assess
- Transitional Safeguarding
- The impact of poverty

The LSAB Scrutiny and Performance Subgroup has met regularly throughout 2023-24 to review single agency partner data on the above themes linked to partnership highlight reports. The LSAB has had some challenges in developing its scorecard to include partner data alongside the usual adult social care data on concerns, enquiries and outcomes. Robust interrogation of performance data continued to be a feature of this Board's work however this has been on a single agency basis.

There has been progress in the production and scrutiny of the single agency themed highlight reports. As part of its mandate to seek assurance about the effectiveness of adult safeguarding, the Board has received performance reports at each meeting, the overall summary of which is contained in this annual report. Work has been completed to develop its performance data and narratives as well as thematic highlight reports developed for single agencies to provide assurance and performance data on each theme. Further information on this is on page 20.

The LSAB has used its performance and scrutiny data to learn more about themes such as Concerns raised, S42 enquiries, timeliness of completion and outcomes. As well as specific themes of safeguarding concerns such as in addition audits have been conducted relating to self-neglect, legal literacy, and the multi-agency aspects of section 42 enquiries. The LSAB has recognised it has been overly ambitious with the data it has sought to collect through its revised metrics and this is clearly an area the LSAB needs to progress in 2024-25.

LSAB STRATEGIC BOARD

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

The Strategic Board has received assurance reports, in line with its strategic business plan and revised delivery plan, covering topics such as:

- Learning from experience including reviews and audits
- Self-Neglect and Neglect
- Domestic Abuse
- Emotional Wellbeing and Mental Health
- Modern slavery and Exploitation
- Board governance and structures

The Board has been actively monitoring the implementation of the recommendations from other learning activity such as from its multi-agency audits which linked to learning from SARs. Themes have included Drug and Alcohol and ELFT Section 42 outcomes. An ongoing theme across this year has been a continuation of our work on application of thresholds and use of policy and procedures. Further information on this is on page 23 onwards.

The LSAB has increased its communication of what safeguarding is through planned campaigns, and provided training around the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing. The LSAB and its partners has continued its work in embedding the principles of Making Safeguarding Personal and maintaining this as an overarching priority weaved through all aspects of its works alongside its engagement with the VCSE sector. The LSAB has reconfigured its approach to engagement this year and its delivery of the LSAB Voluntary Subgroup. The LSAB acknowledges and thanks the VCSE colleagues on this subgroup who are helping to bring a greater focus on this critical part of the LSAB's work.

In Quarter 2, the LSAB Strategic Board held a development day and undertook a full review of its effectiveness against the priorities in its Strategic Business Plan 2020-23 and the structures required to support its work. This included a review of the cross-cutting work and structures undertaken with Luton Children Safeguarding Partnership. As a result, the LSAB developed and published a new Strategic Business Plan 2024-26 and a Delivery Plan for 2024/25 . As a result of its activity undertaken throughout 2023/2024 LSAB has made the following recommendations for deliver on the findings of this Annual Report and to inform its business planning into 2024/25.

LSAB VOLUNTARY, COMMUNITY SOCIAL ENTERPRISE (VCSE) COPRODUCTION SUBGROUP

The LSAB has reconfigured its approach engagement with the Voluntary, Community and Social Enterprise sector via its LSAB Voluntary, Community Social Enterprise (VCSE) Coproduction Subgroup. This sub-group changed its name from LSAB Coproduction Sub-Group as it was recognised the role of the VCSE was not reflective in its name. The LSAB has made significant progress in its wider stakeholder engagement. The LSAB acknowledges and thanks the VCSE colleagues on this subgroup who are helping to bring a greater focus on this critical part of the LSAB's work. However, the LSAB also recognises that it needs to do more to take forward its plan for engaging and ensuring participation of those who have experienced harm, abuse or neglect LSAB Strategic Board.

RECOMMENDATIONS 2024-25

We have identified four priority areas for us to focus our 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 our resources. Based on our analysis of the situation across Luton we have identified the following priority areas:

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

We have also identified the following Golden Threads that will flow through all our work:

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

- Whole family approaches

In order to deliver on these priority areas, we will:
- Develop a Self-Neglect Pathway and Toolkit for practitioners
- Develop our Performance Monitoring metrics and narratives
- Receive and scrutinise single agency thematic assurance reports
- Deliver training on high risk complex cases / Mental Capacity Assessments / Making Safeguarding Personal / Approaches to modern slavery / Trauma Informed Approaches / Practice for Resilience / Whole Family Approaches
- Undertake Multi-agency Themed Audits
- Receive assurance reports from Domestic Abuse Luton Programme Board (DALPB) on the Domestic Abuse Strategy and provision of safe accommodation
- Receive assurance reports from the Community Safeguarding Partnership (CSP) regarding on street sexual exploitation and modern slavery.
- Renew our focus on coproduction alongside lived experienced adults' engagement.

Beverley McConnell
LSAB/LSCP Strategic Business Manager

2. LUTON SAFEGUARDING ADULTS BOARD ARRANGEMENTS

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

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and 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 LSAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in '*Making Safeguarding Personal*'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

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

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 Age Concern UK, Azalea, ResoLUTiONs CGL*)**

LSAB STRATEGIC OBJECTIVES FOR 2023/2024

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

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

LSAB Priorities for 2023-2024
Self-Neglect, 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)
Implementing the learning from SARs
Making Safeguarding Personal

We have also identified the following Golden Threads that will flow through all our work:

- 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

- Whole family approaches

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.**

This requires the LSAB to undertake a programme of learning from experience, undertaking audits and delivering training as well as communicating partners' roles and responsibilities.

3. 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:
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

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 improve practice, rather than to attribute blame to any individual or organisation.

FIGURE 1: SAR REFERRAL OUTCOMES MARCH 2019 - APRIL 2024

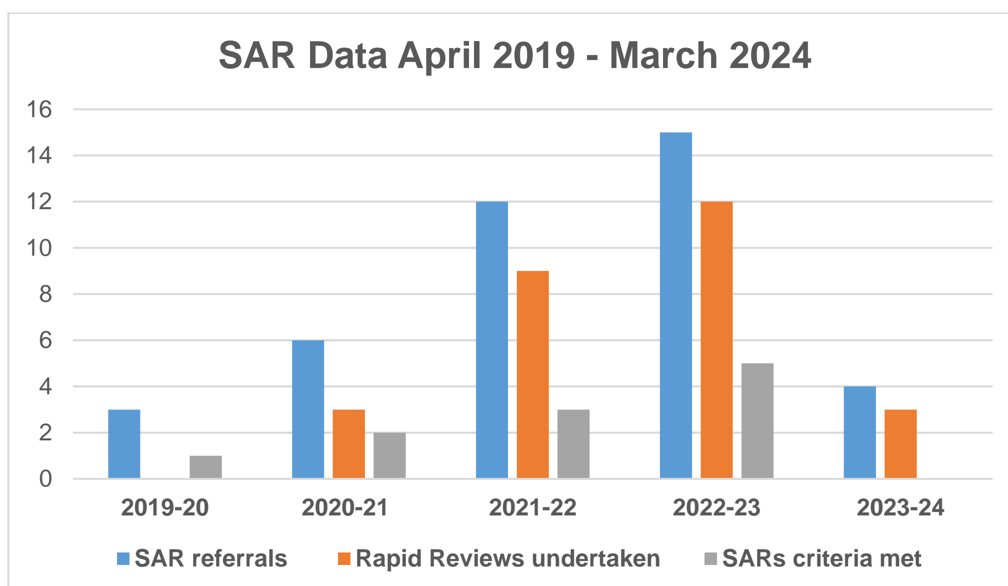


Figure 1 above sets out the SAR data from 2019 to 2024 and details:

- 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 SARs to be conducted*)
- and the number of cases resulting in multi-agency SAR.

