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FINAL REPORT:

Thematic analysis of safeguarding adults' practice and systems in Luton

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Thank you everyone, and if we have missed any of your burning issues many apologies in advance, there was so much richness in your inputs it was difficult to include them all and keep the report and recommendations to a manageable size!

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Participating Organisations

Those that took part in this review included representatives from the following organisations.

- Luton Safeguarding Adults Board
- Luton Borough Council Adult Social Care
- Multi-agency Safeguarding Hub (MASH)
- East London Foundation NHS Trust (ELFT)
- Bedfordshire Police
- Luton Borough Council Housing Department
- BLMK Clinical Commissioning Group
- Resolutions, Change, Grow, Live (CGL)
- Luton & Dunstable Hospital NHS Trust
- Cambridgeshire Community Services (CCS)

Executive Summary

Introduction & Context

Over the last twelve months there have been several cases brought to the attention of the Safeguarding Adults Board (SAB) that have resulted in serious injury or death, and which were not initially referred, but were later identified for either a safeguarding enquiry (s42, CA 2014) or a Safeguarding Adults Review (SAR). These cases, combined with two further historical SAR reports, were included as the sample for a thematic analysis. In each case there were points where a breakdown in the system may have contributed to a failure to prevent harm to an individual or a member of the public. Areas such as risk management, communication, information sharing, pathways and the role of multi-agency working were all examined and considered with an aim of improving safeguarding practice in, and between, the relevant health, social care, and public sector partners.

Report Purpose

For the purposes of this analysis a focus on practice, systems and processes was taken. The aim was to facilitate dialogue between partners to improve safeguarding across the multi-agency partnership and within its member organisations. An interim report was presented to the Board in July 2021 (dated 30/06/2021), which set out the findings of the thematic analysis of the cases included and the methodologies used in the project overall. The purpose of this final project report is to develop those interim recommendations and provide the board with short, medium and long terms options for making the desired improvements against a final set of recommendations addressing key issues and gaps in the four domains set out by the National SAR review (Preston-Shoot et al, 2020).

Summary of Common Case Issues

All reviewed cases had multiple needs – including physical health, drug and alcohol, and housing issues. Three of the five cases were open to the same team within the mental health trust and the individuals were reported as being difficult to engage in care and treatment. This mirrors the historical cases also submitted for review which included significant histories of reluctance to engage with services.

Neglect and self-neglect are two of the key categories of abuse evident in this sample, in one case organisational abuse is specifically stated, in one sexual abuse is evident, and in one further case physical abuse was observed.

Neglect and self-neglect were both indicated in four of the five contemporary cases, and in both the historical cases provided for inclusion. The fifth case (Ms A) was focused on the allegations of sexual assault and is presented from a police perspective rather than a health and social care perspective, however self-neglect, possible neglect of a pregnancy, and consistent disengagement with services are all features of the case information, and as such is considered a common feature to the other cases despite not being identified by referrers from this perspective.

Drug use is noted in three of the five cases (plus one of the historical cases) and it appears that the response to this follows a standard pathway from the information provided by mental health and substance misuse services. There are marked differences in the drug and alcohol consumption and function in the cases, and yet a standard approach appears to have been taken in all the cases reviews, in that signposting to the local drug service provider was carried out.

In several cases the Local Authority had been made aware of harm/death and triggered the safeguarding process as a response, rather than the perceived 'lead' agency. This appeared to have created some tensions between partner organisations in terms of when and how safeguarding processes should be triggered and when the threshold for an alert has been met. A third of alerts within this analysis included police involvement.

Final Recommendations

Following feedback from the Board in July 2021, this final report develops the interim recommendations further and provides a consideration of the key findings to inform decision-making in relation to the implementation of recommended improvements across the system.

Following development of the interim recommendations and further analysis, as noted in the interim report as required, twelve final recommendations have been made across the four domain areas.

These are mapped to the interim recommendations, and broken down into short, medium and long-term actions in section 4 of this report as requested by the Board.

The top-level recommendations arising from this thematic analysis are as follows:

Direct Practice

1. Discharge planning arrangements where safeguarding concerns are evident need to be managed as a multi-agency process and should be developed as a shared policy/procedure across the SAB organisations.

2. Board to issue position statement on application of MSP, roles within the process and how the individual should be involved in their safeguarding enquiry (or prevention plan where relevant).

3. Board to issue guidance on working with carers and supporters within the safeguarding pathways, and the approach that should be taken by those involved in direct practice in all safeguarding cases.

Inter-agency Practice

4. Board to review, and where appropriate refresh and reissue key shared protocols identified as required but either absent or ineffective in current practice responses (e.g., consistent approach to individuals with complex needs; information sharing, contingency planning, discharge planning etc.) It is recommended that new or reissued protocols are accompanied by effective communication and training for the front-line to ensure local awareness and adoption of agreed processes and procedures within service delivery.

5. Board to clarify roles and expectations of individuals, practitioners and organisations involved in, and leading, practice within the safeguarding prevention and protection pathways.

6. Development of shared threshold guidance which is implemented and used by all partner to determine consistent responses to alerts and concerns.

7. Further targeted review of aspects of the system perceived by partners to be effective, e.g., VARAC, to determine the evidence to support partners perceptions and the scalability of the structure to other parts of the system.

Organisational Practice

8. Development of common curriculum and QA process which organisations report against, to the board, to provide assurance that partner training and governance is sufficiently robust and delivers the same core messages within each agency – this will be supported by the development of shared thresholds, discussed within the inter-agency practice section of this report.

9. Review MASH provision and resourcing and develop service specification as a partnership, including key partners in the approach to deliver a fit-for-purpose MASH service that can meet the demands and functions required by the safeguarding system.

10. Key agencies to enable arrangements to provide read-only access across partner IT systems (e.g., for the MASH and/or statutory partner leads to allow for a single point of information for health and social care provision to be established within the local system).

11. Partners to review current s75 arrangements where they relate to safeguarding adults practice and duties, to ensure commissioning and governance of safeguarding within the provider trust is clarified and subject to partnership governance at both practice and strategic level.

SAB Governance

12. Board to consider the commissioning of several key products to support safeguarding practice in Luton, including – thresholds, MSP in practice and core induction and training curriculums and quality assurance measures.

Each of these recommendations responds to the issues identified either within the case analysis or within the workshop consultation events. Each recommendation represent an opportunity to respond to gaps and/or areas of development in the current local system. A summary of the evidence underpinning our recommendations is included within the report narrative. There is additional information in relation to MASH provision and shared thresholds provided as appendices to ensure the Board can consider key factors in their plans to address the findings of this review overall.

1. Introduction

Over a period of three-months during 2021, the review team involved in this project, undertook a range of analysis of information and consultation and scoping exercises with participants from partners across the Luton safeguarding system.

As set out in the interim report, presented to the Luton Safeguarding Adults Board (LSAB) in July 2021, the findings of the review at the interim stage, mirrored closely the findings of National Reviews (REF) and learning identified by numerous Safeguarding Adults Reviews (SARs) carried out both locally and nationally.

Following feedback from the Board in July 2021, the interim recommendations were largely accepted, however more detail and consideration about how to implement the recommended actions was requested. The board direction was that it would be helpful for the final report to identify the short, medium, and long-term options that would be required to realise the partnerships aspiration of a 'no wrong front door' approach that is consistent within, and between, partner organisations.

This final report provides a detailed discussion of the full range of findings arising from the thematic review and seeks to set out the options for the Board in terms of the changes that could be made to strengthen safeguarding practice.

The recommendations are matched against the four key domains of the National SAR review (Preston-Shoot et al, 2020):

- Direct practice.
- Interagency practice
- Organisational practice
- SAB governance.

2. Project Brief & Scope

This project took a mixed-method approach within the context of a thematic analysis of five (+2 historic SARs) cases which had been highlighted by the Luton Safeguarding Adults Board (LSAB). Two core methodologies have formed much of the analysis presented within the interim, and this final report, these included:

- A thematic analysis of provided documentation.
- A series of workshops with partners to explore and further examine the key issues identified within the analysis.

The overall aim of the analysis was to identify where improvements to local practice and systems could be made to prevent further harm from occurring by the partnership being able to respond more effectively to the emerging themes and risks.

An initial review by board members identified the following areas for further enquiry:

- Coordination of care and effective discharge planning across the multi-agency partnerships.
- Communication with families at different stages of case and risk management processes.
- Understanding the impact of ACEs and their implications for practice with adults with underlying trauma and attachment issues.
- Engagement, resistance to support and management of complexity / multiple needs, risks, and issues.

As set out in the interim report, the sample of cases provided by the Board manager was initially subject to thematic analyses to identify key themes and terms that were common across the case examined. These themes were then developed into a series of workshops for consultation that would test the hypothesis of the analysis and add practice depth to the findings.

The information returns from partner agencies were reviewed and coded according to these initial themes and key issues and commonalities within the partnership and its organisations were identified.

It should be noted that much of the information requested was provided by partner organisations, however several key pieces of information were not available at the time of preparing this report, and this is indicated in the summary findings and analysis sections of this report, where relevant.

The interim report, presented to the board in July 2021 includes further details of the analysis methodologies and thematic coding and are not repeated here. This final report is now seeking to compile the range of findings and provide the board with a comprehensive view of the options and evidence to support the recommendations made.

The activities undertaken to inform this report were completed between April and June 2021, with additional interviews taking place in late July with one of the individuals involved.

Throughout the workshop processes participants took part in a range of review and analyses, using evidence-based tools to examine practice and pathways across the range of domains and to generate solutions to identified difficulties.

This work informs the final recommendations and provides the Board with the requisite evidence to support the strategic plan and governance arrangements moving forward.

The initial premise of the workshops was to identify elements which were working well and those which needed improvement. For the purposes of exploring the current system, tools such as force field and root cause analysis tools were used. Full details of the workshop were circulated after each session for comment and clarification as part of the consultation process. The full findings and summaries of each workshop are detailed in the interim report and only those directly needed to support the final recommendations are repeated here.

3. Findings

As with National findings (see Preston-Shoot, 2020; ADASS, 2018 etc.), the Luton partnership identified key areas in relation to practice, organisational arrangements and multi-agency working that were impacting on the response individuals who may need safeguarding support were receiving.

The three priority areas, identified based on the number of references made to each thematic area in the materials reviewed, were:

- Disengagement with services / hard-to-engage individual.
- Behaviour / presentation of the individual; and
- Multiple service contacts / help-seeking behaviour evident.

Following this initial coding, the themes were then further categorised by grouping themes and identifying the related issues that appeared in each set of case materials included. These final themes, present in all five cases, are set out in more detail in the interim report, however it should be noted here that the themes appeared in multiples through both the safeguarding and clinical/practice documents provided on all five cases. Here we have grouped them into the four areas of the national analytic frameworks and mirror the national findings in terms of the barriers and issues evident in multi-agency safeguarding arrangements across England.

