

# Luton Borough Council Safeguarding Adults **Peer Review Report**

January 2017

**Final**

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# Executive Summary

Luton Borough Council (LBC) requested that the Local Government Association undertake an Adult Safeguarding Peer Review of the Luton Safeguarding Adults Board (LSAB) and the Council as part of the East of England ADASS Peer Review Programme. The work was commissioned by Sally Rowe, People Director at Luton Borough Council and Brian Walsh, Independent Chair of the Luton Safeguarding Adults Board who were the clients for this work. They were seeking an external view on the effectiveness of LSAB which included the interface with LBC. LSAB and the Council intend to use the findings of this peer review as a marker on their journey of improvement. The specific scope of the work was:

**Scope:** Partnership working in delivering good safeguarding outcomes for vulnerable people and how this is achieved through:

- Governance and Leadership
- Corporate Capacity
- Financial Resilience
- The operation of LSAB including performance reporting
- The effectiveness of local partnerships across the LSAB organisations
- The integration of Making Safeguarding Personal

After due consideration of the documents read and the people seen by the peer challenge team, the key recommendations are that: there needs to be the development of a systems leadership approach at Luton Safeguarding Adults Board (LSAB) that includes greater transparency and accountability. Presently adult safeguarding at a strategic level is not a wholly shared endeavour and the LSAB needs to be seen to have a clear impact upon the safeguarding of vulnerable adults in the borough. A key recommendation is that LSAB urgently works to ensure consistent attendance by partners and that it ensures sufficient seniority of those partners.

LSAB should create a detailed Strategic Plan outlining key priorities and actions to deliver outcomes within agreed timescales that all partners, especially the three statutory ones are signed up to and can then be held to account for. LSAB needs to review the role of the Board and its Terms of Reference (ToR) and the related responsibilities of LSAB members. The aim of this would be to make all members aware of their roles and how their organisation supports the aims and objectives of the LSAB and also how they will be held to account for the outcomes they deliver.

The representatives on LSAB recognise the need to change and that the culture needs to be different. There is now the opportunity to overtly discuss and agree what cultural change means for members and what this would look like in their future behaviours. LSAB should create fit for purpose sub-groups that deliver outcomes and that the attendance at these meetings should be high and that those involved know the purpose and timescales for their activity.

Adult Safeguarding is a complex business and this report includes further detailed comment across the headings of the Standards for Adult Safeguarding as well as specific answers to the scoping questions posed to help Luton Borough Council, LSAB and partners to continue to develop and improve.

# Report

## Background

1. Luton Borough Council (LBC) requested that the Local Government Association undertake a Safeguarding Adults Peer Review of the Luton Safeguarding Adults Board (LSAB) and the Council as part of the East of England ADASS Peer Review Programme. The work was commissioned by Sally Rowe, People Director at Luton Borough Council and Brian Walsh, Independent Chair of the Luton Safeguarding Adults Board who were the clients for this work. They were seeking an external view on the effectiveness of LSAB which included the interface with LBC. LSAB and the Council intend to use the findings of this peer review as a marker on their journey of improvement. The specific scope of the work was:

**Scope: Partnership working in delivering good safeguarding outcomes for vulnerable people and how this is achieved through:**

- Governance and Leadership
  - Corporate Capacity
  - Financial Resilience
  - The operation of Luton Safeguarding Adults Board including performance reporting
  - The effectiveness of local partnerships across the LSAB organisations
  - The integration of Making Safeguarding Personal
2. A peer review is designed to help an authority and its partners assess current achievements, areas for development and capacity to change. The peer review is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit ‘critical friends’. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement.
  3. The benchmark for this peer review was the Safeguarding Adults Improvement Tool (Appendix 1). These were used as headings in the feedback with an addition of the scoping questions outlined above. The headline themes were:
    - Outcomes for, and the experiences of, people who use services
    - Leadership, Strategy and Working Together
    - Commissioning, Service Delivery and Effective Practice
    - Performance and Resource Management
  4. The members of the peer review team were:
    - **Grainne Siggins**, Director, Adult Social Care, LB Newham
    - **Councillor Amy Cross**, Labour, Executive Member for Reducing Health Inequalities and Adult Safeguarding, Blackpool Borough Council
    - **Verena Cooper**, Designated Adult Safeguarding Manager, NHS Dorset CCG
    - **Julie Sanderson**, Head of Adult Safeguarding and Quality Assurance, Nottingham City Council
    - **Tina Ramage**, Principal Social Worker, Nottinghamshire County Council