This data shows a spike in SAR referrals, rapid reviews and SARs in 2022/23 followed by a significant drop in the SAR referrals received in 2023/24. The Board received **four** SAR referrals in **2023/24** and completed **three** rapid reviews. None of the cases referred in 2023/24 met the criteria for a SAR however, themes were drawn out from the referrals and rapid reviews. The rationale for the reduction in the number of SAR referrals and progression to a SAR, is better understanding of the criteria for a SAR and closer governance of decision to progress to a SAR.

THEMES FROM REFERRALS, RAPID REVIEWS & SARS

FIGURE 2: TYPES OF SUSPECTED ABUSE ACROSS SAR REFERRALS MARCH 2023 - APRIL 2024

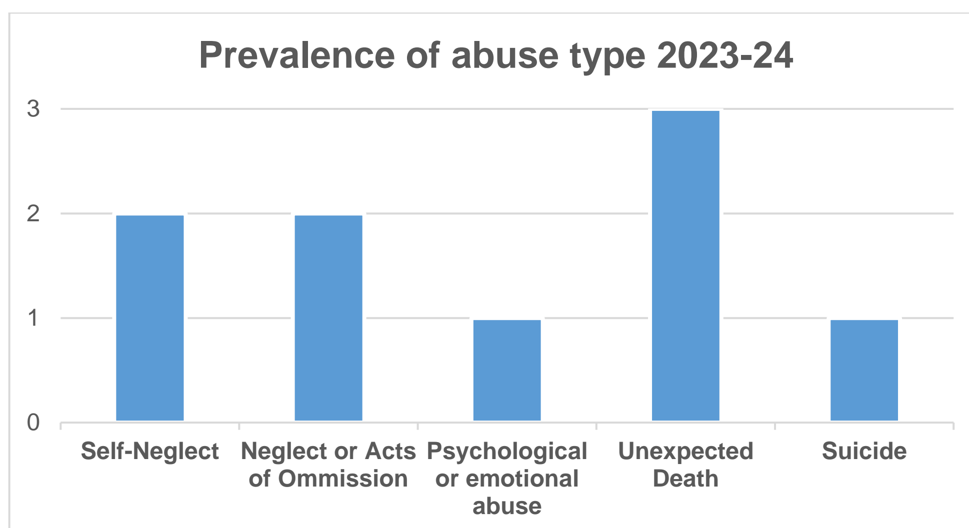


Figure 2 shows the types of suspected abuse and factors occurring within the SAR referrals received. Some of the referrals included multiple factors with all four of the SAR referrals received in 23/24 being in relation to either an unexpected death or suspected suicide. Self-neglect, and Neglect or acts of omission remained the highest occurring type of abuse in referrals for consideration of a Safeguarding Adults Review.

Learning from SARs evaluation days
The LSAB held two in person learning from SARs evaluation days in November 2023. Each agency was allocated a SAR to review and analyse in terms of themes identified, relevant learning and to provide assurance and evidence from their agency as to the impact made. It also examined the multi-agency impact of such learning on policies, procedures and practice to protect vulnerable individuals within the community. The following SAR action plans were reviewed to look at the impact and outcomes from a thematic perspective:

SARs published by the LSAB 2020-2024

- Abdullah 2020 - Isolated, alcohol misuse, self-neglect, poor physical health, housing, experienced PTSD, domestic violence.
- Adult C 2023 - Previous neglect and abuse, trauma, neurodiversity needs (Autism), professionals not listening to service users voice,
- Adult D - Alcohol brain related injury, housing, exploitation
- Beech Care Home - Lack of medical advice (COVID), impact on staff previously and ongoing
- Family U 2021 - Domestic relationship difficulties, mental health, self-harm, emotional abuse, honour based violence, cultural competency and professional curiosity
- Mental Health Thematic Review 2022 - Lack of engagement, self-neglect, neglect, drug use, sexual assault and police involvement
- Mr B - Neglect and acts of omission

SARs completed and yet to be published by the LSAB

- **Anna** - Previously Looked After Child, victim of sexual abuse, exploitation, threats of physical violence Thematic Self Neglect - Isolated, poor physical health, mental health concerns, housing, hoarding and self-neglect, reluctance to engage with services.
- **Family T** - Severe self-neglect, escalation, GCP2, poor physical health and disability, housing, hoarding, adults' needs prioritised above the children's needs, lack of whole family approaches.
- **Thematic Review Self Neglect** – self-neglect, hoarding, poor engagement with and by agencies, concerns re mental capacity assessments, mental and physical health.

The partnership sought assurance that operational practice has improved following the embedment of identified learning and its impact on outcomes. Some of the themes from the historic SARs had also been a feature SARs conducted recently. The repeating themes during this period was felt to be a factor in the high number of SARs and Rapid Reviews undertaken between 2021 and 2023. However, the reduction in SAR referrals and absence of similar themes appears to evidence improved practice in a number of areas.

The assurance provided gave good evidence of practice improvement which could be linked to data and LSAB highlight reports this with next steps is reported below:

Multi-agency assurance and summary of next steps

Evidence of gaps in professional curiosity and questioning: The LSAB Strategic Business Plan 2024 – 2026 identified self-neglect as an area of priority as it is an ongoing theme in a number of subgroups and forthcoming SARs.

- Recent Highlight reports from Bedfordshire Hospital Trusts and Cambridgeshire Community Services show improvements in staff's curiosity within practice.
- Key theme of discussion in LSAB subgroups show that this evidenced in supervision, change in single agency policies, and training
- Cultural competency is a golden thread throughout LSAB meetings / subgroups.

Data is required to show any improvement in use of tools for assessing neglect both local placed based across and Pan Beds for benchmarking.

Self-neglect and Hoarding not always recognised as safeguarding issues

- The introduction of the Hoarding guidance, as well as the Falls guidance (which has information on falls within hoarded properties).
- This falls under the six principles of Care Act 2014 – Protection – for staff to feel supported to identify neglect.

Data is required to triangulate any increase in referrals to Adult Social Care (Safeguarding and MASH teams) from agencies that rarely refer and singles agencies in relation to Falls and Hoarding concerns.

Need to improve confidence in multi-agency working

- The LSAB Strategic Business plan also details the six principles of Care Act 2014 - Partnership – and the next steps are for the voluntary sector agencies to be invited to more LSAB meetings, development days and have a voice in the LSAB. This has also included a change of name for the LSAB Voluntary subgroup to LSAB VCSE Coproduction Subgroup and updated terms of reference.

Data and single agency highlight reports as to the effectiveness of the High Risk Complex Case group, due to be reviewed every 6 months – due June / July 2024.

Need clearer safeguarding plans in some cases and shared effective intervention plans and risk management, as these are often done in isolation

- Highlight reports state more joint up working between agencies (i.e. CCS and ASC),
- Highlight reports from LDH describe joined up working between adults and children's safeguarding depts
- CCS have been working more with MASH to have a joined up approach to safeguarding adults.
- The next steps are to assess the effectiveness of the High Risk Complex Case meetings, continued evidence with single agency highlight reports to the LSAB Scrutiny and Performance meetings and referrals to Adult Social Care Safeguarding team and MASH team.

Data and single agency Highlight report as to the effectiveness of the High Risk Complex Case group, due to be reviewed every 6 months – due June / July 2024.

More training on Mental Capacity assessments

- Mental capacity and executive capacity are an ongoing thread within LSAB subgroups
- There has been joined up working between Resolutions CGL, ELFT and Luton Council Public Health and Adult Social Care to deliver multiagency training
- Single of agencies have provided assurance regarding their staff training for evidence Mental Capacity Assessments and Executive Capacity.
- The LSAB will be gathering data on the number of Mental Capacity Assessments being completed and whether this has demonstrated any impact on the quantity and quality of referrals being completed.

Data in relation whether there is more Mental Capability assessments being completed now more staff have been trained.