Via the workshop process, participants were facilitated to explore the themes and issues in more detail, to clarify and provide depth to the potential reasons behind areas of difficulty and opportunities for solutions. Case summaries of the cases included were used to track the processes and pathways and to identify both areas of positive practice and areas where a gap or issue had occurred in the absence of a multi-agency response.

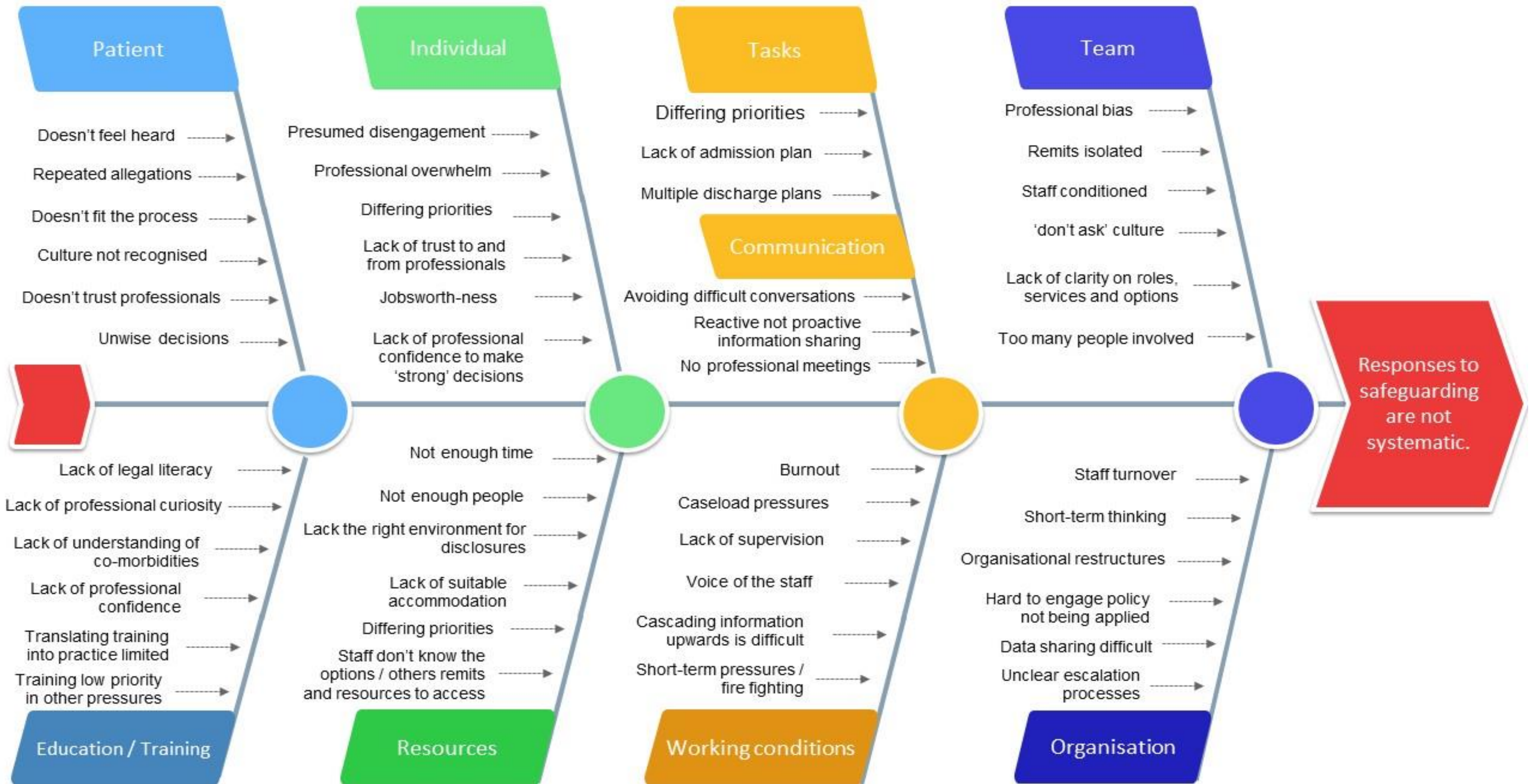
As a group, participants identified both an aspiration and a problem statement at the outset of the workshop series, with the aim of exploring strengths and areas for improvement based on the addressing the issues and working toward the aspiration.

- **Aspiration:** '*No wrong front door'*

- **Problem Statement**: '*Response to safeguarding is not currently systematic'.*

A fishbone analysis completed by the participant group, identified many of the issues found in the national analyses. Figure 3.1 below, illustrates the compiled analysis and sets the context for the recommendations that are made within this report.

Figure 3.1: Compiled Fishbone Analysis



Following this initial exploration of the root causes of the various gaps in the local system, participants undertook a failure-mode-and-effect-analysis (FMEA). This was then used as the risk assessment to inform the findings and recommendations of the analysis. The full FMEA was included in the summary reports that accompanied each workshop, but for the purposes of this discussion, the priority areas, actions, and measures, as represented by the participant group, is presented in Figure 3.2 below.

Figure 3.2: Participant generated priority actions and measures

Priority Actions	Possible Measures
Refresh 'disengagement / hard to engage' policy – This should include a review of the appropriateness of current service procedures where cases are closed following a specified number of missed appointments (Often referred to as '3 strikes and you're out approach) and identify the circumstances where such rules should not apply and/or how service users can re-enter services.	New policy ratified and implemented – reflecting principles of MSP. - No of alerts made. - No of NFA determined. - SAR learning points addressed.
Agree top level threshold and trigger points in the process	Shared needs ratings agreed as a partnership. Ratings and triggers implemented in front line practice. - No of appropriate referrals / alerts made. - No of screenings leading to s42 enquiries. - Updated agency policy, screening tools and training to encompass any agreed ratings / thresholds / screening points.

Establish feedback pathways for referrals.	New process implemented in partner organisations and part of standard operating procedures.
Increase understanding of agency roles and remits across the partnership.	Increased staff confidence in routing referrals appropriately. No of alerts received and actioned. Multi-agency discharge planning established and maintained. Shared training & induction – evaluation of;
Promote use of existing controls within partner's standard operating practice.	Safeguarding supervision is provided to all relevant staff. Shared training and induction agreed. Agency QA audits evidence use of controls – SAB and Management / Peer audits and review agreed and in place.

Each of these areas were incorporated into the interim priority areas, and each is addressed within this final analysis and recommendations arising out of this project overall and mirror the findings in other similar reviews and analyses.

Service User Experience

As part of this analysis the lead reviewer undertook an interview with one of the individuals whose case was included in the contemporary cases for review.

This interview sought to determine the individuals' experience of the local safeguarding system and is included here to provide an insight into how the local services and pathways are perceived by those who need them

Expert by Experience: Mr B

Case Summary:

Mr B: 66-year-old, White British male. Known to adult social care, physical health services and mental health services since 2018. Moved from London to Luton and has resided in several temporary accommodations since relocating to the area. Diagnoses of Autism, Delusional disorder, hypochondrial disorder, psychotic illness, and paranoid personality disorder, among others. Was reported to refuse to work with mental health services and not to recognise mental health issues. Repeatedly help-seeks, fixation on physical health issues which predominates all his interactions with public sector services. Referral made by Healthwatch and Adult Social Care Safeguarding team – organisation abuse and neglect identified as the categories of abuse in this referral.

Mr B's Experience:

Mr B undertook a telephone interview, arranged in advance, with the lead reviewer, as part of the information collated and analysed within this review. Mr B reports that he is disillusioned with local services as he believes they are not responding to his physical health needs, and reports that different professionals have given him different messages and communications that are often at conflict with one another. Mr B has formed relationships with one member of the MASH team but feels that other agencies within the system – mental health, police, and acute health services – do not, and have not listened to his concerns and he feels he is being 'fobbed off' by professionals. Mr B cited examples where an ambulance has been called to take him to hospital but resulted in diversion to mental health services without proper communication with him.

Throughout the interview there was a theme of professionals not listening to the individuals concerns and information sharing being somewhat fragmented. He reported that he had now had to repeat his story on numerous occasions and feels that the services do not talk to each other which has an impact on both the service he receives and the interactions he has with professionals.

As is evident from Mr B's account of his safeguarding support, the experience of staff of a fragmented system and isolated working, is reflected in this service user's experience. In the case of individuals' such as Mr B, whose presentations to services are often chaotic and challenging, resulting in police being called or other emergency service contact, there is a lack of consistency and ownership of the response from the various partners involved. This lack of coordination and ownership will need to be addressed if complexities such as that identified in Mr B's situation, is to be robustly and consistently managed across the system.

As discussed in the interim report, in all cases multiple needs and risks were identified, but a system response was not formulated. Instead partners signposted where appropriate and often recorded contacts as 'disengagement' or 'reluctance to engage' with services, rather than take a proactive and preventative approach to the various issues identified.

Within the workshops, case summaries and chronologies of a selection of the cases reviewed were considered by participants, and the various issues identified by the review team were explored further. What is clear is that whilst the MASH is designated as the central coordinating point, this is neither resourced or equipped to be able to deliver those expectations. There are variations in available information and application of thresholds of harm and the processes that occur as a result, currently lack consistency across the Luton partnership. Good practice is often the result of specific workers or worker relationships and their knowledge and is not consistently available to all professionals or all service users.

4. Final Analysis

Some of the recommendations made at the interim stage are likely to be 'quick wins' for the partnership, for example preparing and publishing guidance for practice, agreeing roles and clarifying process and feedback triggers. This report identifies these short-term actions as way to main the momentum of the review process and the enthusiasm and commitment to more effective integrated safeguarding practices that was initiated through the workshops. Continued consultation and partnership-wide involvement will still be necessary for these changes to be adopted into custom and practice and benefit service users, their families, the wider community, and the professionals that seek to support them.

Other recommendations will require more consideration as they have resource implications and require the sign-up of one or more partner organisations to both agree the specifications and commit resources (people and funding) to become a reality.

Several areas were also highlighted as requiring additional analysis before a final recommendation was made, these included development of a range of policies, guidance, and products to support consistent delivery and response across the partnership, and actions to support improvements in the following areas –

- Further analysis of working practices that require development across the system – including risk assessment, mental capacity act application, communication and recording arrangements. *[Direct Practice].*

- Establishing a shared understanding and transparency of decision-making within safeguarding operational practice – including the development of a shared thresholds document to support and clarify the understanding of all partners *[Interagency Practice].*

- Development and resourcing of the MASH service and its role and function in the local system *[Organisational Practice].*

- Recommendations for SAB governance arising out of the review *[SAB Governance].*

As requested by the SAB at the presentation of the interim report, each of the interim recommendations have been developed further for this final report and a range of possible options for delivery across the short, medium, and longer-term have been proposed for consideration. For ease of reference the initial interim recommendation is repeated followed by the final recommendation and the possible implementation methods and timelines. For consistency with the interim report, these are discussed within the four domains of direct, inter-agency, organisational practice, and SAB governance.

i. Direct Practice

Several of the interim recommendations were applicable to direct practice. These have been more explicitly explored with specific recommendations made here. This section should be viewed in the context of the whole review as all the other domain recommendations will have influence how practitioners on the ground think about and respond to safeguarding concerns. The other domains will shape front-line service delivery, which combined with these specific should result in improvements to direct practice as a matter of course.