- **Marcus Coulson**, Review Manager Local Government Association
5. The team were on-site for three days from Tuesday 17<sup>th</sup> January to Thursday 19<sup>th</sup> January 2017. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:
    - interviews and discussions with councillors, officers and partners, especially those on the LSAB and people using services
    - reading documents provided by the LSAB and Council, including a number of self-assessment from LSAB members
  6. The peer review team would like to thank LSAB, staff, people using services, carers, partners, commissioned providers and councillors for their open and constructive responses during the review process. The team was made very welcome and would in particular like to thank Maud O’Leary, Service Director, Adult Social Care, Brickchand Ramruttun, Strategic Safeguarding Manager and Francoise Julian, LSAB Business Officer for their invaluable assistance in planning and undertaking this review.
  7. Our feedback to the Council on the last day of the review gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the review.
  8. The Care Act has put safeguarding adults on a statutory footing. The Care and Support Statutory Guidance defines adult safeguarding as “protecting a person’s right to live in safety, free from abuse and neglect”. The Care Act requires that each local authority must:
    - make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to other appropriate adult to help them.
    - cooperate with each of its relevant partners (as set out in section 6 of the Care Act) in order to protect adults experiencing or at risk of abuse or neglect
  9. The aims of adult safeguarding are:
    - To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
    - To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives.
    - To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible.
    - To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.
  10. There are six key principles that underpin all adult safeguarding work:
    - **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

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

## Context and Themes

- There has been a change of Independent Chair
  - Issues of: attendance, seniority, awareness of adult safeguarding, strategic priorities
  - Implementation of Making Safeguarding Personal (MSP)
  - Clarity of partner contributions and collective accountability to the work of the LSAB
  - Performance management of safeguarding in and across partner orgs
  - Collection and analysis of data
  - Use of sub-groups
11. The context and timing for this Safeguarding Adults Peer Review at Luton Borough Council are important to understand in order to recognise the position LSAB and LBC find themselves in and the opportunities available to them all at this time. A key issue has been the number staff changes that have taken place over the recent past at LSAB and the Council. In a short period of time and for a variety of reasons the incumbent DASS departed as did the Strategic Manager responsible for Adult Safeguarding and also the manager at the next tier down left. This has created some instability which was addressed through the recruitment of an Interim Strategic Safeguarding Manager. At the same time a reorganisation led to the development of the People Directorate. Last year there has also been a change of LSAB Independent Chair to Brain Walsh an experienced senior manager in adult social care.
12. As for the Luton Adult Safeguarding Board there are a number of issues that everyone involved hold a shared understanding of. These focus on the respective roles and responsibilities by LSAB members and specifically are focused on inconsistent attendance and a lack of appropriate seniority of some individuals representing organisations. This has also led to a questionable awareness of adult safeguarding, what it means and how it is delivered in each organisation. There is also a variable understanding of the Board's strategic priorities and an overall lack of clarity around what the priorities actually are and how these can be achieved. In the light of this there is significant room for improvement, especially as the Board is now a statutory body with increased oversight and responsibility.
13. It is widely recognised by LSAB members that there is inconsistent implementation of Making Safeguarding Personal (MSP) by partner agencies as well as a lack of clarity of what it means for those involved. Furthermore there could be greater clarity of which partners are making contributions either in cash terms or in kind, and little collective accountability to the work of the LSAB. As a result the performance management of safeguarding in, and across, partner organisations could be significantly improved as well as the collection and analysis of data.