The **four** SARS commissioned in 2023/24 involved **seven** individuals and were:

- **Adult Anna** (Integrated SAR/DHR): concluded and awaiting Home Office sign off for publication although a seven minutes briefing has been published here:
- **Adult Kiara** (Incomplete suicide, interfamilial abuse, and honour-based violence): was signed off in May 2024 and is due to be published Sept 2024 once family engagement is concluded
- **Thematic Self-Neglect SAR** (involving two individuals who died in separate circumstances but with similar elements of medical self-neglect and hoarding and a further individual who died by suicide): was signed off in May 2024 and is due to be published Sept 2024 once family engagement is concluded
- **Family T** (Integrated SAR/CSPR - self-neglect, disability, and child neglect): was signed off in May 2024 and is due to be published Sept 2024 once family engagement is concluded.

SARS PUBLISHED IN 2023/24

The LSAB published the SAR report into Adult C in November 2023, and the resulting recommendations and their outcomes are detailed below:

Recommendation 1: Undertake a local training needs analysis in relation to comorbid complexities and agree/develop a multi-agency training and development programme to meet

development needs in relation to Autism, Trauma and Positive Communication. With the aim of improving practitioner capability and confidence as a means of improving local multi-agency management of complex issues across several service areas.
A training needs analysis was undertaken and partners' approach and contribution to the training themes reviewed on Agreement was reached on which components can be provided through reciprocal arrangements or paid for courses and training intervals for each cohort. An LSAB training plan was drawn up based on the gaps identified in partner single and multi-agency training delivery on the identified themes. Partners have routinely provided assurance regarding their training delivery on the themes from this review and through their highlight reports to LSAB Scrutiny & Performance Group. All agencies have regularly trained staff in de-escalation, conflict resolution, trauma informed care training and the Oliver McGowan training on neurodiversity.

Recommendation 2: Care Coordination for complex cases where several agencies are involved is essential if people are to be supported and engaged in the process. This is in local policy but does not appear to be delivered in practice, and as such multi-agency arrangements, which include mediation and consultation with Adult C is required urgently in relation agreeing the most appropriate means of coordinating her care and support arrangements and setting out the expectations and boundaries of those arrangements.
The LSAB complex Care processes are written, published, and are beginning to be embedded in practice. Assurance Report re engagement processes for those with complex presentations through the CASPA process is part of single agency highlight reports. The CASPA process has been embedded in practice and is demonstrating evidence of improved practice.

Recommendation 3a: Mediation between Adult C and Local services is urgently required, the issues and conflicts detailed throughout this analysis continue in the current contact between the two parties. This is not tenable and working relationships have broken down to the point that Adult C refuses to be contacted. It may be possible that with mediation and a plan that is constructed with Adult C is now required, if there is an option to repair these relationships.
The LSAB regularly seeks assurance that local services working with Adult C are offering independent mediation and conflict resolution to Adult C and their approach to develop a care plan for care and support needs with her. A communications plan developed with Adult C which is regularly reviewed is securely in place with all agencies.

Recommendation 3b: If this is not possible, Adult C is still entitled and eligible for adult social care and mental health support and is receiving an adult social care package of support, as such the LA and its partners will need to identify a way in which their duties continue to be effectively discharged, and the support package is regularly reviewed, with the aim of developing a working relationship with a care coordinator that is a more positive experience for both Adult C and the staff involved.
Care duties continue to be effectively discharged, and the support package is regularly reviewed, and staff deployed to develop a working relationship with Adult C. While the care package is appropriate it is recognised that offer by agencies may not meet their expectations.

Recommendation 4: Debriefing of staff in frontline services is required as part of standard practice, and a process needs to be put in place that ensures regular single and multi-agency debrief opportunities, reflective supervision and support is available in case where individuals may be having significant conflict with an individual using the services.
Each agency has in place a formal debrief pathway in place for complex cases. This is completed through informal debriefs and through After Action Reviews as needed. Reflective supervision is offered by each agency and staff affected by their interactions receive support.

Clinical supervision or safeguarding supervision is also available to staff and regularly accessed when staff require individualised support for a particular case.

Recommendation 5:
De-escalation and positive communication training that draws on trauma-informed practice as a core of its content is worth further consideration. Supporting front line practitioners to explore meaning behind behaviour and the impact of trauma on an individual's responses would likely improve both professional resilience and staff capability to build and sustain effective working relationships with individuals who are perceived as challenging or otherwise difficult to engage.
Single agencies are providing appropriate de-escalation and positive communication training to its frontline staff. There is evidence of improved professional resilience and staff capability to build and sustain effective working relationships with individuals who are perceived as challenging or otherwise difficult to engage.

Recommendation 6:
How adult services work with carers is highlighted in this, and other, SAR reports. In response to this theme the board may wish to consider a thematic focus on the involvement and working relationships with carers across the partnership as a strategic objective for future years to ensure this area retains to focus it requires.
The LSAB has utilised the Luton Carers Strategy 2022-27 as a mechanism to engage with carers and this strategy has been co-produced with local organisations and Luton Carers to ensure their views and expertise have shaped it. It is for anyone who regularly supports another person on an unpaid basis, whether that be a friend, child with additional needs, relative, loved one, or a combination of these people.

SELF-NEGLECT AND NEGLECT

Thematic SAR Self Neglect

The LSAB conducted a Thematic Safeguarding Adult Review (SAR) on Self Neglect in 2023/24 this is due to be published shortly. The review considered the response to cases of self-neglect and concomitant poor living conditions and hoarding which is a key challenge in services for adults. Self-neglect results in individuals being unable to care for their basic needs. For those involved, including family and friends, these cases are professionally and personally challenging as they are characterised by the individual suffering of harm whilst they pose considerable quandaries about how to resolve the issues. There are significant ethical and legal considerations, particularly where adults appear to have the mental capacity to refuse support. The focus of the thematic review was to consider the interventions in this case and to raise awareness of the lived experience of the individuals involved in the review. The LSAB received the findings from the review and recommendation from which it is has developed an action plan ahead of publication and taken forward many of the findings already:

Key Findings of the Review

- Self-Neglect and hoarding were not appropriately identified as safeguarding matters 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 actions and impact against the recommendations will be reported on in the next Annual Report. However, the LSAB has reviewed its safeguarding procedures and developed a revised hoarding procedure and pathway which can be found here. Development of a thresholds guidance and a self-neglect toolkit will start and then be published in 2024/25.

DOMESTIC ABUSE

The LSAB shares 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 Programme 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 and poor mental health. Data within SG2A: Concluded Enquiries by Abuse Type and Source of Risk for domestic abuse show the number have increased. The increase for Domestic Abuse is positive as local intelligence has long indicated these are both under reported safeguarding concerns. The number of concerns for domestic abuse has doubled from **9** in 2022/2023 to **18** in 2023/24

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. The Luton Domestic Abuse Strategy 2023 is built around the four priorities:

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

What is already happening in Luton…

- 'Own My Life' - an innovative, creative and educational 12-week course for women. It can be delivered online or in-person and supports women to regain ownership of their lives when they have been subjected to abuse or violence by partner. This is done using short videos, structured discussions, group and individual activities, and a comprehensive learning journal. **https://www.ownmylifecourse.org/what**
- Freedom Programme - a free 12 week programme that examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The programme also describes in detail how children are affected by being exposed to abuse and very importantly how their lives are improved when the abuse is removed. **https://www.freedomprogramme.co.uk/**
- Talk4M - Group support is provided for men who have experienced domestic abuse in a safe, therapeutic environment. This service is for male victims living in Bedford Borough, Central Bedfordshire or Luton. **https://familiesfirstbedfordshire.org.uk/family-services/**

Working together with partner agencies such as the IDVA service and BDAP has led to a change in process for Clare's Law. Since the change 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 2024/25.

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 runs until 10 December, Human Rights Day. In support of this initiative, the United Nations Secretary-General launched in 2008 the campaign UNITE by 2030 to End Violence against Women, which runs parallel to the 16 Days of Activism. The LSAB undertook to promote the daily activities taking place and for its members to participate in selected activities.