Interim Recommendation 3: Partners to consider how discharge planning could be better coordinated to provide a clear plan and contingency arrangements in cases where multiple-agencies and multiple service presentations are a feature of the person's risks and vulnerabilities.

Working with Complex & Multiple Needs

In cases where individuals have multiple areas of need there is an increased likelihood that key areas of need and risk will remain unmet. This was identified in the cases analysed, the service user experience and the feedback from workshop participants. The key areas where direct practice improvements are specifically required includes the following areas:

- In complex cases, where multi-agency involvement is required / appropriate:
    - Discharge and crisis planning should be carried out as a multi-agency response, with a single agreed discharge plan – in one case multiple discharge plans had been produced in isolation and did not refer to other agencies or the individuals' views and wishes.
    - Where an individual has multiple presenting needs – each service to input based on the needs of the individual. Discharge by one or more services where the need is of a long-term nature, should be challenged within a multi-agency working arrangement.
    - Where safeguarding support or enquiry is required, decision making should involve the mental health, or other partner services, and should not be allocated based on a single agency decision – This would be resolved by implementation of the proposals set out under organisational practice in relation to a comprehensive MASH provision.

Final Recommendation 1:
Discharge planning arrangements where safeguarding concerns are evident need to be managed as a multi-agency process and should be developed as a shared policy/procedure across the SAB organisations.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Task-finish group established to scope discharge planning arrangements and develop proposals for a shared protocol for discharge where safeguarding concerns or allegations are present.*

- ***Medium-term****: Board to consider and ratify policy approach and establish performance measures acceptable to partner organisations to ensure action does not drift. Approach to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.*

- ***Long-term:*** *Implementation and governance of policy to be incorporated into organisational and board governance arrangements – including induction, supervision, audit and training from an organisational perspective and audit & review by the board.*

Person-Centred Practice

Person-centred and trauma-informed practice was largely lacking from the cases reviewed, as noted in the interim report. Individuals were responded to in one dimension of need, but not others due to a lack of joined up working across the system. Individuals who have struggled to engage with traditional services are at risk of being repeatedly discharged from services – this included acute health, long-term health, and mental health provisions. In these instances, individuals' needs are repeatedly not met, leading to harm in a range of the well-being domains.

Within the context of Making Safeguarding Personal the person should be involved at each stage of their care and safeguarding journey; unless there is a wider public protection issue that needs to be responded to or where they lack capacity to decide to take part and it is not in their best interest to do so (e.g., a person with a cognitive impairment which results in confusion and distress in meetings with several people).

In these circumstances it can be a proportionate response to see the individual separately and feed their views into the process, however this needs to be an explicit consideration, which based on participant responses in the various workshop activities, is not currently part of standard practice.

One key area of dispute within the workshop participants was whether the individual at risk of harm should attend any / all the meetings that take place within both the prevention and protection pathways. The same inconsistencies were identified in terms of partner agencies working alongside carers and families, and the extent to which supporters are involved in any safeguarding practice or protection planning where this is required.

Final Recommendation 2:
Board to develop and issue position statement on application of MSP, roles within the process and how the individual should be involved in their safeguarding enquiry (or prevention plan where relevant).

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Board to consult partners and then clarify expectations of partner agencies to ensure the individual attending meetings within their safeguarding enquiries, is the standard practice and not exception which appears to currently be the case. This will also require agreement on the support that services will offer the individual to enable them to accept the invitation – for example, this may include the opportunity to have an advocate, supporter or representative, the option of making written contributions or support with practicalities such as travel or venue accessibility.*

- ***Medium-term:*** *Board to review occurrence of individual being invited to safeguarding meetings and agree performance monitoring reporting to support the maintenance of a personalised approach in the longer-term.*

- ***Long-term:** Incorporation of the approach into all organisational procedures (including induction, supervision, audit, and training for staff, as well as care planning and communication approaches for service users) and audit & review by the board.*

Whilst indicated in the initial brief and remit for this analysis, issues such as the application of trauma-informed practice and staff awareness of aspects of a person's presentation because of childhood adverse experiences (ACEs) have not been possible to fully explore.

Within workshops these areas, along with management and promotion of social GRAACES, were all highlighted as training needs across the workforce, and as such these need to be considered within the training, supervision and other governance arrangements set out throughout this final report. (See also 'Limitations' section of this report).

Working with Supporters

As highlighted briefly in the interim report and identified in the patient pathway and thematic analysis of cases, the relationship of local services with families and carers is an area where practice could be further developed and supported. There should undoubtedly be some caution and professional discretion applied where supporters are the person alleged to be causing harm, and in such situations a multi-agency response taken; but this should guide the assessment of their potential involvement not automatically exclude them.

In many cases communication and information sharing from/to families is experienced as inconsistent, both by the individuals and the professionals involved.

As highlighted in the interim report this requires some exploration and strengthening in terms of local approaches and ongoing care and support planning across the system.

Final Recommendation 3:

Board to issue guidance on working with carers and supporters within the safeguarding pathways and the approach that should be taken by those involved in direct practice in all safeguarding cases.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term –*** *Agencies to discuss with service-users the involvement automatically and proactively of their family and network in both ongoing and crisis scenario's, document wishes and respond accordingly.*

- ***Medium-term:*** *Exploration of the role of carers and families in safeguarding cases to be explored via local peer review to establish whether the issues identified in the case analysis and workshop feedback is the experience of a narrow sample or the pervading practice approach within the partnership.*

- ***Long-term:*** *Family involvement and the role of carers considered as a strategic priority for the Board in future strategic planning processes.*

ii. Interagency Practice

As already noted, there are significant differences in how different agency's views, rate and respond to potential/actual safeguarding concerns. There is a lack of preventative approach due to these differences. A shared vision of what safeguarding is and what it can achieve would support the introduction of a more coordinated and consistent response across services.

Interim Recommendation 7:

Partners to identify and agree key terms, standard actions / expectations, and roles within the local processes to ensure common understanding of the safeguarding processes in both the prevention and protection pathways.

Refresh and Develop Shared Policies & Procedures

As highlighted in the interim report, the Board has previously developed and published a range of policies and procedures to underpin a consistent approach, examples of these include:

- A hard to engage policy, ratified 2017 and signed by all current partners and providers
- Information Sharing Policies, ratified 2019
- VARAC information sharing protocol, ratified 2019

Whilst these documents exist the application of them and awareness of the agreements by front-line and clinical practitioners is limited. An inconsistent approach has developed, with some services taking an assertive outreach approach to engaging individuals with complex and multiple needs and other operating on motivation to engage with services as the pre-requisite for receiving appropriate support.

Each organisation has established its own internal governance of safeguarding, whilst context and proportionality of arrangements needs to be a consideration, there is also a need for consistency in approach, which is not currently being achieved. The roles and responsibilities for organisational response range from a team through to an individual who manages all safeguarding concerns which does not easily facilitate a partnership approach.

A lack of understanding of how safeguarding is managed within each service contributes significantly to a disjointed approach, where duplication and omission are more likely, and the service user experience is likely to be confusing and/or fractured.

Shared policies and procedures, led and assured by the Board, have the potential to begin to establish consistent responses in different organisations. Both the cases analysed, and the feedback from workshop participants, indicate that a shared understanding and guidance, in relation to how individuals who are reluctant to engage could be managed, would be beneficial to agencies and the individual service user.

This who would be provided a framework and clarity of what is expected of partnership services in the context of safeguarding concerns.

Final Recommendation 4:

Board to review, and where appropriate refresh and reissue key shared protocols identified as required but either absent or ineffective in current practice responses (e.g., consistent approach to individuals with complex needs, information sharing, contingency planning, discharge planning etc.) It is recommended that new or reissued protocols are accompanied by effective communication and training for the front-line to ensure local awareness and adoption of agreed processes and procedures within service delivery.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Task-finish policy group to review and scope the requirement for shared policies and procedures based on the findings of this review and make recommendations to the Board in terms of next steps required.*

- ***Medium-term:*** *Refresh, and where identified develop, shared policies and procedures within safeguarding practice (e.g., engagement, contingency planning, discharge, complex needs, person-centred practice, working with supporters etc.). Approach to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.*

- ***Long-term:*** *Incorporation of the approach into all organisational procedures (including induction, supervision, audit, and training for staff, as well as care planning and communication approaches for service users). Incorporation of protocols into Board governance, including performance management data against protocols where relevant.*

Development of Shared Thresholds

Within the pathways mapped during the workshop process, several roles and activities within the safeguarding pathways were explored. What was evident was that agencies were using different language for the same things or the same language for different things!

This meant the process was not always clear – these included terms such as 'lead professional', 'professionals' meetings' and 'multi-disciplinary team meetings', among others. ADASS are currently consulting on roles within the process from an adult health and social care perspective (ADASS, 2021), and this could be used as a starting point for role discussions that are required in the local system.

Final Recommendation 5:
Board to clarify roles and expectations of individuals, practitioners and organisations involved in, and leading, practice within the safeguarding prevention and protection pathways

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Board to define key terms within both prevention and protection pathways with its partners e.g., Lead Professional, Lead Supporter and key meetings / forums, to ensure a consistent language for safeguarding practice in Luton is established.*

- ***Medium-****term: Agreed Glossary & expectations of roles and processes to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.*

- ***Long-Term****: Incorporation of the approach into all organisational procedures including induction, supervision, audit, and training for staff, as well as care planning and communication approaches for service users from an organisational perspective. Incorporation of protocols into Board governance, including performance management data against protocols where relevant.*

Much of the evidence for the implementation of a successful approach to adult safeguarding highlights the importance of a shared understanding of risk, the threshold at which action should be taken, and what level the intervention should be.

It was clear from our analysis of the cases highlighted by Luton SAB for review that different organisation did have very different understandings of risk and responses, and this was confirmed in the workshops and supported by the alert-enquiry conversion rate reported by the MASH practitioners.

Options and rationale for the development of the MASH are set out in more detail under the organisational practice section of this report, and this forms a critical underpinning aspect of the recommendations arising from this analysis overall.

It should be noted however, that whether the Board and its partners accept and action those recommendations, a shared understanding within the current system is a key aspect of local practice that requires improvement as a short-to-medium term action. This can be developed independently of other recommendations and used within the medium- and longer-term action plan for the partnership.