14. It was also reported that the use of sub-groups by the LSAB requires further consideration. Issues to be addressed would be to achieve clarity over what they are and how they can be used to achieve the strategic priorities of the Board, the present poor attendance at them and the need to ensure that they meet regularly to address the issues they have been tasked with and thereby be seen to deliver outcomes.



## Key Recommendations

- Development of system leadership that includes greater transparency and accountability
  - Develop consistent attendance by partners
  - Ensure sufficient seniority of partners attending
  - Create a detailed Strategic Plan outlining key priorities and actions to deliver outcomes within agreed timescales
  - Review the role of the Board (ToR) and responsibilities of LSAB members
  - Clarify what cultural change means for the LSAB
  - Create fit for purpose sub-groups that deliver outcomes
  - Use insightful data to drive performance management
15. There needs to be the development of a systems leadership approach that includes greater transparency and accountability at the LSAB. Presently adult safeguarding at a strategic level is not a wholly shared endeavour and the LSAB needs to be seen to have a clear impact upon the safeguarding of vulnerable adults in the borough.
16. A key recommendation is that LSAB urgently works to ensure consistent attendance at meetings by partners.
17. That LSAB ensure sufficient seniority of partners attending so they have the sufficient seniority in their own organisations to ensure effective safeguarding activity is delivered.
18. That there is the creation of a detailed Strategic Plan outlining key priorities and actions to deliver outcomes within agreed timescales that all partners, especially the three statutory ones, are signed up to and held accountable for.
19. The peer review team recommend that there is a review of the role of the Board and its Terms of Reference (ToR) and the related responsibilities of LSAB members. This would result in all members being aware of what their roles are and how their organisation supports the aims and objectives of the LSAB and how they will be held to account for the outcomes they are tasked to deliver.
20. There is an awareness that the LSAB needs to change and that the culture needs to be different. There is now the opportunity for LSAB to overtly discuss and agree what cultural change means for members and what this would look like in their behaviours in the future.
21. It is clear that LSAB needs to create fit for purpose sub-groups that deliver outcomes with clear terms of reference. That attendance at these is consistently high and that those involved know the purpose and timescales for their activity.

22. The LSAB needs to use insightful data to drive performance management. To do this will require someone collating and analysing data that is presented in a useful way for LSAB members to make informed decisions.

# Governance and Leadership

## Strengths

- All of the agencies we spoke to have a real passion to drive the safeguarding agenda forward to benefit the people of Luton
- There is clear political support for adult safeguarding at Luton BC from the Leader, Portfolio Holder and the wider Membership and there has been financial support for Adult Social Care and safeguarding
- The Leader Chairs the HWB and Councillor Naseem Ayub is the Vice-Chair (hence link with LSAB)
- The Portfolio Holder gives clear direction to adult social care, has open dialogue with the Independent Chair and strong oversight and leadership of the current issues
- Partners recognise the positive leadership and engagement from the Independent Chair
- The Chief Executive and the People Director are committed to strengthening the role and function of the LSAB
- Joint Assurance Board meeting provides useful cross over between political and operational issues
- Health partners have developed good internal governance and assurance structures for adult safeguarding within their organisations
- LSAB members recognise they are all on a journey and there needs to be a realistic understanding of priorities
- Member safeguarding training and development programme

## Areas for Consideration

- Clarify the authority, scope, role and time commitment of the Independent Chair
- Establish an Executive Group, Chaired by the Independent Chair with statutory partners – call in sub-groups leads as required for updates on progress and review of the ToR
- Identify how each partner contributes to the delivery of safeguarding objectives/priorities
- Ensure that the focus on adult safeguarding maintains parity with the Children's agenda
- Consider how to achieve proportionate responsibility across all partners for Board activity