Bedfordshire Police undertook a collaboration with Luton based community group Nine Red Presents to share 16 survivors' voices through a series of blogs and poetry as part of an international campaign against gender based violence. During this period, partners and other organisations across the county to raise awareness of key topics such as male violence against women and girls (MVAWG), domestic abuse, stalking and harassment and serious sexual assault. One survivor spoke about when she was in a coercive and controlling domestic abuse relationship, and the breakdown and changes in the relationship as he started to overcome her. She said:

“There wasn’t a definitive change in his behaviour. It was slow changes, barely noticeable. He made me feel safe. Until he didn’t. He’d already taken my job, so I had no money and he had full financial control. In doing so, he prevented me from being able to go back home to see my friends and family.”

The 16 voices demonstrate the raw emotions survivors face when going through and rebuilding from domestic abuse, sexual assault and other crimes.

MODERN SLAVERY AND SEXUAL EXPLOITATION

The LSAB is aware from its dataset that safeguarding concerns raised for modern slavery and exploitation remain low in 2023/24. 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 Scrutiny & Performance T& F Group received single agency highlight reports with a theme on modern slavery and adult exploitation at its meeting in March 2024. The Partners provided the following assurance:

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). There is also a statement regarding this on the website and there is an Adult safeguarding helpline. However, there had been no calls to the helpline regarding modern day slavery. There are not any current cases with regards to exploitation and MDS known to CCS.

BHT: Bedfordshire Hospital Trust arrange specialist Exploitation Awareness days for staff and they represent the Trust at the Modern-Day Slavery group.

Cases involving exploitation, sex work, drug and alcohol are 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. 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.

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.

ResoLUTiONs 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.

ELFT: within Quarter 4 there is only one person open to ELFT for a Section 42. 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.

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 slavery and exploitation working closely with the On Street Sexual Exploitation Group led by Public Health.

The LSAB has also revised its multi-agency safeguarding procedures to include new chapters on the following subjects linked to this priority:

- sexual exploitation
- mate crime
- modern slavery

After Action Report

The LSAB received an After Action Review (AAR) report in February 2024 following an incident of modern slavery with regard to international recruitment sponsorship licence irregularities operation which identified safeguarding concerns for both vulnerable adults, foreign workers and their children. The Partnership approach to manage this incident was very robust with police, health, adult and children's safeguarding working together intensely to manage the risk to residents and support the international recruits. The AAR was a partnership approach to understanding the learning from the management of the incident to support us to deliver this even better, should the need arise. Actions required as a result of this activity are below and will report to LSAB in 2024/25:

- Review Market Failure policy to ensure we cover international recruitment and wider impact this can have
- Work with International Recruitment East Partnership to draft guidance and process flow for authorities, providers and displaced recruits
- Support development of a national approach with partner organisations to standardise incident management of this type
- Collaborate with the Home Office to support a review of the application process for providers to obtain a License to recruit international workers

Modern Day Slavery will continue to be on the LSAB will risk register due to the low number of referrals received and the improvements to be made to identify MDS within the care sector.

EMOTIONAL HEALTH AND WELLBEING

Trauma Informed Care - As part of the focus on emotional health and wellbeing the Joint Quality Assurance & Learning Group received presentations on the Pan Beds approach to Trauma Informed Care (TIC) from East London NHS Foundation Trust (ELFT). This gave examples of where Luton and other areas of Bedfordshire are in relation to their counterparts, with regard to ELFT activities. The Trust is collaborating across boroughs and deliver training. Examples of areas already practicing in trauma informed way:

- Violence Reduction Initiative – safety huddles utilising the TIC approach
- Consistent staff offering care
- DialogPlus to identify people's needs
- Offering choice re intervention /staff

The LSAB Strategic Board received presentations from Bedfordshire Police and ELFT on the roll out of the **Right Care Right Person** (RCRP) initiative, which is an approach designed to

ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. Central government agencies as well as local partners have been at the centre of planning and delivering this change which involves greater care to be delivered by mental health or other support services, rather than the police.

Phase 1, 'concern for welfare' went live on 31 January 2024 and by the end of March 2024:

- The RCRP multiagency training programme had been delivered to 600+ staff across Bedfordshire and Luton
- A multiagency escalation pack had been developed
- A Multiagency service directory had been developed
- Multiagency twice daily huddles were in place to monitor escalations and disagreements. These huddles were reduced to three times per week in response to reducing levels of escalation in the Phase 1 rollout
- A welfare protocol was in place with policy changes across the system.

Right Care Right Person (RCRP)

The LSAB has received regular reports within the LSAB Strategic Board regarding RCSP and has provide focus and challenge on the response to welfare calls and received data regarding the numbers of calls for welfare and their outcomes. Of the **197** incidents called in across Pan Bedfordshire, the police attended **82 (40%)**, it is estimated that previously they would have attended **171 (83%)** incidents. Signposting to other services has freed up resources for other core police activities. However, the LSAB has been 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.

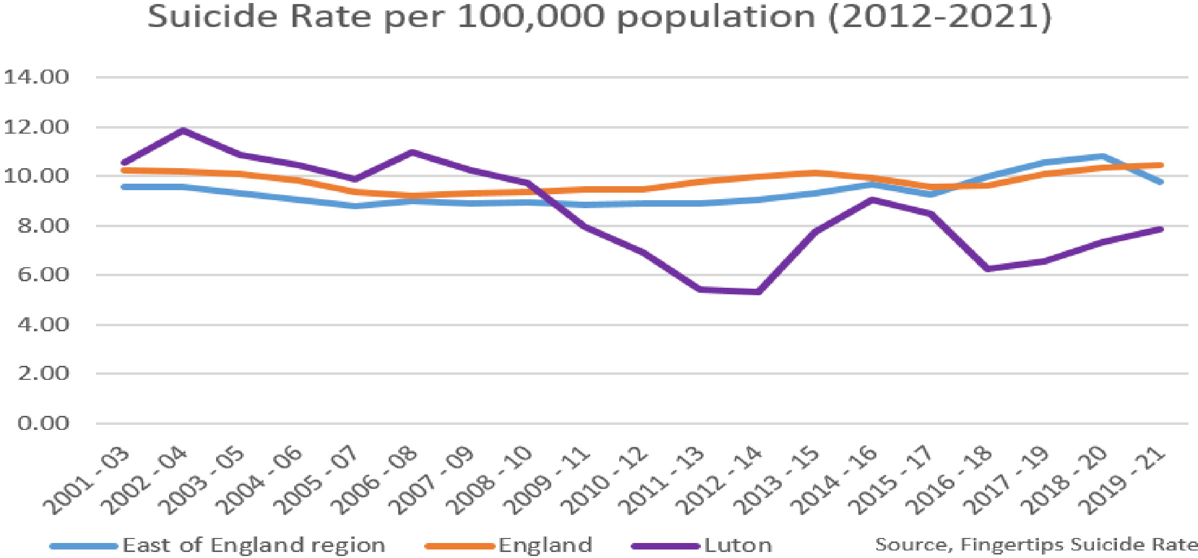
Suicide Audit 2022/2023

The LSAB also received a report from Public Health on the findings from the Suicide Audit 2022 at its Strategic Board in December 2023.

<u>Summary of Findings</u>

- **50** people died by suicide between 2019 and 2022
- **84%** of those were male, greater than that seen nationally and from the Luton 2014-18 suicide audit
- **72%** of those were UK nationals, with a further 16% Eastern European nationals, (most commonly Polish) – indicating that these groups were overrepresented in suicides.
- **24%** of those who completed suicide were working in the warehouse or logistics industries, with a further **24%** working in Construction or Manufacturing.
- **48%** of those who died were between **41 and 60 years old**, with an average age of **43.4 years old** between 2019 and 2022.
- **62%** of completed suicides were completed within a permanent home address
- **58%** of completed suicide by means of hanging/ligature.
- **12%** completed suicide by overdosing on prescription medication
- A review of Inquest reports shows that **32%** of those involved displayed prior suicidal ideation.
- Overall, **28%** of reports show prior mental health concerns, such as depression and anxiety.