There are a wide range of these tools already in existence in the public domain that the Luton SAB working group for implementing these recommendations can utilise for the formation of one that works locally.

For example, the ADASS Northeast (2011) document highlights those thresholds that may need to be lower or higher in different settings (e.g., community versus inpatient / residential settings). The West Sussex tool flags that multiple ‘non-reportable’ incidents should be reconsidered for consultation if referring to the same adult with care and support needs, the same staff member, or the same organisation. The Newcastle Tool gives more explanation to staff on how to use the risk ranking table and the Nottingham tool combines thresholds with processes so that in each scenario the actions that need to be taken are also clear.

The documents used by area partnerships vary widely in language and approach, for example from ‘low to critical’ or ‘non-reportable/requires consultation/reportable’ – which sends different messages across the partnership and will be of importance in deciding what best supports the Luton Model when Pathways, Roles and Terms of Reference are agreed/refreshed.

A summary of several of these threshold documents are included in the appendices of this report to aid Board consideration of the ways in which this element of the recommendations could be approached. The examples summarised here are simply illustrative of the range of tools that exist, and this report has not undertaken a comprehensive analysis of the available options to recommend a specific template to follow.

The evidence base discussed throughout this report highlights that agency cultures and requirements can be a barrier to successful implementation of thresholds and other joint protocols. It will be critical that any Threshold Document is produced with comprehensive consultation, rolled out with a communications strategy and effective training. The use of it will need to be monitored and reviewed by a robust governance structure to ensure it stays true to its intentions and does not significantly change as a result of agency interpretations. This will be key across any documents the board decides to develop including pathways and assessment or contingency tools.

N.B. This is an area of development on a national level, Interim joint guidance on roles and responsibilities within safeguarding has been published by CQC, ADASS, NHSE, LGA and the Association of Chief Police Officers (June 2021) which attempts to clarify the various roles within the process. This is currently out for consultation and once finalised will represent guidance to support the local partnership to achieve clarity in the processes and pathways examined in this review. It would be our recommendation for preparatory work to be undertaken and for final decisions to be made alongside this final national guidance.

Final Recommendation 6:

Development of shared threshold guidance which is implemented and used by all partner to determine consistent responses to alerts and concerns.

Delivery Options – Suggested Methods and Timescales:

- ***Short- to Medium- term**: Establish task-and-finish group with representatives from key partners to undertake a review of available documentations and develop proposals for how the Luton thresholds should be applied for the Board to approve.*

- ***Medium- to Long-term:** Board to oversee/lead the development, implementation, and governance of the tool via links with provider services safeguarding leads. Incorporation of the approach into all organisational procedures (including induction, supervision, audit and training for staff)*

Identifying what works

Throughout the process partners identified the Vulnerable Adults Risk Assessment Conference (VARAC), led by Police colleagues, to be positive and effective, and an interim recommendation was offered in our report to board in July 2021.

> ***Interim Recommendation 5:***
> *VARAC as a positive example to be examined further to identify key learning that could be replicated elsewhere in the system.*

On examination of this meeting, there are several elements which contribute to the perspective, and which could be mirrored elsewhere within the system, including:

- Small size
- Consistent membership
- Consistent leadership
- Focused meetings
- Funded manager/coordinator with clear role description

Whilst partners were keen that the VARAC was not expanded to incorporate a great number of cases/professionals, this does not mean that the structure and function cannot be replicated for other areas of practice and linked into the SAB from a governance perspective.

Whilst the review team did request information in relation to the VARAC operation and its governance, this was not provided. The team were able to locate publicly accessible documentation (e.g., information sharing agreement and VARAC Coordinator role description) however the governance of this forum is not clear and its relationship to the board would benefit from clarification.

Whilst across the workshops and partner feedback, the partners involved in the VARAC advocated for it, the detail of how people are referred to and/or taken on/discharged from the VARAC and what is achieved because of its operation was not discussed in the workshops. In the absence of evidence being provided for further analysis, this review could not verify the perceptions shared at the workshops. A more targeted review of this structure would be beneficial to clarify its governance, consider any learning from its operation, and explore whether the model can (and should) be replicated in other areas of practice.

Final Recommendation 7:
Further targeted review of aspects of the system perceived by partners to be effective, e.g., VARAC, to determine the evidence to support partners perceptions and the scalability of the structure to other parts of the system.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term****: Full review of VARAC operation, governance, and outcomes to determine applicability and scalable within the local system of this approach.*
- ***Medium-term:*** *Depending on findings, consider replication of model where effectiveness is evidenced.*

iii. Organisational Practice

Inconsistencies in training and knowledge, along with structural issues such as representation of organisations in the MASH and transparency of decisions and information sharing, were highlighted by participants and within the cases considered. Several recommendations were made in the interim report, and these remain valid, however after further analysis there are two areas that could be developed to support a more consistent and multi-agency approach to be established.

Training & Induction Curriculum & Assurance

Through the process of engaging with participants, one of the key areas highlighted was a lack of knowledge of complex needs and inconsistency in the availability and accessibility of Staff training.

Key issues highlighted included:

- lack of knowledge in areas such as MCA, co-morbidity and working with multiple risks are all areas highlighted by partners as being required.
- lack of consistent internal training and staff induction.
- Lack of joint training that would improve communication, networking, professional understanding, and challenge.

Whilst some of the recommendations associated with addressing these areas of practice are directly linked to SAB governance, there is a need for partners to develop a shared view, and shared curriculum, for internal safeguarding training and practice.

Each organisation has a lead officer and delivers its own induction and level 1 & 2 training, the SAB then commissions more specialist learning and development as determined by local reviews, practice and learning from SARs etc.

Whilst this is a common model of delivery there is a need for consistency of content in terms of foundation knowledge and understanding which does not appear to be in evidence between partners within the system.

Whilst organisations report to their own governance structures and the board in terms of compliance with mandatory training, the impact of this on practice is less clear, and differences in practice and understanding are evident. As such it would be beneficial to establish a core curriculum and common induction between partners to ensure that the messages and knowledge of safeguarding in Luton is consistent.

There are several frameworks that could be used to achieve this aim, for example national competency framework (safeguarding & MCA), ADASS standards or locally defined adaptations of some of these national products that could be adopted by the Luton partnership.

In addition to MCA and Safeguarding training, topics such as professional curiosity, risk assessment, trauma-informed practice, adult attachment, positive risk management, case recording, analysis into assessment and accountable decision making would all be beneficial in addressing many of the concerns found in the cases examined and raising the overall standards of interventions and professional accountability.

Final Recommendation 8:

Development of common curriculum and QA process which organisations report against, to the board, to provide assurance that partner training and governance is sufficiently robust and delivers the same core messages within each agency – this will be supported by the development of shared thresholds, discussed within the inter-agency practice section of this report.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Review of partner organisations training and induction provision on which to base the development a common induction and shared curriculum for internal and external training.*

- ***Medium-term:*** *Task-finish group to develop a common induction and training curriculum for internal use by partners that can be agreed by the Board.*

- ***Long-term:*** *Link assurance arrangements for training and induction to Board governance via training sub-group. Including an annual LNA & peer audit.*

Developing & resourcing the Multi-agency Safeguarding Hub (MASH)

The MASH service is a key element of the safeguarding pathway across the Luton partnership, and as highlighted in the interim report, is not currently commissioned to include the full range of appropriate partners.

Interim Recommendation 8:

Statutory partners to review MASH service specification and resourcing to consider whether current resources are sufficient to meet the aims and aspirations for this key team within the local safeguarding system.

Whilst social care and CCG colleagues operate within the service, no other partners are included, and as identified throughout the review, this service needs to be sufficiently resourced if it is to fulfil the function it is designed to deliver.

The cases analysed within this review all included elements of mental health, housing, physical health, substance use, and criminal justice. None of these partners are incorporated into the MASH. As such the shared decision making is not being achieved.

Whilst potential section 42 alerts are being sent to the MASH team, the conversation rates from different partners, and the thresholds being applied by the partners, varies significantly. This is resulting in frustrations from the various partners involved, an over-demand on the MASH team and a lack of consistency of approach being delivered across the locality.

Throughout the analysis and development workshops the issue of whether the MASH provided the necessary functions within the system was a key discussion area. Participants were positive overall about the role and support they received from this team; but a number of information and communication gaps were identified. It was clear that there were limitations on that service due to a lack of resource and multi-agency presence within the service.

Much of the research into the effectiveness of Multi-Agency Safeguarding Hubs (MASH) is in relation to Children's Social Care. This has been acknowledged by the Home Office (2014) as a gap; however, the Home Office Report "Multi Agency Working and Information Sharing Project" published in July 2014, accepts that the premise is sound and applicable to safeguarding adult's practice.

A significant proportion of Safeguarding Adult Reviews (SARs) highlight failings in information sharing, multi-agency working, shared risk management and decision-making, communication and timeliness of responding, the purpose of a MASH is to address these key areas.

The evidence from Children's Social Care is that a MASH, in isolation, does not guarantee better outcomes, as each agency still needs to discharge its individual safeguarding responsibilities effectively. A MASH does however reduce barriers, maximise resources and improve coordination significantly and will enhance good inter agency working and deliver the identified benefits if effective cultures and processes are developed.

The common principles of all MASH or Multi-Agency Safeguarding Arrangements are effective and timely information sharing, joint decision-making & coordinated intervention. A summary of the current evidence to support MASH in safeguarding and possible models is included in the appendices to this report to inform the Boards consideration of this recommendation overall.

In Summary, the Home Office Project research indicated that the commonly agreed benefits of a MASH approach included:

- *More accurate and timely assessment of risk and need*, as safeguarding decisions are based on coordinated, sufficient, accurate and timely intelligence – a large proportion of respondents also felt this resulted in less repeat referrals and less 'No Further Outcome' responses.

- *More thorough and driven management of cases* because the case doesn't get lost between services, there is more ownership and accountability for the cases and clearer processes for follow up – most respondents felt this approach reduced risks caused by drift and delay and prevented failures of safeguarding that occur when roles, responsibilities and accountability are not clear.

- *Better understanding between professions of each other's roles and remits* – Most also agreed this allowed for more professional challenge and prompted more curiosity.

- *Greater Efficiencies* – the responses identified that a MASH approach is not less work, but avoids duplication and results in better allocation of resources of the right services to the right person at the right time.

All the above benefits have a direct link with reducing key failings in Serious Case Reviews and were all areas of desired improvements highlighted within the workshops of this thematic review of safeguarding practice and systems in Luton.

Currently, the CCG and Local Authority Adult Social Care Team, who are the only members of the current MASH, expressed some of these benefits with each other and highlighted a lack of these benefits as consistent factors in the relationships with services that, at present, sit outside of the MASH (i.e., Mental Health, Probation, Police, Housing, Drug and Alcohol Services).