- STP - ensure service reconfiguration is understood at the local level and that implications are considered from a safeguarding perspective
23. It was refreshing to hear that all of the agencies we spoke to have a real passion to drive the safeguarding adults agenda forward to benefit the people of Luton. This common purpose is a strong place to be able to deliver the changes required to make LSAB functioning more effective.
  24. There is clear political support for safeguarding adults at Luton BC from the Leader, the Portfolio Holder and the wider Membership. Furthermore at a time of austerity there has been financial support for Adult Social Care and safeguarding that will allow for the work of the LSAB to be supported by the Council.
  25. The Leader chairs the Health and Wellbeing Board (HWB) and Councillor Naseem Ayub is the Vice-Chair. This gives a positive link to the work of LSAB.
  26. The Portfolio Holder gives clear direction to adult social care, has open dialogue with the Independent Chair and strong oversight and leadership of the current issues.
  27. All the partners with whom we spoke recognise the positive leadership and engagement from the Independent Chair since the beginning of his tenure. He has delivered greater clarity to the purpose of the LSAB and the responsibilities of those around the table. He has also actively encouraged other agencies to attend and enabled their voices to be heard.
  28. The Chief Executive and the People Director are committed to strengthening the role and function of the LSAB and the support it receives from LBC. They recognise the benefits a more fully functioning LSAB can bring to the wider partnership landscape and improved outcomes for the people of Luton, especially those who are more vulnerable.
  29. The newly constituted Joint Assurance Board meeting provides useful cross over between political and operational issues enabling an improved awareness of the key issues and the opportunity to consider how these strategic leaders can seek to influence positive operational outcomes.
  30. Health partners have developed good internal governance and assurance structures for safeguarding adults within their organisations. The peer team heard from the Acute Foundation Trust and the good work that is being done to ensure safeguarding training is being delivered up to Level 3 across the organisation. There was evident passion and clarity of purpose.
  31. All LSAB members with whom the peer review team spoke recognise they are on a journey and there needs to be a realistic understanding of priorities that are shared by all members of the LSAB.
  32. There is an Elected Member safeguarding training and development programme that ensures the awareness of safeguarding is updated and embedded in the work of Councillors at Luton BC.

33. Having spoken to all the stakeholders involved it is important to clarify the authority, scope, role and time commitment of the Independent Chair. This would ensure that the authority of the role is clear and the parameters of influence well defined. The role should be properly resourced and supported to enable the Chair to run any relevant sub groups and have the capacity to make contact with partners to drive the LSAB business between meetings.
34. The peer review team recommend that an Executive Group be established that is Chaired by the Independent Chair with statutory partners. This group would effectively drive the business of the LSAB between quarterly meetings and be able to call in sub-group leads as required to hear of the updates on progress and review the ToR.
35. It is important that the LSAB discuss and identify how each partner contributes to the delivery of safeguarding priorities. This should be shared and these organisations held to account as necessary. Presently representatives do not routinely hold this understanding.
36. The peer team recommend that Luton BC and the LSAB itself ensure for themselves that the focus on safeguarding adults maintains parity with the Children's agenda. This would particularly be the case if the lead manager at LBC has a Children's Service focus as it is the experience of colleagues across the country – and the peer team – that the issues around Children's can swamp those of safeguarding adults when both are in the same support system.
37. The LSAB should consider how to achieve proportionate responsibility across all partners for Board activity. The three statutory partners, Luton Borough Council, Luton Clinical Commissioning Group and Bedfordshire Police will drive the work of the LSAB through an Executive Sub-group but the priorities are shared. Some partners will have a greater role on the LSAB than others and this involvement needs to be recognised and proportionate.
38. The Sustainability and Transformation Plan (STP) of which Luton is a part is published here:  
<http://centralbeds.moderngov.co.uk/documents/s65074/Appendix%20A%20-%20STP%20Board%20Pack%20May%202016.pdf>. As the plan develops and seeks to include political colleagues across the footprint, all those involved should ensure service reconfiguration is understood at the local level and that implications are considered from a safeguarding perspective. Presently the STP does not include adult safeguarding with any significant clarity.