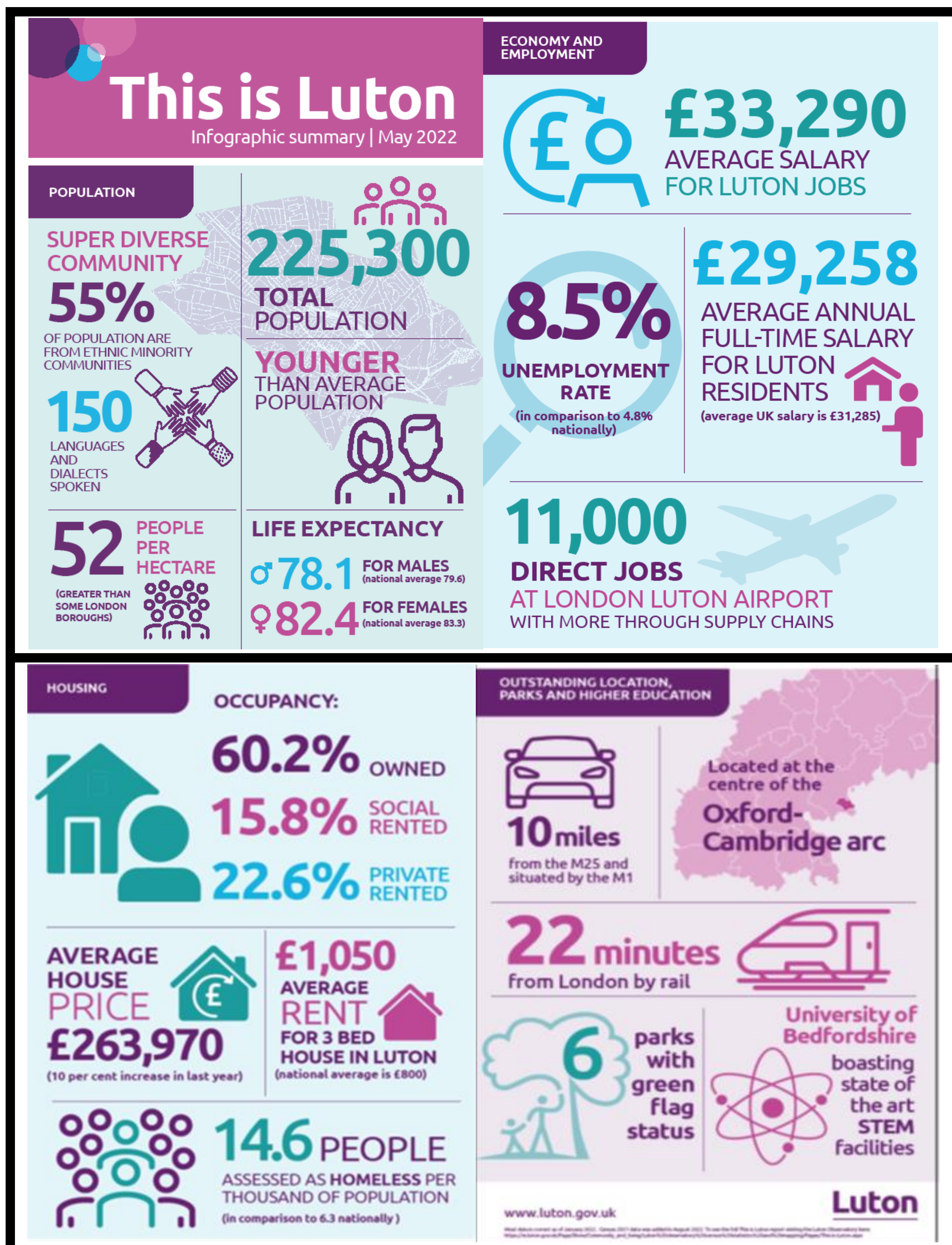
FIGURE 3: SUICIDE RATES PER 100,000 POPULATION 2012- 2021



In 2021, there were 5,583 deaths by suicide registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people. The Luton rate in the same year was lower, at 7.8 deaths per 100,000 people. London had the lowest suicide rate of 7 deaths per 100,000 (*HoCL, 2023*).

4. 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 new single agency thematic highlight reports which began in Q3 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

LSAB SCRUTINY AND PERFORMANCE SUBGROUP

The Year reporting year 2023/24 has recorded a total of 2956 safeguarding concerns received into the Adults MASH. In comparison to the 3209 concerns received in the period 2022–23, there was a noticeable drop in the total number of concerns into the MASH. The reduction in concerns 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.

2023-24 has seen a total of 346 safeguarding concerns progressed to s42 in comparison to 294 in 2022-23. This is 52 less than in the previous year but represents an increase of 3.4% 13% in terms of conversion rate from concern to enquiry, from 9.6% to 13% due to the reduction of overall concerns previously inaccurately recorded. 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.

From the **346** S42 enquiries in 2023-24 the safeguarding outcomes were recorded as:

- Risk removed following safeguarding interventions in **98** cases, reduced in **241** cases and remaining in **43** cases.
- During the year 2023-24, the single biggest referrer was Social Care Staff at **1029 (35%)** with **109** cases progressing to a S42 enquiry.
- The referrer with the second highest number is the Police with **337** with only **20** cases progressing to s42 a conversion rate of **5.9%.**
- Hospitals are the third biggest referrer with a total of **316** cases with **31** progressing to s42 making a conversion rate of **9.8%**.

The Partnership continues to update its safeguarding documentation and processes by way of audit and recommendations on a routine basis.

The Safeguarding Adult Collection (SAC) 2023-24 Overview Summary which shows how contacts have been made and safeguarding enquiries addressed are attached as Appendix A.

MULTI-AGENCY AUDITS

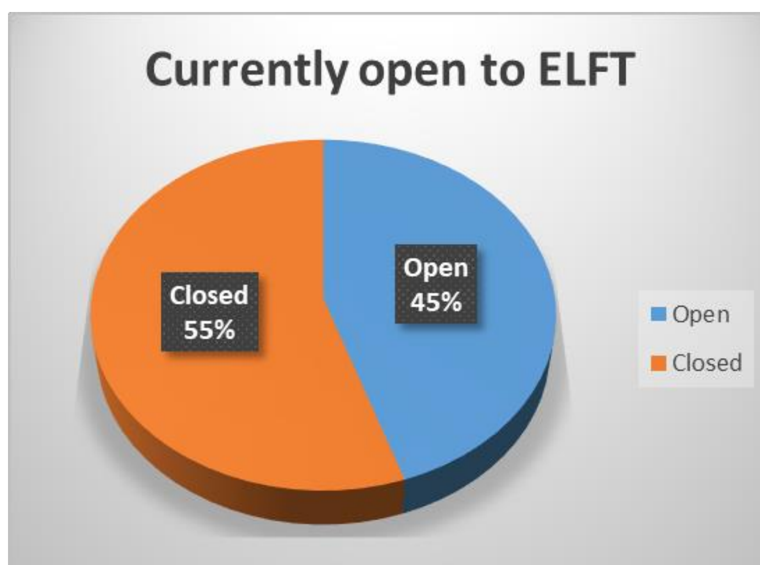
The LSAB Multi-agency Audit Group has established a rolling programme of audits and highlight reports throughout 2023/24 which included themes linked to learning from reviews.

Audit of section 42 enquiries

The audit reviewed cases conducted with people who have a primary support need of mental health under our partnership arrangements with ELFT within Quarter 1 2024/24. There were 29 individuals open within the 30 cases audited. 1 individual had 2 separate S42 enquiries audited. The audit looked at cases that had taken longer than 56 days to conclude, how many adults had additional safeguarding needs identified during the conduct of the enquiries, and adults with further safeguarding enquiries raised.

