Safeguarding in Luton

The Annual Report for
Luton Safeguarding Adults Board

2021 – 2022 Annual Report

February 2023

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INDEPENDENT CHAIR - INTRODUCTION

It is with great pleasure that I present Luton's Safeguarding Adults Board's Annual Report for 2021/22. The report highlights the work carried out by the Board and its Partners, reflecting their commitment to the safety and wellbeing of adults with care and support needs.

Alan Caton OBE
Independent Chair
Luton Safeguarding Adults Board

Safeguarding remained challenging and complex during this reporting period because of the ongoing national pandemic and its associated restrictions and lockdowns. Covid remains significant, and the partnership has faced unprecedented challenges to support and safeguard vulnerable adults with care and support needs. The partnership mobilised effectively during this uncertain time and worked tirelessly to support and safeguard vulnerable people who were at risk of harm, abuse or exploitation. I recognise the extraordinary efforts made by all frontline practitioners to keep people safe in these unprecedented times.

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

Luton, like many areas across the country, has seen the Health and Social Care system have to cope with a significant increase in demand. We have seen an ever-increasing volume and complexity of safeguarding issues and concerns with individuals experiencing severe and multiple disadvantages, including, homelessness, domestic abuse, substance abuse, mental health, alcohol abuse, contact with the criminal justice system and sex work. This has been further analysed in a number of commissioned Safeguarding Adult Reviews (SARs).

The purpose of a SAR is to identify improvements to be made to prevent deaths or serious harm occurring again. Such reviews should seek to inform effective learning and reduce the recurrence of similar incidents. It is the responsibility of the SAB to identify such cases and to commission reviews as appropriate so that improvements can be made. This report highlights the volume of SARs that are being undertaken by the Board.

Luton Safeguarding Adult Partners have a well organised group of multi-agency professionals that oversee reviews and ensure there is a culture of learning and continuous improvement. Learning from reviews is a Board priority. The report highlights the key themes that are emanating from these reviews.

Unfortunately, it is taking some time to embed the learning into practice. I will continue to monitor the process of learning from reviews to ensure that learning is indeed embedded, and practice is improved.

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

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

Alan Caton OBE
Independent Chair Luton Safeguarding Adult Board

1. THE ROLE OF THE SAFEGUARDING BOARD IN LUTON

LSAB BOARD PARTNERS

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

Bedfordshire & Luton Clinical Commissioning Group (now ICB)	**Bedfordshire Police**	**Bedfordshire Fire and Rescue Service**
Cambridgeshire Community Services	**East of England Ambulance service**	**East London Foundation Trust**
Healthwatch Luton	**Luton Borough Council (including Adult Social Care, Housing and Public Health)**	**Luton and Dunstable Hospital Trust**
Lay member - vacancy	**National Probation Service**	**Lay member - vacancy**

The LSAB has a Strategic Board which meets four times per year which is responsible for making sure that agencies, work together effectively to help keep adults in Luton safe from harm and neglect, and to protect their rights. The *Care Act 2014* requires the Board:

- to develop and publish an annual strategic plan setting out how we will meet our objectives and how the board members and our partner agencies will contribute
- to make sure that Safeguarding Adults Reviews take place were the criteria is met
- to develop and publish an annual report showing that we have done what we should be doing

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

LSAB STRATEGIC OBJECTIVES

The full LSAB Strategic Business Plan can be found here: along with its structure to support delivery.

LSAB Priorities (2021-2023)

Strategic Structures to Support Delivery

2. UNDERSTANDING THE CONTEXT OF LUTON – DEMOGRAPHICS

Population

- **213,500** residents in the town.
- One of the youngest populations in the country – **27%** of residents aged below 18.
- Super diverse town – **55%** non-White-British.
- Approximately **50%** population churn since 2011.

Economy

- Luton economy worth **£7.2** billion per year prior to the pandemic.
- **Among the worst-impacted places in the country during pandemic** – second highest number of vulnerable jobs during the pandemic of major towns and cities.
- Claimant count of **8.4%** - up from **3.4%** in March 2020 – the sharpest rise in the country.

Employment

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

Education

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

Housing

- The median house price in Luton is **£258,000 – 34%** increase since 2015.
- The Median house price is **8.5 times** the median gross annual earnings for residents.
- **22%** of Luton households are in the private rented sector.
- **15,000** additional homes required by 2031.