## Corporate capacity and financial resilience

- Action the intention to provide resources to support the Independent Chair to deliver the Strategic Plan, Board cultural change and outcomes
- Clarify the roles within the proposed strategic support function for the Adults and Children's Safeguarding Boards and how the roles will support the LSAB and the delivery of its duties
- Create transparency on partner contributions (financial or in-kind) and how they support the work of the LSAB

39. The peer review team recommend that LBC and LSAB action the intention to provide resources to support the Independent Chair to deliver the Strategic Plan, LSAB cultural change and the delivery of outcomes. The shared awareness of what needs to change includes improved support to the LSAB Independent Chair so that the role is fully resourced in terms of allocated days to make contact with partners between quarterly meetings to drive activity. It also includes resources for the LSAB support function to run Board and Sub group meetings with the required paperwork and data that has been analysed and produced in an accessible format that makes decision making easy. It is the intention that this resource makes the delivery of outcomes easier.

40. It is necessary to clarify the roles within the proposed strategic support function for the Adults and Children's Safeguarding Boards and how the roles will support the LSAB and the delivery of its duties.

41. It has been previously mentioned that partners play different roles on the LSAB. It is worth considering the creation of greater transparency around the contributions made by partners that are either financial or in-kind (such as providing rooms) and share how these contributions support the work of the LSAB. This would clarify the different roles involved in the partnership and who could be asked to account for what.

# The operation of LSAB including performance reporting

## Strengths

- There is a real feel that in the last nine months health and other agencies are engaged on the LSAB
- Data collection is on an upward journey
- Quality Practice Standards are a positive development
- Beginning to develop audit activity related to safeguarding
- The number of DoLS assessments completed on time is a commendable achievement
- LSAB Policies are beginning to take shape (e.g. Hard to Engage)
- Good Quality Monitoring and market intelligence

## Areas for consideration

- Review the role of the Board membership and responsibilities of LSAB members (work to begin immediately and completed within six months)
- Consistent reporting format and cycle required that are in line with the Forward Plan for the LSAB
- The new sub-group structure requires ToR, work plans and reporting lines
- Continue use of away days or thematic meetings to develop the LSAB work plan
- Escalation routes to the LSAB need to be formalised
- The agency updates at the LSAB need structure
- Consider how the progress on recommendations of SARs are monitored and reviewed through formal sub-group processes
- Consider how to capture the service user experience and bring it to LSAB (e.g., Healthwatch, Pohwer, LSCB)
- Develop a communications strategy that includes raising awareness of adult safeguarding
- Consider how the outcomes from audits are included in the assurance processes to the LSAB
- Clarity for LSAB members on the types of reviews available, related processes and how the outcomes are reported to the LSAB (e.g. SARs, DHRs, SILPS, SUI, etc.)

- Consider how the work of the LSAB is informed by changes in national legislation and guidance
  - Safeguarding terminology and language requires a review to put it in line with the Care Act (e.g. adult at risk rather than vulnerable adult)
  - Maximise the use of all partner websites to promote safeguarding
42. From evidence heard by the peer review team there is a real feel that in the last nine months health and other agencies are more engaged on the LSAB. This is thought to be due to the actions of the Independent Chair.
43. The LSAB collects data and is seeking to use it. In the recent past the LSAB has been collecting data and presenting this at Board level. There is now a move to analyse this information and have it discussed in a subgroup forum and then to have items of concern escalated to the LSAB. For this reason it is possible to say that this aspect of the work is on an upward journey. However, the data presented is still perceived as 'local authority' data and further work is required to develop performance reports which present partnership activity.
44. The development and implementation of Quality Practice Standards are a positive development for Safeguarding Adults and Best Interest Assessor (BIA) practitioners, ensuring consistency in process and practice.
45. LBC Adult Social Care department is beginning to develop audits that is a positive step and a further improvement in the overall system would be for LSAB to development multi agency audits.
46. The number of Deprivation of Liberty Safeguards (DoLS) assessments completed on time is a commendable achievement. At a time where the number of assessments has risen hugely it is impressive that there is an 80% completion rate.
47. The LSAB is developing policies such as those for Hard to Engage people that is beginning to take shape demonstrating that actions from previous SCRs are being taken forward and implemented. However, there were a number of actions from SCRs that had been outstanding since 2009 onward. The relevant subgroup needs to ensure that these outstanding actions are advanced swiftly, reported to the Board and monitored.
48. The Local Authority Quality Monitoring processes are robust and as a result of this and the open communication between contract monitoring and safeguarding practitioners, market intelligence is well developed. Links with Luton Clinical Commissioning Group are being strengthened which is a positive development.
49. It is central to the ongoing development of the LSAB that there is an urgent review of the role of the Board's membership and responsibilities of partners. The aim should be to raise awareness of safeguarding adults and ensure consistent attendance of partner representatives with the appropriate seniority. This work should begin immediately and be completed within six months.