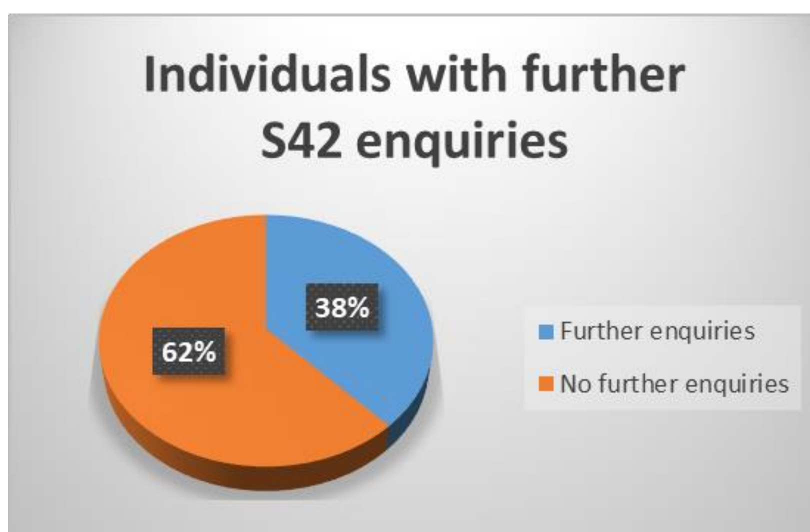
The below table shows the number of clients that remain currently open to ELFT, total 13 individuals.

FIGURE 4: SECTION 42 ENQUIRIES OPEN TO ELFT 2023/24



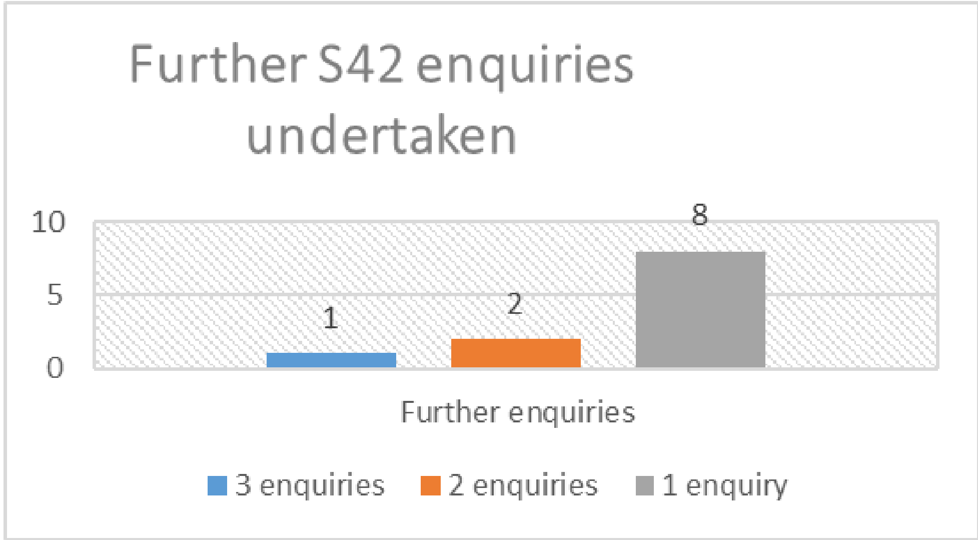
Out of the 29 individuals 11 have had additional safeguarding concerns raised and investigated.

FIGURE 5: INDIVIUDALS WITH FURTHER SECTION 42 ENQUIRIES 2023/24



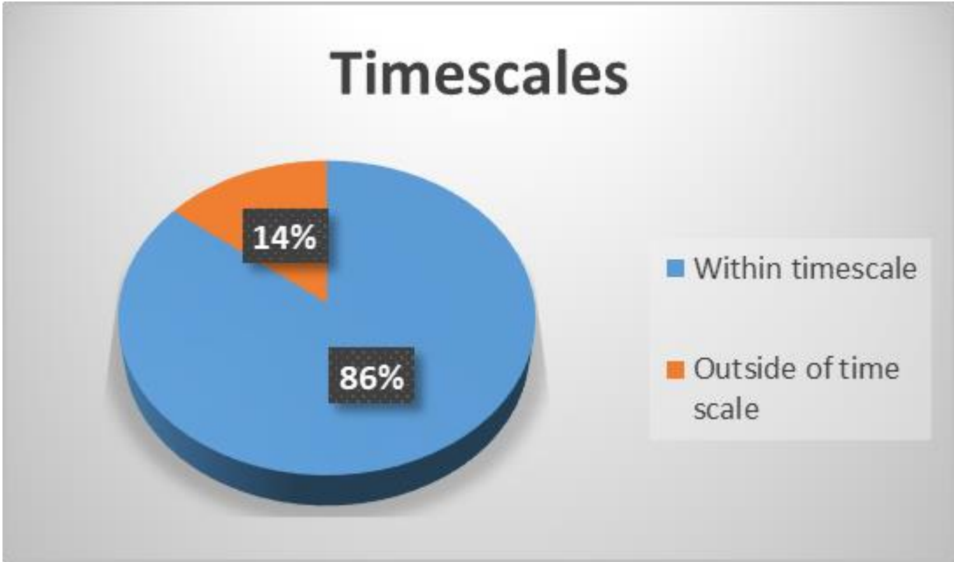
A total of 11 individuals had further S42 enquiries raised. 1 individual had a further 3 enquiries, 2 individuals had 2 further enquiries, and 8 individuals had a further enquiry raised. Out of the 8 cases, 1 is a recent enquiry and is currently underway.

FIGURE 6: FURTHER SECTION 42 ENQUIRIES UNDETAKEN BY ELFT 2023/24



Out of the 14 further S42 completed enquiries 12 were completed in a timely manner within expected timescales, 2 were outside expected timescales (3 & 4 months respectively).

FIGURE 7: SECTION 42 ENQUIRIES OPEN TO ELFT APRIL 2024



The audit demonstrated a significantly improved position on the previous section 42 ELFT audit undertaken in 2022/23.

Luton Drug and Alcohol Audit September 2023

Drug and Alcohol issues are prevalent in Luton and an emerging safeguarding issue especially since the COVID 19 pandemic where there has been increased presentations.

The purpose of the audit was to assess how adults and families using and or experiencing the impact of Drug and Alcohol and how they are supported in accordance with LSAB safeguarding policies and procedures and the Care Act 2014.

Methodology
Resolutions CGL selected a sample of 10 cases of vulnerable adults who were at medium risk of harm or abuse. An audit template was devised and circulated to partners who had involvement with the subject adults to grade the quality of their single agency involvement and how well the multiagency safeguarding system had worked to meet the adults care and support needs and keep them safe.

The audit took place in September 2023 over two virtual meetings with attendance of relevant staff from Cambridgeshire Community Services, Bedfordshire Hospital Trust, East London Foundation Trust (ELFT), BLMK ICB, Beds Police, Luton Probation Services (NPS), ResoLUTiONs CGL, LBC Housing and Luton Adult Social Care. The meetings were chaired by the LSAB Business Unit to maintain independence of all agencies and organisations.

Each case was considered against a set of indicators and the audit endeavoured to identify good practice as well as any gaps. All participants were invited to ask questions, to reflect on the elements of best practice and gaps at a practice, organisational or system level. A Risk Matrix was used to grade the areas under consideration:

- Evidence of Risk Management/Safeguarding referrals undertaken
- Whether Mental Capacity Assessments captured issues around mental capacity linked to drug and alcohol issues
- The quality of communication and how was this managed between partner agencies
- Evidence of any multiagency multi-disciplinary team approach and working across services when appropriate
- The use of the whole family approach and carers assessments

Areas identified as good practice

- People are assessed with regards to hearing their voice in custody and fit to interview. A series of questions are asked and offered during Police custody. The police will seek evidence of paraphernalia, checking telephone number to assess charge of possession with intent
- Evidence of good inter agency working - Police and Resolutions noted as multi-agency working, representatives in court, custody and hospital
- ReSolutions are vigilant to safeguarding people within their service.
- ReSolutions are often the lead professionals and demonstrate a persistent and proactive approach to highly complex cases
- Panel members noted representation the on street sex exploitation group and Vulnerable Women's groups
- The implementation of the ReSolutions Aggressive Incidents Protocol enabled people to access treatment safely at the Service.