The Home Office Project research went on to indicate that the commonly agreed Core Functions of a MASH approach include:

- *Acting as a single point of entry* – gathering all notifications related to safeguarding in one place.

- *Enabling thorough research of each case to identify potential risk* and therefore the opportunity to address that risk.

- *Sharing information between agencies*, supported by a joint information sharing protocols.

- *Triaging referrals*, exemplified in the use of agreed risk ratings.

- *Facilitating early intervention* to prevent the need for more intensive interventions at a later stage.

- *Managing cases through co-ordinated interventions.*

Our review of the current Luton MASH is that it does not achieve some of these functions at all, and others are only partially met. The MASH is not able to access all the critical information in a timely manner, information sharing agreements exist but have lapsed and are not widely used, there are no agreed risk ratings and there is not a clear prevention pathway in place. The MASH does not produce a multi-agency coordinated interventions plan that all the relevant services that are required, have contributed to and are accountable for.

The Home Office Report did recognise that how many, and which agencies are part of a MASH, is a common area of debate, particularly in relation to the inclusion of voluntary partners, with some areas recommending starting small and building membership gradually. Some of the key elements in terms of operational delivery, which are mapped to the recommendations made here, include:

- *Co-location* – The highest proportion of respondents stated co-location as being critical and views that a virtual approach is as effective was in the minority. It is likely that Covid Pandemic will have shifted how many MASH Teams function and this is an area that may need revisiting [recommendation 9].

- *Shared risk assessment tool-* Most respondents recognised significant differences in their organisational understanding of risk which dominates without agreed thresholds and tools [recommendation 6].

- *Good leadership/governance/ Strategic Buy-in* – This was viewed universally as essential and that a lack of leadership, governance and resources were key reasons a MASH might fail to meet its objectives. There was a split view on whether this should include oversight by SAB [recommendation12].

- *Frequent review* – It was consistently agreed that reviewing the arrangements frequently to ensure they are still effective is essential with multiple services and changing contexts [recommendation 4].

- *Agreed IT Solutions* – The most common view was the need for access to each other's systems [recommendation 10].

- *Rotating Staff* – several areas highlighted that rotating staff into the MASH from other teams reduced burnout, refreshed knowledge in the MASH and good understanding of the MASH across partnership services.

- *Joint training* – The majority of areas felt Joint training was beneficial to help agencies have a similar level of understanding and expertise across key areas and to build and maintain relationships [recommendation 8].

- *Joint Protocols* – As with thresholds and risk assessments, it was viewed as essential for al partners to be signed up to joint protocols for key areas such as information sharing [recommendation 4].

These areas were all identified in the Luton Workshops as critical, except for rotating staff, which was not specifically explored, although there was discussion in respect of the impact of staff turnover and how to achieve and maintain the knowledge and working arrangements with new and existing front-line staff. There were also discussions on how to avoid burnout. The current MASH and partners do not have or use shared protocols and tools or have consistent access to each other's IT systems.

During the Luton Workshops it was evident a lot of good practice occurred because of individual relationships/knowledge, and that this was then not consistent or available across the partnership to all service users or professionals.

The research available in respect of MASH arrangements that are not fully integrated or co-located noted the same pattern, that results in these arrangements relied on individual relationships and knowledge and were not consistently available to all service users or all professionals, whereas more comprehensive models underpinned by agreed policies and procedures were able to deliver more consistently effective services.

These findings clearly support our own recommendations for:

- The inclusion of a wider range of agencies in the MASH.
- Clear governance structures and joint accountability at a senior level.
- Multi-Agency induction and training.
- Joint decision-making and intervention planning.
- Clear, updated and communicated:
    - Information Sharing Agreements
    - Risk Thresholds and Tools
    - Prevention and partnership pathways.
    - Feedback & communication processes.

The Luton Workshops identified issues around information sharing, understanding of the MCA and issues of Capacity, Resources and Risk Thresholds as key areas for improvement. These are all areas which impact on other elements of the system and the practice of different organisations and teams. These key elements require a consistent approach if the aspirations of the partnership are to be realised.

<u>Final Recommendation 9:</u>
Review MASH provision and resourcing and develop service specification as a partnership, including key partners in the approach to deliver a fit-for-purpose MASH service that can meet the demands and functions required by the safeguarding system.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Seek commitment from statutory partners to undertake a full review of MASH requirements and resourcing to determine whether current provision is fit-for-purpose based on national evidence base.*

- ***Medium-term:*** *Scope specification for the MASH based on agreed specification and resource commitments from partner organisations and commissioners.*

- ***Long-term:*** *Re-commissioning or re-structure of MASH service based on reviewed and refreshed specification and subject to commitment of partner resources.*

Information Sharing Arrangements

Access to information and communication between partners is one of the key issues that was identified via the workshops. This was mirrored in the cases reviewed, for example in one case where the service user was thought to be pregnant, this was not shared appropriately across all the services involved in responding to her presentations. This led to increased risk to the individual and unborn baby.

How information is accessed, how trends and patterns, including low level repeated incidents that collectively constitute concerns (as highlighted in ADASS and other related guidance) are identified, timeliness of responses and coordinated amongst partner agencies, are all areas that need improvement in the local systems.

Multiple IT systems and ensuring information flow within multi-agency arrangements are a common concern which have been highlighted in national review as a key issue. Participants of the workshops identified some solutions to supporting better information flow, especially at times of crisis for individuals, for example each agency identifying a single point of information which could be used by the MASH to access partners systems quickly and/or establishing read-only access to partners systems within the MASH hub to streamline communication across the system overall.

Specific recommendations about the MASH provision are made under organisational practice, however short-term solutions are possible to improve the current information flows whilst other developments and reviews of system elements are undertaken.

Final Recommendation 10:
Key agencies to enable arrangements to provide read-only access across partner IT systems (e.g., for the MASH and/or statutory partner leads to allow for a single point of information for health and social care provision to be established within the local system).

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Each partner agency to identify information point for safeguarding concerns who has access to that partners information system.*

- ***Medium-term:*** *Information sharing protocols which will allow for read-only access to be developed and agreed (including any required resourcing to support said access).*

- ***Long-term:*** *MASH provided on-site access to the relevant range of health and social care information and record systems.*

Review & Clarification of s75 arrangements for safeguarding practice

As noted in the interim report, the arrangement for safeguarding where mental health is a presenting issue are referred, as standard, to the mental health provider trust. This was highlighted as a key issue in the workshop process and gave rise to a recommendation for clarity in our interim recommendations.

> ***Interim Recommendation 4:***
> *Different entry criteria need to be clearly aligned to ensure allocation of safeguarding duties and tasks are appropriate for the receiving service. Commissioning arrangements and representation of key services within the MASH, as highlighted elsewhere in this report, would also further clarify responsibilities, and provide direction for staff on the front-line in terms of how cases should be assessed and managed and under which statutory framework*

This recommendation has been developed further and separated into aspects of delivery that relate to commissioning and partnership arrangements, and those which comprise part of the review of the MASH service set out within this analysis.

Delivery of social care services within an NHS setting was established under the Health Act 1999, superseded by the NHS Act 2006. For mental health and social care this has been, in many areas, the favoured delivery vehicle for meeting the mental health needs of local populations.

Within Luton Borough Council area there is one primary provider of mental health services – currently East London Foundation NHS Trust, with several third sector providers delivering specific elements of support and treatment (e.g., drug & alcohol services, advocacy, and carers services amongst others).

This model was, at one time, the dominant approach and historically two, later three Local Authorities, all transferred their social care provisions and duties into a partnership NHS trust, retaining little in terms of direct service, governance, or leadership within the Local Authorities.

Since this time developments across the country have both supported and discouraged different models of integration between and health and social care and Luton remains one of a small number whose social care duties are fully integrated into the NHS provider service (other examples of this model include Sussex, Lincolnshire, and Staffordshire). With this being the case the relevant LAs do not have mental health social care presence within its own workforce, but rather operating within the secondary provider service.

Whilst many of the social care functions operate in conjunction with secondary health provision, the entry criteria into the service are such that the wider social care needs of individuals with lower-level mental wellbeing issues rather than a diagnosable mental health disorder, have no other option that to enter secondary services when a safeguarding concern is identified. The provider trust clinical and management leads perceive this as a task outside of their remit where a mental illness is not present, despite the fact a s75 arrangement is, and has been in place for over a decade between the LA and a series of provider NHS trusts.

Allocation of the enquiry officer [lead professional] was an aspect of the local decision making that requires greater clarity for practitioners in local partner agencies. The entry criteria for services, for example social care ‘an adult in need of, or appearing to need, care and support’ and the mental health trust criteria ‘suffering from a mental disorder’ are not aligned.

This means that individuals that come to the attention of social care, or who are received by the MASH as an alert that requires a formal or informal enquiry, are referred to mental health services for safeguarding support, but do not otherwise meet the threshold for secondary services.

This arrangement has occurred because of the s75 arrangements between the LA and the NHS trust; however the detail of this, and the expectations placed upon the mental health trust staff lack clarity and creates difficulties within the services. The team requested a copy of the s75 agreement as part of this review, however this was not provided.

During the workshops participants from the mental health services reported that they were not clear on why individuals who did not require secondary provision were being referred into their services and that this was creating several difficulties, including:

- Subjecting individuals to the stigma of being open to a secondary mental health service when this is not required.
- It can be difficult for Service Users to exit the secondary level services and receive more appropriate level support once involvement has been recorded. This is reported to be because there is a perception from voluntary and other lower tier services that the person is now too complex or risky for them to manage.
- Increasing staff workload with cases who did not meet the mental health service threshold for entry but who need safeguarding support which then remain in the service as there are no appropriate services to transfer the person to for low level ongoing social care support.
- Conflict with managers and medical colleagues in relation to cases who are open to the team for safeguarding purposes only.

- Provider services undertaking safeguarding enquiries within their own teams is seen by trust staff as a conflict of interest requiring external enquiry support and there is a resistance within the workforce to take such cases. LA partners confirmed that enquiries regarding organisational abuse or allegations against a specific member of staff should have enquiries led by staff from other mental health teams rather than the team implicated, however this is not currently the case and staff feel uncomfortable and unsafe in these situations.

Whilst these concerns are valid, the LA view is that the trust is responsible for delivery of mental health social care on their behalf, which includes duties under section 42 of the Care Act 2014. Whilst this may be the case, no details of what is included in this arrangement, or what the quality assurance and governance arrangements comprise of, in relation to the discharge of safeguarding duties and the assurance of safeguarding practice, and as such it is difficult to comment further within the remit of this report.