50. When there is a clear LSAB Strategic Plan with priorities outlined, there would also need to be a Forward Plan covering the schedule of activity. Aligned to this would be a consistent reporting format and cycle to give clarity to what is being reported, who is responsible for what and by when. Partners need to take a more active role in preparing relevant reports and report to the Board in line with the Forward Plan.
51. All partners agree that there is a need for new sub-group structure from revised Terms of Reference (ToR). From this there would flow work plans and reporting lines and accountability.
52. The peer review team recommend the continued use of away days or thematic meetings to develop the LSAB work plan as the recent event was a success.
53. There needs to be a formal agreement on the escalation routes to the LSAB of issues that occur in partner organisations related to the safeguarding of adults and shared understanding of what constitutes an important issue.
54. The agency updates at the LSAB need structure to better use the limited time available.
55. The LSAB could consider how the progress on recommendations of Safeguarding Adults Reviews (SARs) are monitored and reviewed through formal sub-group processes. A methodology could be developed for the Training Workforce and Development sub-group to have sight of SARs as well as DHRs and Case File Audits to produce learning themes that could be shared at an early phase in the process, then a set of final Lessons Learnt created to support this compromising of any investigations.
56. Consider how to capture the service user experience and bring it to the LSAB. Many Board's across the country engage service users to bring the experience of those who use services to Board members and 'ground' them. This however needs to be done with care and thought to make it effective. At LSAB it should be possible to use the ongoing work by amongst others; Healthwatch, Pohwer and the LSCB to do this.
57. LSAB should develop a communications strategy that includes raising awareness of safeguarding adults for LSAB members and the public at large. This could be held and disseminated through a number of routes.
58. Consider how the outcomes from audits are included in the assurance processes to the LSAB. It should be possible in the future to create an audit cycle to include multi-agency audits looking at current safeguarding processes that would promote clarity for agencies so they know when they are due and that there is a formalised method for sharing the findings.
59. There are a number of agencies involved in safeguarding adults each with their own processes, procedures and terminology. It would be useful for LSAB members to have access to some clear definitions and explanations on the types of reviews available, the related processes and how the outcomes are reported to the LSAB. For example there are SARs (Safeguarding Adults Reviews), DHRs (Domestic Homicide Reviews), SILPs (Significant Incident

Learning Process) and SUIs (Serious Untoward Incidents), which could do with greater explanation.

60. Further to the point made above consideration should be given to how the work of the LSAB is informed by changes in national legislation and guidance.
61. The safeguarding terminology and language used in LSAB papers and partners organisations requires a review to ensure it is in line with the Care Act (an example being the phrase 'adult at risk' rather than 'vulnerable adult'). All documents should have a consistent use of language in line with the Care Act.
62. Maximise the use of all partner websites to promote the safeguarding of adults.

# Effectiveness of local partnerships across the LSAB organisations

## Strengths

- Consistent feedback on positive operational working
- The creation of the MASH located with the Police is a very positive move
- Safeguarding Leads network is valued

## Areas for consideration

- Create an overarching multi-agency safeguarding adults policy
- LSAB sub-group to develop a Training Strategy which is Care Act compliant
- Create and implement an Induction Pack for LSAB Members
- Create opportunities for multi-agency learning from cases for professional development including celebrating good practice
- Enact the protocol that facilitates the Board Chairs from the HWB, LSCB, LSAB and Community Safety Board to meet quarterly to share and discuss current common themes, e.g. DV, CSE, Neglect & Human Trafficking

63. It is a strength that there is consistent feedback on positive operational working. This was reinforced when members of the peer team met with partner agencies who felt there were strong operational relationships. At this operational level there was evidence to suggest a good understanding of the different roles and responsibilities the agencies took and a strong willingness to work together to make the people of Luton safe.