Conclusion and recommendations

1) **Case coordination is missing from many of the above cases**, a gap which identifies professionals became task centred more than person-centred. ReSolutions

do not have a dual diagnosis commissioned service and are unable to provide mental health support.
CASPA has provided a pathway for more person-centred case coordination. Public Health are reviewing the drug and alcohol contracts to include dual diagnosis provision and this should be in place in 2024/25

2) **There was a lack of victimless prosecution.** The Police view was that if the victim does not engage they are unable to investigate any forced activity however, they are working to increase the number of evidence led prosecutions for example if there was any evidence of violence and body worn footage of initial interviews.
The Police have undertaken work in this area and have agreed to build metrics to understand the number of victims of crimes against the person and the number of evidence led prosecutions that take place as a result. An assurance report is due to come to the Strategic Board in June 2024.
3) **There were and increasing number of women who are subject to sex work**, Resolutions are looking to undertake additional work with Azalea to support women like 'Anna' and already have over 400 women involved in in street sexual exploitation linked to their service.
This work has commenced and the LSAB is a member of the On Street Sexual Exploitation Group led by Public Health and has agreed to take forward objectives around awareness raising and multi0agency procedures as part of the On Street Sexual Exploitation Strategy.
4) **Not all cases presented appear to be medium risk**, the panel assessed several of the cases as very high risk of safeguarding harm through abuse or self-neglect through drug related death, homelessness, self-harm and sexual or domestic violence. The panel agreed that there were concerns around high risk vulnerable people who are known to the safeguarding systems and groups such as MARAC and Vulnerable Women's group that would benefit from more collaboration.
A review was undertaken of the cases and MDT meetings held to review the safety planning in place for relevant individuals who were high risk.
5) **The Luton VARAC forum (or alternative) if re-started will provide new opportunities for exploration**, new guidance to provide a platform to discuss high risk complex cases. There needs to be an awareness for agencies to refer into this forum.
CASPA has been launched with awareness sessions rolled out to over 50 practitioners and the pathway, policy and procedures published. CASPA is reviewing up to 12 cases on a monthly basis.
6) **It was agreed for ReSolutions to organise an OPEN day** for all partners to visit.
An open day was held in December 2023 which was attended by many of the partners and members within the LSAB Strategic Board.
7) **Due to capacity issues** related to inspection, children social care was unable to complete chronologies relating to families known to children services.
The MAAG reflected on the audit process and the need for sufficient time for completing cases audits so that the audit can reflect whole family approaches.
8) **The recommendations from the recent Adult D SAR and LS Rapid Review clearly identify the areas of improvement within this report**. A SAR Development Day to be organised to review all learning and action plan from the recent and past SARS. As part of the agenda for the learning and actions from the Multi Agency Drug & Alcohol audit will be added for wider consideration to link with the Adult D action plan.

The Learning from SARs Development Day was held in November 2023 and provided good evidence of triangulation of learning and its impact.

This report was one of the drivers to take forward improvement work at pace alongside the Drug and Alcohol Board and the above recommendations progressed as noted.

TRAINING

The LASB provides multi-agency safeguarding adults training in 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 35 delegates
- Awareness of safeguarding adults – delivered to 82 delegates
- Trauma informed approaches – delivered to 24 delegates
- Learning from reviews – three sessions to 56 delegates
- Multi-agency procedures – three sessions to 102 delegates
- Safeguarding Bedfordshire – webinar accessed by 94 people

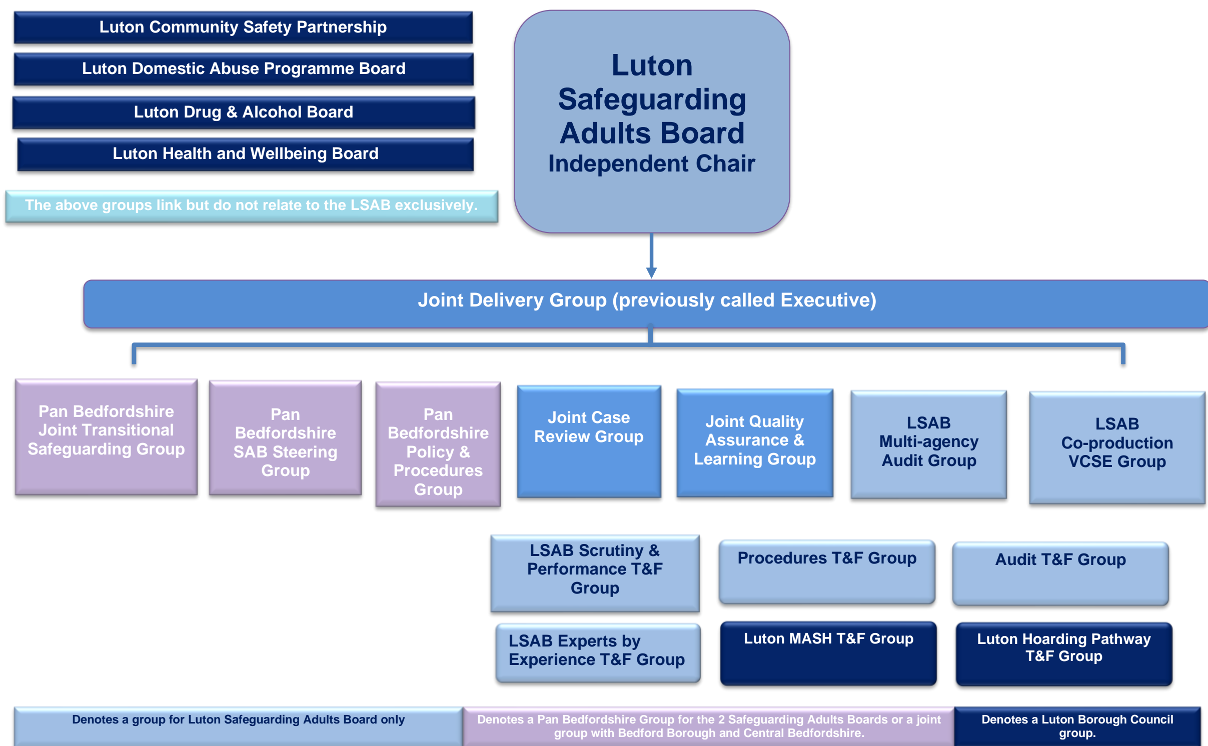
Training is integral to the LSAB's improvement cycle and the LSAB continues to explore alternative ways of working and new technology to support the delivery of adult safeguarding. Following delegate feedback have continued to offer a hybrid training programme with both classroom-based and virtual trainer-led training in 2023-24 and intend to extend a hybrid delivery model into 2024-25 whilst also exploring AI functionality. The LSAB also wishes to be able to collect data on both single agency and multi-agency training delivery and impact in 2024/25.

5. BOARD FUNCTIONING AND GOVERNANCE

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.