Final Recommendation 11: *Partners to review current s75 arrangements where they relate to safeguarding adults practice and duties, to ensure commissioning and governance of safeguarding within the provider trust is clarified and subject to partnership governance at both practice and strategic level.*

Delivery Options – Suggested Methods and Timescales:

- ***Short-term****: Secure commitment of partners to undertake a review of safeguarding arrangements and clarify expectations with front-line staff and managers in the interim in the context of this discussion and the issues raised.*

- ***Medium-term:*** *Review of safeguarding duties and responsibilities sitting within the s75 agreement to be carried out and reported to the board, with specific detail in relation to how the LAs safeguarding adults' responsibilities are discharged and assured by the relevant organisations (in this instance ELFT and LBC).*

- ***Long-term:*** *Expectations and responsibilities for safeguarding enquiries and care and support plans within the remit of sections 1, 2 & 42 of the Care Act 2014, to be clarified and communicated to all front-line and clinical staff within ELFT, the CCG and the LA safeguarding and MASH teams once agreed.*

iv. SAB Governance

As noted in the interim report, SAB governance was not a specific part of this analysis, however several elements of the recommendations arising from this work have specific implications for Board governance which will need to be considered in the short, medium, and longer term.

These include how the Board assures itself of:

- Consistency of practice.
- Communication pathways.
- Strategic focus.
- Application of pan-county and Borough wide policy and procedures.
- Effectiveness of board structures and governance.
- Delivery of strategic performance and objectives.
- Delivery of the MSP approach.

Where the board had stated a policy position or procedure, for example the information sharing arrangements or hard to engage policy, these were not routinely applied in practice and a significant number of those involved in the various activities accompanying this analysis where not aware of the arrangements.

Whilst it may be that processes and mechanisms are in place to provide this assurance, a lack of awareness amongst workshop participants of these was identified. It is therefore likely that there are areas where board governance could be strengthened further to support the desired developments in the other three domains – practice, interagency & organisational practice.

Throughout this report ,areas where Board governance or oversight is required has been highlighted, and whilst largely out of scope of this review, these relate to establishing and quality assuring a range of practice, policy, and development to strengthen the local arrangements.

Two specific recommendations were made for the board in the interim report, these have been further developed for the purposes of this final report. These included:

Interim Recommendations 1 & 2:

1. *LSAB to consider the viability of developing the products identified by member representatives during the workshop programme.*
2. *LSAB to clarify prevention and protection pathways and consider the development of a shared threshold matrix to increase multi-agency alert conversion rates and transparency of decision making within the partnership.*

Throughout the workshops the team worked with participants to identify specific products or guidance that could be developed to strengthen both practice and the system overall. These are incorporated into medium- and longer-term recommendations, but represent a 'quick win' for the Board if partners are able to begin the planning and collaboration required for medium- and longer-term implementation.

The products identified by partners during the analysis, which would also provide a basis and focus for Board governance activities, were as follows:

- **Cross partnership flowchart / process diagram to prompt practitioner thinking** (*Appendices 4 and 5)*
  The pathways mapped represent both the current structures and the aspirations of the partners involved in the workshop process.

These pathways represent the approach that participants agreed was the desired circumstances but are reliant on other recommendations being accepted and actioned (e.g., confirmation of preferred roles and definitions, expansion of the MASH etc.), they could then be accepted as the operational pathways if all partners agree.

We would not recommend that the current pathway is mapped and published due to the inconsistencies identified throughout this analysis. We would propose that this action is a longer-term product that can then be shaped to account for the changes and improvements made by partners across the system.

- **Updateable shared Directory and Resource Guide.**

Participants repeatedly reported that they did not know what was available in terms of the services and resources in the area. The proposal of a directory that can be updated as services change over time received mixed responses from workshop participants due to the likelihood of partners maintaining the information it contains. The introduction of the virtual world into health and social care does mean that online resources are becoming more common place. With an identified lead for its maintenance, the proposal does have some merit in terms of mapping the various partners and provider organisations that are operating in the area who may be accessible to provide a more robust preventative response.

The board itself is likely to be best placed to host this directory, however partner agencies will need to ensure they keep the board up to date of any local or team changes. As such this product is a short-term action in terms of compiling the necessary information but will require the support of a longer-term maintenance plan to ensure continued currency and relevance to local practice.

It should be noted that partners, and the staff within them, appear to be taking a passive response to this difficulty, for example this issue was repeatedly identified, and no participants or agencies involved sought to address the deficits in their awareness via the contacts the workshops created.

Whilst it is recognised that front-line staff have significant demands on their time, familiarity with the local sector and provision is an essential element of a holistic approach and this needs to be rectified if a joined-up safeguarding response is to be achieved.

Participants did also talk about involving each other in new staff inductions as standard, open days and joint training as other ways of building and maintaining knowledge and relationships.

One further element to consider in the context of shared training, vision, and messaging is the input from external providers - during the analysis the lead consultant on the project attended a workshop in relation to the management of street drinkers.

This workshop had been commissioned by the LSAB and included presentation of the work undertaken by Professional Michael Preston-Shoot and colleagues at alcohol concern. Whilst useful in terms of thinking about safeguarding with this complex group the attention to the mental capacity act within this event was unhelpful, stating *'it doesn't really work for this group'*.

This is a worrying message to be endorsing and giving out to partner agencies and in our view represents a misconception of the relevant legal frameworks that is prevalent both nationally and locally in relation to complex case management. It is critical that legal accuracy, key messages, and local procedures are part of all commissioned training, CPD or networking events.

Final Recommendation 12:
Board to consider the commissioning of several key products to support safeguarding practice in Luton, including – thresholds, MSP in practice and Core induction and training curriculums and quality assurance measures.

Delivery Options – Suggested Methods and Timescales:

- ***Short-term:*** *Partners to identify a lead for the compiling, and maintenance, of an online service directory and resource guide to support practitioners in all agencies and ensure up to date information is accessible [Short-term development with longer-term maintenance plan in place].*

- ***Medium-term:*** *Provide oversight and scrutiny for local and partnership training strategies, delivery, and quality assurance to ensure equivalence and alignment to organisation and professional requirements, to ensure the board can assure itself of the quality and messaging that is delivered across all partners training activities.*

- ***Long-term****: Board to agree & publish process pathways once action plan arising from these recommendations are implemented.*

As other recommendations are acted upon or national developments occur (e.g., changes in policy and legislation, learning from SARs and peer reviews etc.) it may be that the board opts to develop further guidance or pathway resources, however in the first instance thresholds and practitioner guidance on their application, training needs analysis and a comprehensive partner directory accessible to all within the system, are identified as the highest priority for product developments based on the analysis underpinning these final recommendations.

Priority Areas

The priority areas identified by partner representatives within each domain are set out in detail throughout both the interim report and this final report. Whilst many of the recommendations and suggestions represent changes in working arrangements and clarification of expectation to support improvements in practice, there are a number of system issues that require more significant developments if the aspirations of the partnership are to be achieved.

The most significant recommendations arising from this review require operational change and investment of resources by key partners, these include:

- The development of a system wide threshold and practice guidance tool to promote consistent and transparent decision-making *(final recommendation 6)*
- The review and re-specification of the MASH service to include all relevant partner organisation *(final recommendation 9*); and
- Review and clarification of the mental health providers statutory responsibilities within the current section 75 arrangements for safeguarding adults *(final recommendation 11)*.

In the absence of these three developments, other improvements can be made, as indicated throughout this report, however a robust governance arrangement, commitment from partners and agreement of key terms, actions, and desired outcomes, will be required to realise some of the aspired gains set out by the partners through this analysis and review.

As with other reviews that have been undertaken nationally in relation to safeguarding practice and processes, the issues identified in the Luton system are in evidence elsewhere, and these represent common failings in safeguarding adults practice and processes across the country.

Those representatives who took part in the workshops, which included consistent representation from partners such as the current MASH team, the CCG and police colleagues, were candid in their appraisal of the local system and where able to identify key areas where improvement could be made; which was a real strength of the review. The key areas included induction, training, quality assurance, communication pathways and transparency of decision making. Some of these require sign-up from all the organisations involved, at all levels, to ensure a consistent approach is developed and sustained over time. Other recommendations could be led by the Board to promote and scrutinise local systems and practices as part of its system leadership role.

Each recommendation arising from this review has been developed to include actions that could be implemented on a short, medium, and longer-term basis to achieve the aspiration that each recommendation addresses. These are included throughout the narrative of this report and are collected in figure 4.1 below, for ease of reference.

Figure 4.1: Final Recommendations and associated actions

Final Recommendation	Short-term	Medium-term	Long-term
Direct Practice			
1. **Discharge planning arrangements where safeguarding concerns are evident need to be managed as a multi-agency process and should be developed as a shared policy/procedure across the SAB organisations.**	Task-finish group established to scope discharge planning arrangements and develop proposals for a shared protocol for discharge where safeguarding concerns or allegations are present.	Board to consider and ratify policy approach and establish performance measures acceptable to partner organisations to ensure action does not drift. Approach to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.	Implementation and governance of policy to be incorporated into organisational and board governance arrangements – including induction, supervision, audit and training and audit & review by the board.
2. **Board to issue position statement on application of MSP, roles within the process and how the individual should be involved in their**	Board to consult partners and then clarify expectations of partner agencies to ensure the individual attending meetings within their safeguarding enquiries, is the standard	Board to review occurrence of individual being invited to safeguarding meetings and agree performance monitoring reporting to support the	Incorporation of the approach into all organisational procedures including induction, supervision, audit and training for staff, as well as care planning and communication

safeguarding enquiry (or prevention plan where relevant).	practice and not exception which appears to currently be the case. This will also require agreement on the support services will offer the individual to enable them to accept the invitation – this may include the opportunity to have an advocate, supporter or representative, the option of making written contributions and support with practicalities such as travel or venue accessibility.	maintenance of a personalised approach in the longer-term.	approaches for service users and audit & review by the board.
3. **Board to issue guidance on working with carers and supporters within the safeguarding pathways and the approach that should be**	Agencies to discuss with service-users the involvement automatically and proactively of their family and network in both ongoing and crisis scenario's,	Exploration of the role of carers and families in safeguarding cases to be explored via local peer review to establish whether the issues identified in the case analysis and workshop	Family involvement and the role of carers considered as a strategic priority for the Board in future strategic planning processes.

taken by those involved in direct practice in all safeguarding cases.	document wishes and respond accordingly.	feedback is the experience of a narrow sample or the pervading practice approach within the partnership	
Interagency Practice			
4. **Board to review, and where appropriate refresh and reissue key shared protocols identified as required but either absent or ineffective in current practice responses (e.g., consistent approach to individuals with complex needs; information sharing, contingency planning, discharge planning etc.) It is recommended that new**	Task-finish policy group to review and scope the requirement for shared policies and procedures based on the findings of this review and make recommendations to the Board in terms of next steps required.	Refresh, and where identified develop, shared policies and procedures within safeguarding practice (e.g., engagement, contingency planning, discharge, complex needs, person-centred practice, working with supporters etc.). Approach to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.	Incorporation of the approach into all organisational procedures including induction, supervision, audit, and training for staff, as well as care planning and communication approaches for service users. Incorporation of protocols into Board governance, including performance management data against protocols where relevant.

or reissued protocols are accompanied by effective communication and training for the front-line to ensure local awareness and adoption of agreed processes and procedures within service delivery.			
5. **Board to clarify roles and expectations of individuals, practitioners and organisations involved in, and leading, practice within the safeguarding prevention and protection pathways**	Board to define key terms within both prevention and protection pathways with its partners e.g., Lead Professional, Lead Supporter and key meetings / forums, to ensure a consistent language for safeguarding practice in Luton is established.	Agreed Glossary & expectations of roles and processes to be rolled-out to all partners simultaneously, utilising a comprehensive communication strategy and training plan.	Incorporation of the approach into all organisational procedures including induction, supervision, audit, and training for staff, as well as care planning and communication approaches for service users. Incorporation of protocols into Board governance, including performance management data

			against protocols where relevant.