64. The creation of the Multi Agency Safeguarding Hub (MASH) located with the Police is a very positive move. This should enable Multi Agency relationships to strengthen further allowing early discussion around the perceived risk and management strategies required to promote effective safeguarding at an early stage in the journey.

65. The Safeguarding Leads Network is valued and led by health although it is multi agency and enables specialist leads across the partnership to tackle operational issues and learn from case discussion.

66. Whilst each partner on the LSAB has its own safeguarding adults policy, the peer review team recommend that LSAB and partners create an overarching multi-agency safeguarding adults policy so that all partners are working together with an agreed set of principles, are able to explicitly articulate their respective roles and responsibilities and citizens can see where responsibility sits.

67. Elsewhere in this report it is recommended that the sub-group structures are reconstituted to ensure they are fit for purpose and deliver effective outcomes.

One of these sub-groups should be on Training and Development and it should develop a Training Strategy which is Care Act compliant.

68. To enable new LSAB members to be fully briefed on safeguarding adults, what the purpose and structure of the LSAB is and the roles and responsibilities of partner organisations it is recommended that LSAB create and implement an Induction Pack for LSAB Members. This could be supported by online tools and information on the LSAB and partner websites.
69. Create opportunities for multi-agency learning from cases for professional development that would include celebrating good practice. Health have been undertaking significant events around pressure areas, falls etc., and these generate valuable learning which could be shared across the partnership. Furthermore the Safeguarding Leads Network could take ownership of this work and feed practice examples into the Training and Development subgroup for dissemination to safeguarding trainers across the partnership.
70. Enact the protocol that enables a quarterly meeting of the Board Chairs from the Health and Wellbeing Board (HWB), Local Children's Safeguarding Board (LSCB), LSAB and Community Safety Board to share and discuss current common themes such as Domestic Violence, Child Sexual Exploitation, Neglect and Human Trafficking.

# The integration of Making Safeguarding Personal

## Strengths

- Stocktake completed and acknowledgement of the development required to implement MSP

## Areas for consideration

- Work on what MSP means for Luton and how the LSAB will be assured of progress
- Consider use of national MSP resources (SCIE, ADASS etc.)
- Provide guidance on Making Safeguarding Personal across the partnership

71. A strength of the LSAB is that a stocktake has been completed and there is acknowledgement of the need to develop the implementation of MSP across the partnership. From this place there is the opportunity to improve.

72. The peer review team recommend that LSAB spend time discussing and creating a shared understanding of what MSP means for Luton as a place and each partner on the LSAB. Following on from this would be agreement as to how the LSAB will be assured of progress and by what mechanisms. An action plan could then be drawn up that clarifies meaning and activity for the LSAB so that individual organisations could be held to account in agreed timescales.

73. There are a number of national MSP resources available that could be used by LSAB and its partners that are referenced here:

- a. Social Care Institute for Excellence (SCIE) - <http://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/>
- b. Association of Directors of Adult Social Services (ADASS) - <https://www.adass.org.uk/making-safeguarding-personal-publicaitons>.

74. It is necessary to provide guidance on Making Safeguarding Personal across the partnership that can be accessed by individual members and organisations to ensure a consistency of understanding that will cover for the potential turn-over of representatives in the future. For example it is unreasonable to expect representatives from blue light services to be in-post for a number of years. Each partner should have an explanation of what it means in their organisation, their roles and responsibilities and how this relates to the work of the LSAB.