Outstanding Location

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

London Luton Airport

- 5th largest airport in the UK.
- Over 17 million passengers per year prior to the pandemic – down to 5.4 million in 2020/21.
- Contributes £1.8 billion per year to the UK economy.
- Provides more than 11,000 jobs directly, with more through supply chains.

Poverty

- **39.6%** of children growing up in relative poverty in March 2021.
- **6th most** deprived area in East of England by Indices of Multiple Deprivation.
- **4** wards in Luton are within the **10%** most deprived in the country.
- **26%** of working households in relative poverty.

Skills

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

Health and Wellbeing

- Life expectancy gap of **6.9** years between women in Luton's most deprived and most affluent wards – for men this gap is **5.1** years.
- Male life expectancy in Luton one year less than the national figure.

The Board and its sub groups have looked at the demographic analysis in relation to ethnicity, as Luton has a *"super diverse"* population. The highest number of enquiries remains the white ethnic group

accounting for 63% of all enquiries. There were slight increases in the number of enquiries relating to the Asian and Black ethnic groups. Detailed analysis of ethnicity in highlighted that:

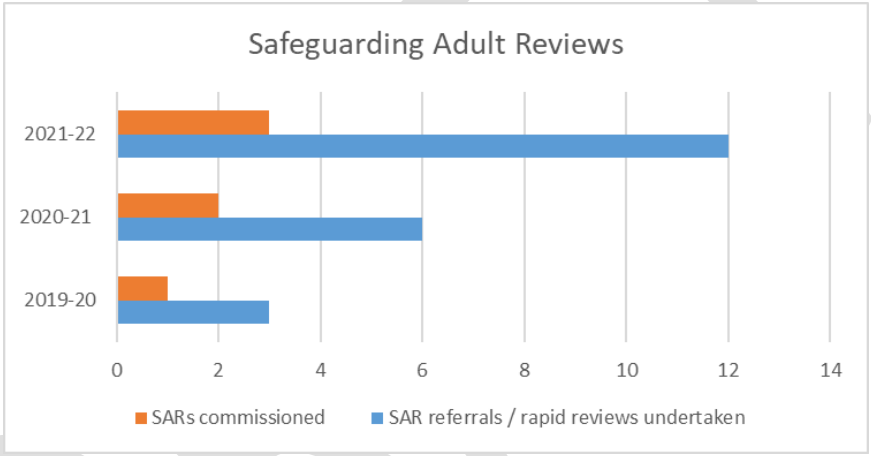
- Learning disability was the primary support reason for enquiries within the Asian ethnic group
- Mental health was the primary support reason for the Black ethnic group; figures appeared to be high (13%) and disproportionate compared to this group representation in the 2011 census (10%).

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

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

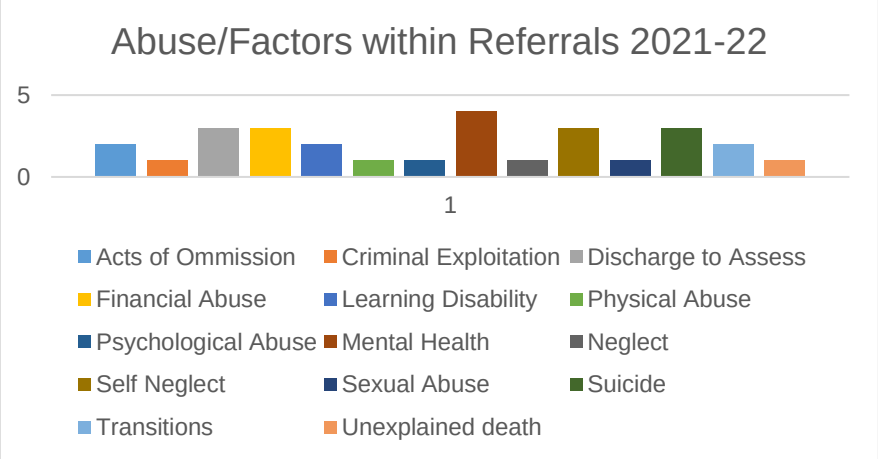
IMPLEMENTING THE LEARNING FROM SAFEGUARDING ADULTS REVIEWS

Section 44 of the Care Act states that the LSAB we must carry out a Safeguarding Adult Review (SAR) if certain criteria are met. This is so that we can learn lessons where an adult, in vulnerable circumstances, has died or been seriously injured, and abuse or neglect is suspected. It is not to blame any individual or organisation.



The Board has received **12** referrals in 2021/22 and has completed rapid reviews (initial scoping of the review in a timely way) for each of these referrals. Three SARs were commissioned as a result of these referrals and rapid reviews, two of which have been concluded.