6. **Development of shared threshold guidance which is implemented and used by all partner to determine consistent responses to alerts and concerns.**	Establish task-and-finish group with representatives from key partners to undertake a review of available documentations and develop proposals for how the Luton thresholds should be applied for the Board to approve.	Board to oversee/lead the development, implementation, and governance of the tool via links with provider services safeguarding leads. Incorporation of the approach into all organisational procedures (including induction, supervision, audit, and training for staff)
7. **Further targeted review of aspects of the system perceived by partners to be effective, e.g., VARAC, to determine the evidence to support partners perceptions and the scalability of the structure to other parts of the system.**	Full review of VARAC operation, governance, and outcomes to determine applicability and scalable within the local system of this approach.	Depending on findings, consider replication of model where effectiveness is evidenced.
Organisational Practice		

8. **Development of common curriculum and QA process which organisations report against, to the board, to provide assurance that partner training and governance is sufficiently robust and delivers the same core messages within each agency.**	Review of partner organisations training and induction provision on which to base the development a common induction and shared curriculum for internal and external training.	Task-finish group to develop a common induction and training curriculum for internal use by partners that can be agreed by the Board.	Link assurance arrangements for training and induction to Board governance via training sub-group. Including an annual LNA & peer audit.
9. **Review MASH provision and resourcing and develop service specification as a partnership, including key partners in the approach to deliver a fit-for-purpose MASH**	Seek commitment from statutory partners to undertake a full review of MASH requirements and resourcing to determine whether current provision is fit-for-purpose based on national evidence base presented here.	Scope specification for the MASH based on agreed specification and resource commitments from partner organisations and commissioners.	Re-commissioning or re-structure of MASH service based on reviewed and refreshed specification and subject to commitment of partner resources.

service that can meet the demands and functions required by the safeguarding system.			
10. **Each partner agency to identify information point for safeguarding concerns who has access to that partners information system.**	Information sharing protocols which will allow for read-only access to be developed and agreed (including any required resourcing to support said access).	MASH provided on-site access to the relevant range of health and social care information and record systems.	Key agencies to enable arrangements to provide read-only access across partner IT systems (e.g., for the MASH and/or statutory partner leads to allow for a single point of information for health and social care provision to be established within the local system).
11. **Partners to review current s75 arrangements where they relate to safeguarding adults**	Secure commitment of partners to undertake a review of safeguarding arrangements and clarify expectations with front-line staff and managers in the interim in the	Review of safeguarding duties and responsibilities sitting within the s75 agreement to be carried out and reported to the board,	Expectations and responsibilities for safeguarding enquiries and care and support plans within the remit of sections 1, 2 &

practice and duties, to ensure commissioning and governance of safeguarding within the provider trust is clarified and subject to partnership governance at both practice and strategic level.	context of this discussion and the issues raised.	with specific detail in relation to how the LAs safeguarding adults' responsibilities are discharged and assured by the relevant organisations (in this instance ELFT and LBC).	42 of the Care Act 2014, to be clarified and communicated to all front-line and clinical staff within ELFT, the CCG and the LA safeguarding and MASH teams once agreed.
SAB Governance			
12. **Board to consider the commissioning of several key products to support safeguarding practice in Luton, including – thresholds, MSP in practice and Core induction and training curriculums and**	Partners to identify a lead for the compiling, and maintenance, of an online service directory and resource guide to support practitioners in all agencies and ensure up to date information is accessible [Short-term development with longer-term maintenance plan in place].	Provide oversight and scrutiny for local and partnership training strategies, delivery, and quality assurance to ensure equivalence and alignment to organisation and professional requirements, to ensure the board can assure itself of the quality and messaging that is	Board to agree & publish process pathways once action plan arising from these recommendations are implemented.

quality assurance measures.		delivered across all partners training activities.	

Limitations of this Review

As with any research or analyses there are limitations to this review because of a range of factors outside the control of the review team. This included – lack of engagement from some organisational leaders, inconsistent representation from some partners, requiring specific briefing sessions to be completed outside of the commissioned sessions, and a failure to provide information requested to inform the review, as noted throughout this document.

Issues such as record keeping and recording are identified within other recommendations, however it should be noted that in the documents reviewed there were several errors and inaccuracies in the returns from all partners. These included – service users referred to under the wrong name or initials, comments on alert forms that are both inappropriate and disrespectful, and a lack of ownership from individual professionals completing alert and review forms. These are noted here and were reported to the board manager as an issue requiring attention in terms of practice improvement and training; but the team do not view it as helpful to specify or highlight these issues in this document which is focused on the wider issues and solutions.

Whilst the board manager and designated professionals involved in the commissioning of this review highlighted several themes, they had themselves identified, not all of these fell naturally into the schedule of work undertaken and as such have not been fully addressed within this review beyond the comments made under person-centred working, working with supporters, and workforce training needs. The specific areas originally identified that are not addressed here is:

- *Understanding the impact of ACEs and their implications for practice with adults with underlying trauma and attachment issues*.

The focus on acquisitive enquiry and fostering positive working relationships within the system meant that to delve further into the practice of one (or more) specific organisations was not viewed as conducive to developing a more robust partnership at this time.

The experience and responses of some of the organisations within the system has become defensive over time and the decision was made with the board manager at the initial workshop planning discussions to retain focus on the system issues and alignment with national themes rather than to direct the review specifically toward any one area of organisational practice.

5. Conclusion

The analysis and subsequent workshop sessions detailed in this and the project interim report, supported participants to examine and explore their own processes and systems and identify both positive examples from practice, areas for development and aspirations of the partner organisations.

As with national and regional findings concerning SARS and safeguarding practice, the Luton system has both strengths and areas which need clarification or streamlining. Communication, risk assessment, record keeping, and the multi-agency management of complex cases have all been identified as areas of concern. Issues such as thresholds, resourcing, and knowledge of other services within the partnership and the roles and remits of these, are all issues identified by workshop participants as needing further development.

The conclusion of the work includes recommendations for the development of shared services, tools, systems, and pathways, establishing information sharing systems, and ensure areas of the system are adequately resourced for the functions they are required to deliver.

Two key areas of development are identified as underpinning elements of the pathways that the partnership wishes to develop, these are the development of a shared threshold and associated practitioner guidance to support consistent practice and decision-making, and the development of the MASH to ensure that key partners are present, and the outcomes of the MASH model can be delivered.

The recommendations set out in this report are targeted towards making achievable change that will serve to strengthen current arrangements if developed and maintained by the partner agencies involved.

Appendix 1: Summary evidence-based for MASH provision

The Home Office Project surveyed all LAS and visited & interviewed a further 37, 26 of which had a fully co-located MASH Model. The findings were verified by a follow-up questionnaire and two expert panels to review what could be identified as options, benefits, key features, and challenges to establish best practice. It explored the three most common models – agreed coordination / virtual links/physical co-location and looked at others such as 'An Open-Door Team' or 'First Response Team' that is not multi-agency but gives one service lead responsibility specifically for safeguarding.

This research provides information for consideration, as it recognises that differences of opinion were present and different contexts may impact the appropriateness of an approach for a particular model, therefore it does not endorse one model. The Home Office report also references the HMIC publication 'Everyone's business: Improving the police response to domestic abuse' – March 2014. This report found that many forces, to increase the effectiveness of their partnership working in domestic abuse, are supporting the creation of MASH's. HMIC strongly supports the development of these approaches and recommended that forces and partners make sure there is a clear understanding of the relationship between the MARAC and the MASH, which should be linked to avoid duplication.

The Home Office acknowledges that empirical evidence on the benefits of the MASH approach is limited but highlights two areas where some data is available. A study of five London boroughs by the University of Greenwich which found that the implementation of a MASH resulted in a more accurate assessment of risk which benefited outcomes. http://www.londonscb.gov.uk/mash. The Camden MASH has created a 'Management Information Dataset' consisting of case data showing: the initial source of referral, the presenting issue for referral, changes in risk rating before and after MASH, case outcomes and time taken to complete.

This data enables analysis and evaluation of the patterns of referrals received and how these are dealt with. (Source: Collecting MASH data, by Michael Hillier. http://www.londonscb.gov.uk/mash)

The Home Office Project research indicated that the commonly agreed Barriers to a successful MASH approach include:

- *Misunderstanding and/or anxiety about Information Sharing* – this was especially identified as a concern where the information is about adults with capacity.
- *Workplace cultures* – this was where a MASH exists but services still work in Silo's, according to their own policies, procedures and common working practices.
- *Assessment of performance* – As detailed previously there is a lack of assessment of the MASH which makes it difficult to evaluate areas of success or difficulties.
- *Risk thresholds too high* – many respondents felt having very high thresholds blocked preventative work that might reduce later serious issues.
- *Resources* - There was consistent feedback that a successful MASH needs to be resourced sufficiently and needs its own manager and an Accountable Operations Group.

The Home Office Report contains a set of recommendations in setting up a MASH - which can be found in Annex C (p. 22) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf

As our review for Luton recommends a review and relaunch of the MASH to include a wider range of key services underpinned by joint protocols, training and processes. It is recommended that the implementation group familiarise themselves with the recommendations of the Home Office Report as well as our own recommendations. Areas covered include:

- Leadership and Governance
- Co-location
- Accommodation
- Resources
- Contractual/Security Issues
- Staff Training
- Information Technology
- Performance Framework
- Process
- Information sharing
- Communication/Marketing Strategy
- Multi-Agency Funding/Structured Funding

The report also has an Appendix that includes areas where the MASH Model has been implemented and has been largely successful, this includes contact details of those involved that put themselves forward as being willing to be contacted by others, those that included Adult MASH services were Hampshire and Kent.

Another piece of research lead by the University of Central Lancashire in 2019 explored "Practitioner perspectives of multi-agency safeguarding hubs (MASH)" and was published in the Journal of Adult Protection (2020). The research took place in a specific Adult MASH looking at factors that encourage or hinder a multi-agency approach to safeguarding vulnerable individuals.