## Safeguarding Adults resources

- 1. LGA Adult Safeguarding resources web page**  
[http://www.local.gov.uk/web/quest/search/-/journal\\_content/56/10180/3877757/ARTICLE](http://www.local.gov.uk/web/quest/search/-/journal_content/56/10180/3877757/ARTICLE)
- 2. Safeguarding Adults Board resources** including the Independent Chairs Network, Governance arrangements of SABs and a framework to support improving effectiveness of SABs  
[http://www.local.gov.uk/web/quest/search/-/journal\\_content/56/10180/5650175/ARTICLE](http://www.local.gov.uk/web/quest/search/-/journal_content/56/10180/5650175/ARTICLE)
- 3. LGA Adult Safeguarding Knowledge Hub Community of Practice** – contains relevant documents and discussion threads  
<https://knowledgehub.local.gov.uk/home>
- 4. LGA Report on Learning from Adult Safeguarding Peer Review**  
[http://www.local.gov.uk/web/quest/search/-/journal\\_content/56/10180/4036117/ARTICLE](http://www.local.gov.uk/web/quest/search/-/journal_content/56/10180/4036117/ARTICLE)
- 5. Making links between adult safeguarding and domestic abuse**  
[http://www.local.gov.uk/web/quest/search/-/journal\\_content/56/10180/3973526/ARTICLE](http://www.local.gov.uk/web/quest/search/-/journal_content/56/10180/3973526/ARTICLE)
- 6. Making Safeguarding Personal Guide 2014** – the guide is intended to support councils and their partners to develop outcomes-focused, person-centred safeguarding practice.  
[http://www.local.gov.uk/web/quest/publications/-/journal\\_content/56/10180/6098641/PUBLICATION](http://www.local.gov.uk/web/quest/publications/-/journal_content/56/10180/6098641/PUBLICATION)
- 7. Social Care Institute for Excellence (SCIE) website pages on safeguarding.**  
<http://www.scie.org.uk/adults/safeguarding/index.asp>

## Contact details

For more information about this Safeguarding Adults Peer Review at Luton Borough Council please contact:

**Marcus Coulson**

Programme Manager – Adults Peer Challenges

**Local Government Association**

Email: [marcus.coulson@local.gov.uk](mailto:marcus.coulson@local.gov.uk)

Tel: 07766 252 853

For more information on adults peer challenges and peer reviews and the work of the Local Government Association please see our website [http://www.local.gov.uk/peer-challenges/-/journal\\_content/56/10180/3511083/ARTICLE](http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3511083/ARTICLE)

# Appendix 1 – Safeguarding Adults Improvement Tool

## Overview

There are four key themes for the standards, with a number of sub-headings as follows:

Themes	Outcomes for, and the experiences of, people who use services	Leadership, Strategy and Working Together	Commissioning, Service Delivery and Effective Practice	Performance and Resource Management
Elements	<p><b>1. Outcomes</b></p> <p><b>2. People’s experiences of safeguarding</b></p> <p>This theme looks at what difference to outcomes for people there has been in relation to Adult Safeguarding and the quality of experience of people who have used the services provided</p>	<p><b>3 Collective Leadership</b></p> <p><b>4.Strategy</b></p> <p><b>5 Local Safeguarding Board</b></p> <p>This theme looks at:</p> <ul style="list-style-type: none"> <li>the overall vision for Adult Safeguarding</li> <li>the strategy that is used to achieve that vision</li> <li>how this is led</li> <li>the role and performance of the Local Safeguarding Board</li> <li>how all partners work together to ensure high quality services and outcomes</li> </ul>	<p><b>6. Commissioning</b></p> <p><b>7. Service Delivery and effective practice</b></p> <p>This theme looks the role of commissioning in shaping services, and the effectiveness of service delivery and practice in securing better outcomes for people</p>	<p><b>8. Performance and resource management</b></p> <p>This theme looks at how the performance and resources of the service, including its people, are managed</p>

Download the Safeguarding Adults Improvement Tool from this page:  
[http://www.local.gov.uk/peer-challenges/-/journal\\_content/56/10180/3510407/ARTICLE](http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3510407/ARTICLE)