THEMES FROM REFERRALS, RAPID REVIEWS & SARS



The above chart shows the factors occurring within the referrals received, rapid reviews undertaken and SARs commissioned including multiple factors. Mental Health was the highest occurring factor in referrals for consideration of a Safeguarding Adults Review.

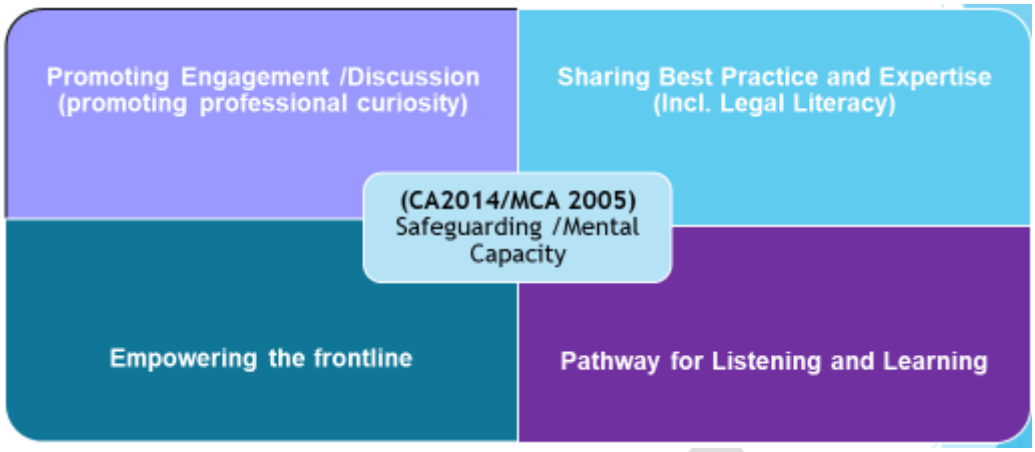
THEMES FROM CONCLUDED SARS

In 2021-22 the LSAB concluded their **Thematic SAR Mental Health**, this considered the learning from six cases over a twelve month period that 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 historical SAR reports, were included as the sample for a thematic analysis. In each case there were key episodes or breakdown in the system which may have contributed to a failure to prevent harm to an individual or a member of the public. Areas such as risk management, communication, information sharing, pathways and the role of multi-agency working were all examined and considered with an aim of improving safeguarding practice.

The report identified **13** aspirational areas for action with a timeline of activity over three years. These were broken down into the four areas identified with the LGA 4-Domain Framework of Direct Practice, Interagency Practice, Organisational Practice and SAB Governance and grouped into **5** themes.

Since receiving the report the LSAB have commenced work on these themes and has also looked to map any similar learning from its rapid reviews to this action plan. Considerable work has been undertaken within the partnership around improving shared understanding of thresholds, discharge pathways and Vulnerable Adults Risk Assessment Conference (VARAC) role. The work on **Making Safeguarding Personal** and Co-production was begun in 2021/2022 and has continued into 2022/2023 with two new subgroups being set up. Work has also continued on the key concepts below:



The full SAR Thematic Report and overarching action plan can be found here:

The LSAB also concluded a SAR in relation to **Adult D** in 2021-22. The review examined the multi-agency response to Adult D who had been found seriously injured in a sleeping bag outside a block of flats in Luton. Paramedics were called and Adult D was taken to hospital. CCTV identified four people carrying Adult D from the flat where she lived to where she was found. Four individuals in her flat were taken into custody, on suspicion of grievous bodily harm. Adult D died the next day in hospital as a result of head injury and liver disease. Both Adult D and the people initially considered as potential offenders were heavy drinkers.

Work streams and strategy improvement include, in summary:

- Current service provision: (REsoLUTiONs CGL- the substance misuse service, comparison to 'best practice' guidance or good practice from elsewhere), views from service providers, trauma informed
- Service usage and access issues – access to recovery groups. Identifying those that do not access treatment or are not in system.
- Stakeholder input

As part of the dissemination and implementation of learning the LSAB Board has:

a) Fed learning into Pan Bedfordshire's LSCB training unit workshops and events
b) Brought learning into Luton Borough Council practice weeks and partnership practice days
c) Produced one page summaries of each SAR and its findings

d) Received assurance reports at LSAB Strategic Board regarding mental health, section 117 aftercare arrangements, the 'Bluelight Project', street drinkers, alcohol misuse and the VARAC.
e) Impact is being checked through the analysis of data and theme based audits as highlighted previously.