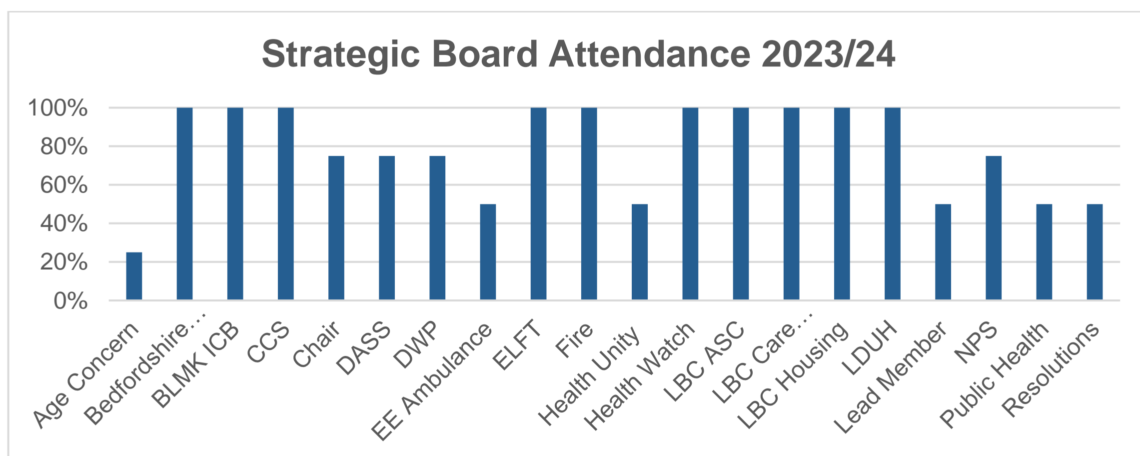
LSAB Structures to support delivery
Luton Joint Statutory Partners Chairs Safeguarding Assurance
LSAB Strategic Board
Luton Joint Safeguarding Executive (shared with Luton Safeguarding Children Partnership (LSCP) to review cross cutting themes)
Luton Joint Quality Assurance & Learning Group (joint with 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 June 2023 is shown below:



AGENCY ATTENDANCE AT BOARD 2023 – 2024

FIGURE 10: BOARD ATTENDANCE MARCH 2023 - APRIL 2024



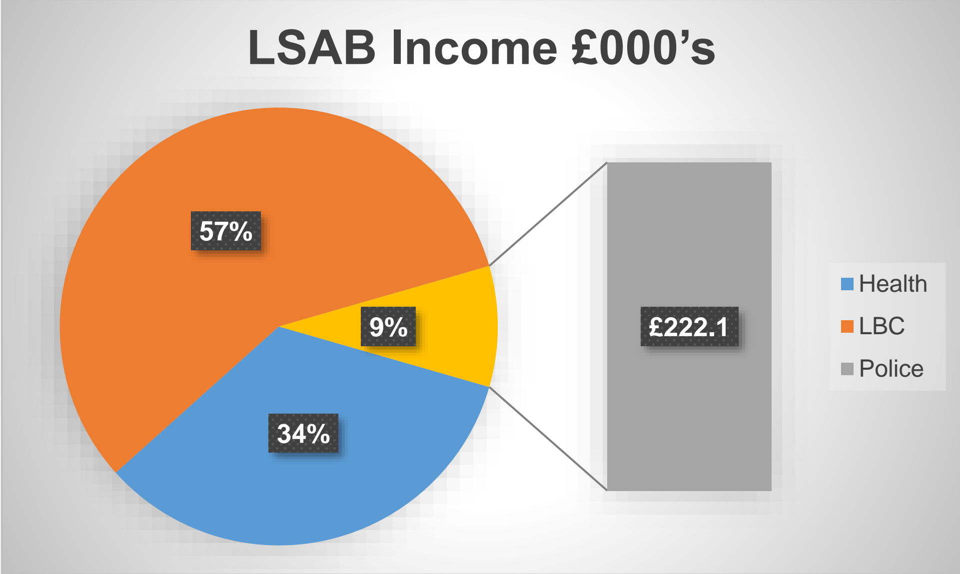
LSAB Strategic Board meetings have continued to be held via Teams with their Development Day held in person and attendance across all meetings and subgroups has continued to be good. Board partners have contributed as required fully to audits, rapid reviews and two days if in person *learning from SARs evaluation days*. Attendance has dropped off from Age Concern, Public Health, EEAS and the Lead Member which the Chair will address in 2024/25.

BOARD BUDGETS 2023/2024

The LSAB total budget increased by **13.9%** in total, this was to cover the cost of completing the SARs begun in 2022/23 and for increases in staffing costs including agency cover. The

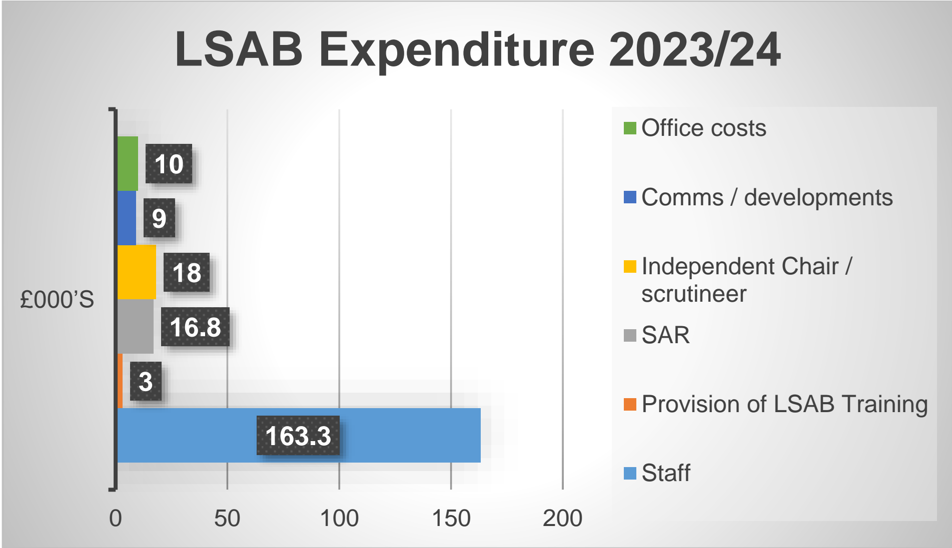
contributions had remained static over the last five years with income contributions shown below. The Local Authority provided **57%** of the income at **£127,000**, BLMK ICB provided **34%** at **£75,300** and Bedfordshire Police **9%** at **£19,800**.

FIGURE 11: LSAB INCOME MARCH 2023 - APRIL 2024



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

FIGURE 12: LSAB EXPENDITURE MARCH 2023 - APRIL 2024



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

The LSABs three core objective are outline 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 safeguarding adult referrals and rapid reviews which has been and implemented through briefings and training.

The LSAB has continued to work collaboratively with our neighbouring Safeguarding Adults Board to ensure there is a more joined up approach to safeguarding. This is particularly important where agencies deliver services across and are represented on several Partnerships. In 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. Single agency safeguarding reports are also attached as Appendix B.

The three statutory partners meet quarterly via the Statutory Partners Chairs and Safeguarding Assurance meeting that meets to discuss key issues, demands and to prioritise areas of work to be taken in regard to the safeguarding and promoting the welfare of adults. 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 and 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 and their joint work is overseen by Joint Executive Group who report into each Strategic Board and ensure 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.

In terms of 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 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 people and communities. This can be evidenced in its new website and the renamed and refreshed LSAB Coproduction VCSE subgroup with a new Chair, extended membership and revised terms of reference. However, this currently remains as a stakeholder engagement group.

As shown in the budget section above, the LSAB expenditure on SARs has remained high and the majority of the costs have been picked up the local authority in 2023/24. There has been limited funding available for delivery of training and development activity however, we have worked hard to ensure that training is delivered at low cost or through reciprocal arrangements. The LSAB remains mindful that it needs to ensure it provides focus on specific priority areas and that it cannot spread its limited resources too wide.

The LSAB as a strong and supportive partnership will continue to hold challenging conversations and scrutinise practice to improve the outcomes for vulnerable adults in Luton. The LSAB has a new Strategic Business Plan and Delivery Plan for 2024/25 and for each of the areas of focus, we have set out our rationale for selecting the priority and selected the key deliverables, leads, activities, impact measures and timescales. 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 also work to continue to meet its statutory responsibilities and to develop its approach to learning and improving to ensure early intervention in the safeguarding of vulnerable adults.