Much of this research by Shorrock et al reinforces the findings of the Home Office report, stating that the creation of a MASH in the area they focused the research upon had significantly improved information sharing and trust between agencies and the opportunity to intervene with vulnerable adults effectively at an earlier stage; but that workers felt the absence of a common governance structure, management system, practices and procedures and shared pool of resources, limited the effectiveness of the MASH.

The research highlights that the transition to collaborative practices needs to be planned, with agreed practices and processes implemented from the beginning and reviewed regularly. The paper provides a useful literature review of the benefits of agencies working collaboratively, the advantages of working across professional boundaries, using resources more effectively and reduced opportunities for vulnerable individuals to slip through the net but highlights that it is unrealistic to expect agencies and practitioners to merge cultures, approaches and practices without policies, procedures, processes and tools being proactively agreed and communicated.

Shorrock et al highlight the work of Jaques (2017) and Walter et al 2015) which both look at shared procedures, handbooks and systems but also that of Sullivan and Skelcher (2017) that identifies that too much formalisation can also cause conflict for practitioners in terms of their professional identity/role/judgement. The literature review and their own interviews repeatedly emphasise the need for planning, engagement, and trust to be built for the MASH approach to be successful.

As with the Home Office Project, issues highlighted by the practitioners in this piece of research included difficulties with inconsistencies in processing times, ways in which agencies identified risks and variations in thresholds, a lack of feedback to referring agencies, a lack of knowledge of input from other services or outcomes of interventions and identified solutions were formal timescale and information sharing pathways, multi-agency training, shared IT systems or access and clear leadership.

A third piece of research with a wider aim of exploring the “Advantages and Disadvantages of Different Models of Organising Adult Safeguarding” published by Norrie et al in the British Journal of Social Work (2017), explored models where Adult Safeguarding sits in specialist teams compared with it sitting within generic teams. The research identified the MASH approach as key, and explored the impact of different models from information-sharing arrangements through to fully integrated co-located models as part of the wider remit. The feedback in this research suggested that less structured and integrated models relied heavily on the quality of individual relationships at practitioner and managerial levels but that the development of a MASH supported the strengthening of partnerships. Joint working and training, and regular interaction between specialists and other teams were identified as key ingredients to successful implementation and running of multi-agency approaches.

Resources

1. Multi Agency Working and Information Sharing Project Final report July 2014 – Home Office

2. Practitioner perspectives of multi-agency safeguarding hubs (MASH) Sarah Shorrock (University of Central Lancashire, Preston, UK) Michelle M. McManus (Public Health Wales, Cardiff, UK) Stuart Kirby (University of Central Lancashire, Preston, UK) The Journal of Adult Protection ISSN: 1466-8203 Article publication date: 10 December 2019 Issue publication date: 22 January 2020 https://www.emerald.com/insight/content/doi/10.1108/JAP-06-2019-0021/full/html

3. This is a repository copy of The Advantages and Disadvantages of Different Models of Organising Adult Safeguarding. White Rose Research Online URL for this paper: https://eprints.whiterose.ac.uk/101630/ Norrie, Caroline, Stevens, Martin, Graham, Katherine Elizabeth (2017) The Advantages and

Disadvantages of Different Models of Organising Adult Safeguarding. British Journal of Social Work. pp. 1205-1223. ISSN 1468-263X https://doi.org/10.1093/bjsw/bcw032 and https://eprints.whiterose.ac.uk/101627/1/MOS_first_phase_findings_PURE.pdf

Appendix 2: Summary of other SAB threshold documents

Much of the evidence for the implementation of a successful MASH approach to Adult Safeguarding highlights the importance of a shared understanding of risk, the threshold at which action should be taken and what level the intervention should be. It was clear from our review of the cases highlighted by Luton SAB for review that different organisation did have very different understandings of risk and responses and this was confirmed in the workshops.

There are a wide range of these tools already in existence in the public domain that the Luton SAB working group for implementing these recommendations can utilise for the formation of one that works locally.

For example. the ADASS North East 2011 document (https://www.adass.org.uk/adassmedia/stories/Regions/North%20East/Safeguarding_thresholdsNEJan12.pdf) highlights that thresholds may need to be lower or higher in particular settings; giving the example that nursing or residential care may need to be lower to reflect the likelihood and risk of abuse and that the decision to intervene will be determined partly by the context and environment where the alleged abuse has occurred. This example also highlights the need for services to track cumulative impact of smaller incidents constituting neglect or abuse over time – to address this the tool includes an obligation on all commissioned services, to log incidents that classify as a concern that cumulatively could amount to a safeguarding concern.

The West Sussex SAB Guidance (2020) (safeguarding-thresholds.pdf (westsussexsab.org.uk)) with a flowchart to help staff to understand what fits into the remit of a s42 Safeguarding concern, to reduce referrals that are unlikely to be progressed as the person does not have care and support needs as defined by the Care Act 2014. It also flags that multiple 'non-reportable' incidents should be reconsidered for consultation if referring to the same adult with care and support

needs, the same staff member or the same organisation. This may have been helpful in the cases that we reviewed for Luton as in a number of the cases there was a building picture of concern that as stand-alone events may not have been safeguarding issues but collectively suggested a deteriorating picture where earlier or coordinated interventions may have been beneficial. This Thresholds document contains a wide range of areas for potential identification of concerns including areas such as Modern Slavery, Radicalisation & Terrorism and Organisational Abuse which can prompt staff to remain professionally curious and vigilant to areas of safeguarding that are not such a regular occurrence.

The Cumbria Tool (2021) contains more contextual information at the beginning of the document outlining Safeguarding definitions and obligations under the Care Act 2014 and providing areas for consideration to guide professional judgement (https://www.cumbria.gov.uk/eLibrary/Content/Internet/537/6683/17937/44112152158.pdf)

The Newcastle Tool (https://www.cntw.nhs.uk/content/uploads/2017/01/NTWC24-App5b-3-NSAB-SA-RiskThreshTool-V04-Iss1-Jan17.pdf) gives more explanation to staff on how to use the risk ranking table.

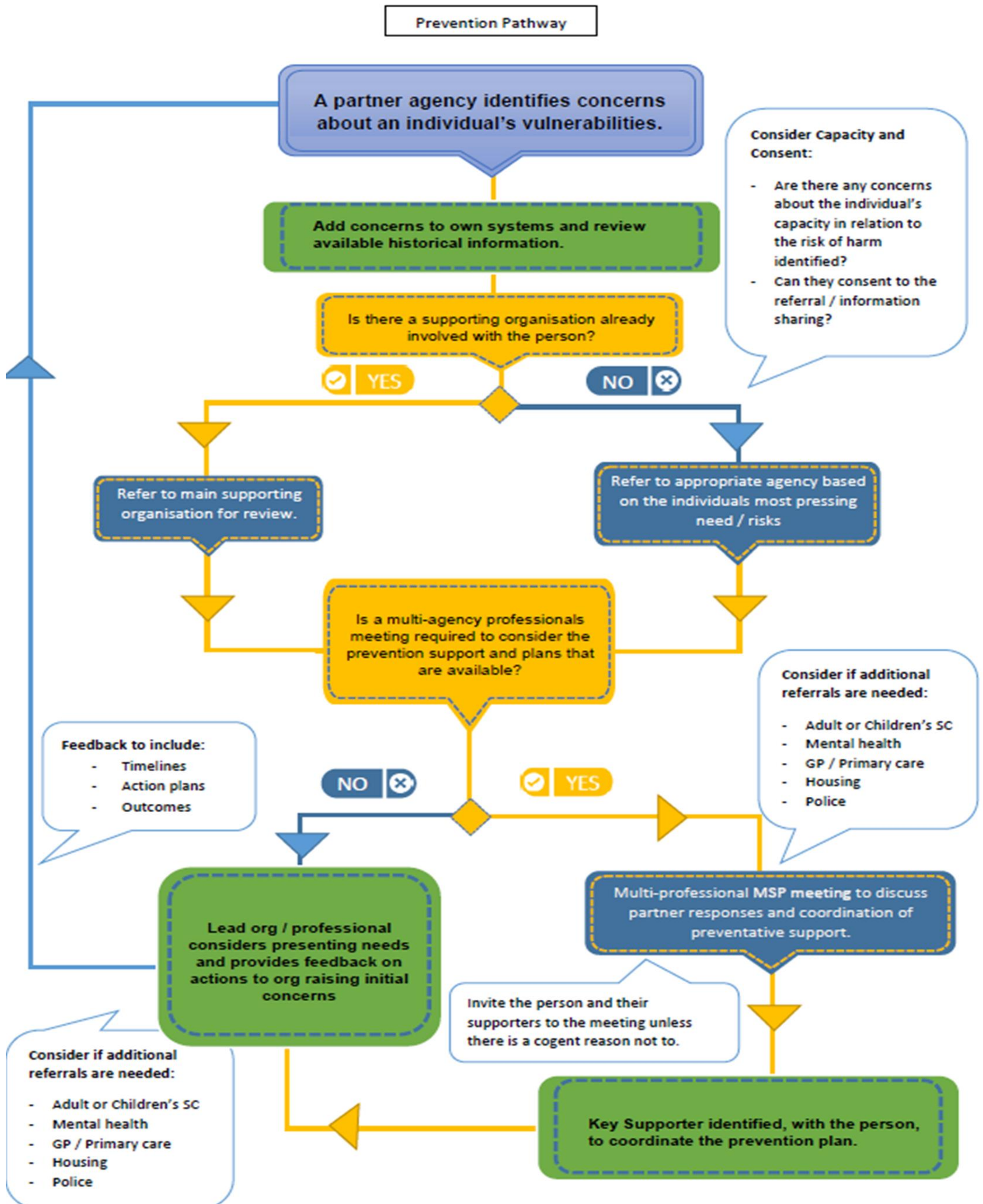
The Nottingham tool combines thresholds with processes so that in each scenario the actions that need to be taken are also clear (Thresholds & Pathways Guidance (nottinghamshire.gov.uk)).

The documents very widely in language for example from low to critical or non-reportable/requires consultation/reportable – which sends different messages across the partnership and will be of importance in deciding what best supports the Luton Model when Pathways, Roles and Terms of Reference are agreed/refreshed.
In addition to looking at existing examples, there are other public access resources such as advice from legal teams e.g., Drafting threshold documents (localgovernmentlawyer.co.uk).

The above examples are simply illustrative of the range of tools that exist, and this report has not undertaken a comprehensive analysis of the available options to recommend a specific template to follow.

It will be critical that any Threshold Document is produced with comprehensive consultation, rolled out with a communications strategy and effective training and the use of it is monitored and reviewed by a robust governance structure. This will be key across any documents the board decides to develop including pathways and assessment or contingency tools.

Appendix 3: Prevention Pathway



Appendix 4: Protection Pathway