MULTI-AGENCY AUDITS

Review of the **Multi-Agency Safeguarding Hub (MASH) data** including **S42 enquiries** has been undertaken on a quarterly basis, with all agencies participating in review of data through the LSAB Scrutiny & Performance Group. Work has also taken place to evidence improvement in the quality of recording and decision making within agencies. The performance data also led to LSAB seeking assurance on the timeliness organisations are taking to complete S42 enquiries.

Domestic Abuse is one of the priorities for the LSAB and one of the emerging issues from the COVID 19 pandemic has been an increased presentation of domestic abuse. The purpose of this audit was to assess how older people experiencing domestic abuse are supported in accordance with Luton's SAB safeguarding policies and procedures and the Care Act 2014. A sample of eight cases were selected, four that had been discussed by Multi Agency Risk Assessment Conference (MARAC), three that had been presented at Luton and Dunstable University Hospital (LDUH) and one from Cambridge Community Services (CCS). The audit provided a good opportunity for reflection by all partners and a recognition that for older people, there was a clear need to improve understanding of the issues for staff in all agencies and to identify a differentiated pathway which recognised the complexities for this group.

Strengths
LDUH staff picked up on the vulnerabilities of some adults and had good measures in place to ensure that person was spoken to.

Areas for development

- **Voice of the victim**: A consistent theme was around access to the victim and then being able to speak to them in a safe environment where they could speak freely. This especially poses challenges for agencies who generally see them in the home environment. It is therefore important that agencies liaise with each other in order to create opportunities for the person to be seen alone e.g., GP health checks or outpatients appointment. Allied to that, how do staff manage when they are refused access, do they escalate to the Police, for example, and under what circumstances? This poses a significant issue as this is a relatively new area for health staff working in community health and who may lack knowledge / confidence in managing the sometimes difficult conversations to gain entry.
- **Gender**: Discussion highlighted that men were commonly victims in the older age group. This was not commonly known and presented a key learning point for services in terms of recognising the loss of physicality for men was significant. This became more important if there had been a previous history where the male had been the perpetrator.
- **The choice to be a carer**: A common question asked in the audit was how much choice did the partner have in becoming a carer? Had they been asked if they wanted a carer's assessment?
- **Dual roles of victim and perpetrator**: There is an ethical issue for staff in dealing with incidences of Domestic Abuse (DA) where the victim had previously been the perpetrator. At one level, there may be empathy with the perpetrator because of the past experience and potential trauma they may have experienced. This then poses a challenge as to what is an effective response especially for organisations such as the Police.

- **Health issues and DA**: One case flagged the challenge of how an issue such as dementia can in some cases lead to DA. The DA is a consequence of the illness rather than a deliberate conscious act. Again, this poses significant challenges in terms of determining what would be a reasonable and proportionate response that safeguards both the victim and the perpetrator.
- **Impact of trauma**: Two of the cases involving younger adults also raised questions as to whether the impact of trauma had been considered and the consequent ability of the victim to make decisions to either leave or enforce prosecution. In these cases, a multi-agency meeting may have enabled consideration of a non-crime investigation. Trauma can also lead to unwise decisions and one organisation recognised that there was a need for a cooling off period when a client decided they wished to end contact. With hindsight, it would have been helpful to have come back to them later to see if their decision still stood.
- **Care & Safety Planning**: Irrespective of the reasons for the DA, the cases all flagged challenges of care and safety planning and the options available to the victim. There was a clear need for a multi-disciplinary approach, but this was not often clearly evidenced. The audit clearly identified a need for clear DA pathways for this group including the need for victimless prosecutions. Some of the cases had been discussed at MARAC and in one case VARAC, however it was not clear if the actions identified had been fed back.

Conclusion
The cases highlighted an increased complexity for the older age group. Consideration of need to be sophisticated and to consider family dynamics, the relationship history, the impact of health conditions and support for affected family members. As a result of this learning the LSAB contributed to developing a multi-agency pathway and guidance for domestic abuse for elderly people which can be found here:

COVID 19

COVID recovery plans has been a particular area of development for the board. Although the COVID arrangements in place during the first year of the pandemic enabled the SAB to demonstrate the strength of partnership working such as improved communication, understanding of and sharing risk. It is important to understand the ongoing impact that COVID has had.

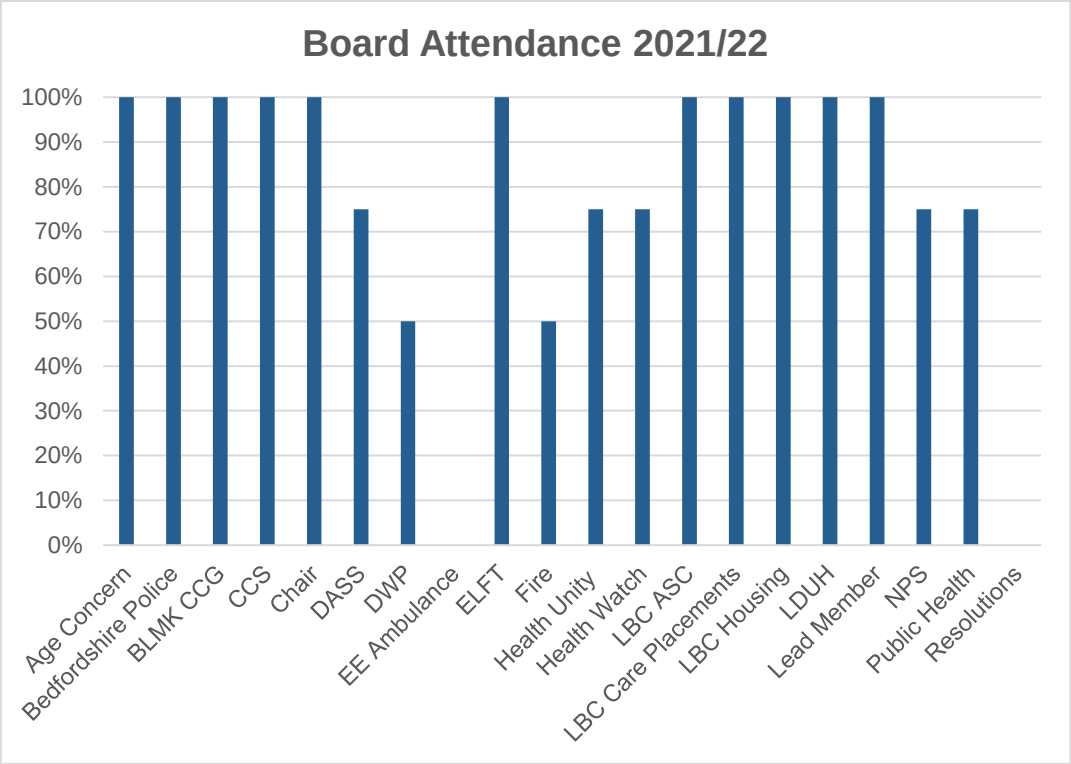
The domestic abuse audit also found that some presentations were picked up as a result of attendance at hospital. However, there was recognition that the restrictions introduced during the pandemic meant there would have been a number of people who would have been at greater risk and a group who would have become at risk because of the pressures the carers experienced having to cope in isolation. There is therefore a need for the learning from the audit to feed into agencies to help support the decision making on which clients would have a face to face visit.

The Board received a paper in June 2021 setting out a summary of the work of the *COVID 19 National Foresight Group* and how SAB's are well placed to ensure greater collaboration between existing partnership arrangements and offer the opportunity to develop, embed and promote new multi-agency structures so there is clarity of roles and clear understanding of responsibilities and less duplication. It was agreed as a positive that whatever the incident is that requires the Local Resilience Forum, the Board needs to link in and consider issues of vulnerability.

During 2021-2022 there was also focus on the discharge to assess process which was introduced during COVID, to reduce risks to patients where assessment are done in the community as opposed to in hospital. The LSAB sought assurance regarding the model and how the risks are being managed. The aim is to send people home, and includes increase numbers in re-ablement, as well as short term bed based placements with assessment for long term care post discharge, where assessment cannot be done at home. Those patients with complex needs are allocated a social worker while the assessment takes place. It was noted that the discharge pathway is in place with a review of those who go back to hospital and a performance agreement. Going forward the LSAB wishes to develop a complex needs pathway which includes an MDT process.

BOARD FUNCTIONING

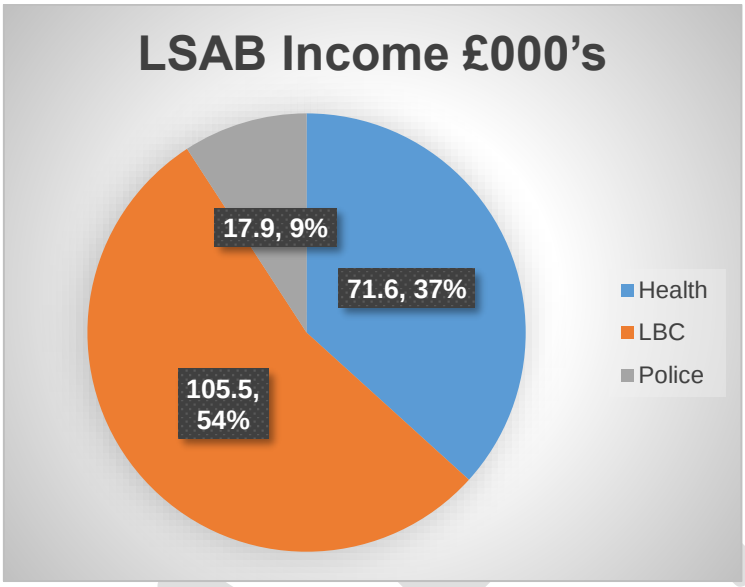
AGENCY ATTENDANCE AT BOARD 2021 – 2022



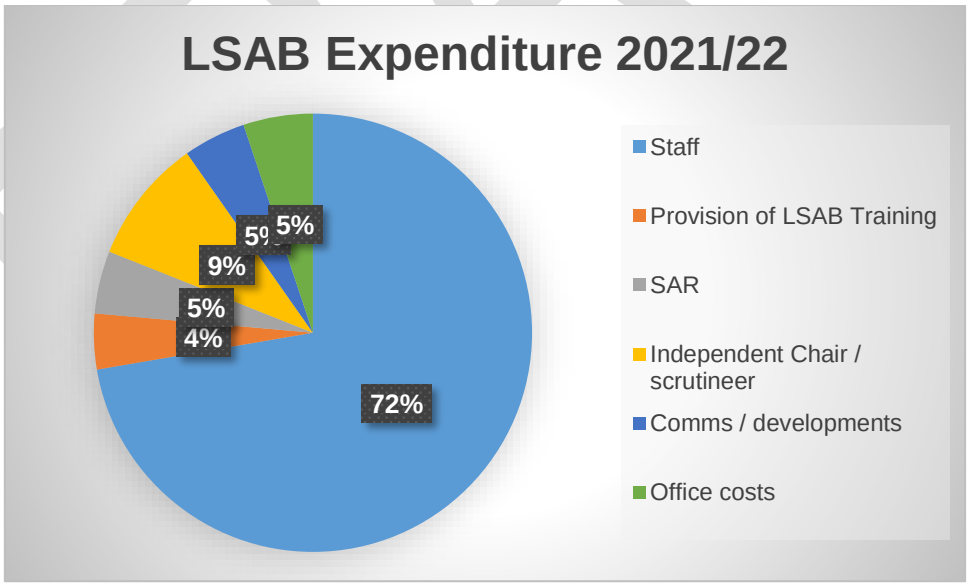
LSAB Strategic Board meetings have continued to be held via Teams and attendance has continued to be good. Some board partners have not attended strategic board meetings but have contributed fully to rapid reviews and Safeguarding Adults Reviews as needed.

BOARDS' BUDGETS 2021/22

The LSAB budget has remained the same over the last four years with income contributions shown below.



LSAB Expenditure is static and is predominately on its staff which takes up 72% of its budget. Expenditure on reviews and training has remained stable at 5% of its expenditure.



FUTURE PRIORITIES 2022/23

The LSAB have agreed to continue work on the priorities established this year in 2022/23. While the Board has made progress in improving governance and is using data and audit to assure itself of the quality of practice it recognises it needs to undertake further work. LSAB and its partners has only made partial progress in embedding the principles of Making Safeguarding Personal, hence it has agreed it is maintained as an overarching priority weaved through all aspects of its works.

The LSAB also needs to, as part of its Covid 19 recovery plan, re-establish key groups linked to its governance and priorities. This includes the Pan Beds Steering Group and Pan Beds Policy and Procedure Group as there is a need to refresh several pathways and procedures across Luton and the Pan Beds Space including hoarding, VARAC and complex presentations.

It also needs to ensure better communication of what safeguarding is, and the role that all people can play in providing support and advocacy to enable a person to disclose the harm or abuse they are experiencing. The LSAB will also use its Scrutiny and Performance space to learn more about themes such as self-neglect, legal literacy and the multi-agency aspects of section 42 timeliness.