Central
Bedfordshire
Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

TO EACH MEMBER OF THE
CHILDREN'S TRUST BOARD

01 December 2015

Dear Member

CHILDREN'S TRUST BOARD - Thursday 3 December 2015

Further to the Agenda and papers for the above meeting, previously circulated, please find attached the following background information:-

9. Standing Item: Update from other Boards

Attached is a copy of the Bedford Borough and Central Bedfordshire Adult Safeguarding Board Annual Report.

Should you have any queries regarding the above please contact Sandra Hobbs, Committee Services Officer on Tel: 0300 300 5257.

Yours sincerely

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Safeguarding Adults from Abuse, Maltreatment and Neglect in
Bedford Borough and Central Bedfordshire

Annual Report of the
Bedford Borough and Central Bedfordshire Adult Safeguarding Board

April 2014- March 2015

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Abuse is Everybody's Business

This annual report covers the fifth year of operations as two unitary councils for Bedford Borough and Central Bedfordshire. It outlines the progress made during the year from April 2014 to March 2015 and is provided to inform individuals, their families and carers, who use social care and health services, elected members, those who work in social and health care, all partner agencies, and residents of Bedford Borough and Central Bedfordshire.

During the past 12 months, all agencies signed up as members of the Board continued their improvement programmes based on the previous years annual report and other learning from practice and audits undertaken throughout the year. Robust strategic leadership and operational arrangements have been implemented providing a basis for more effective safeguarding but we recognise that achieving excellence in this area requires sustained improvement on the part of all partner agencies

During the past 12 months we focussed on

- Preparation for the new duties under the Care Act 2014 for adult safeguarding and for managing quality and safety in care provision
- Ensuring the implications of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as "Cheshire West") are robustly managed
- Making safeguarding personal, ensuring that person centred outcomes are at the forefront of safeguarding work

Over the coming 12 months we will be focussing on

- Embedding the well being principles of the Care Act, including making safeguarding personal
- Growing awareness of sexual exploitation, modern slavery and self neglect and improving working arrangements with the LSCBs and CSPs
- Ensuring the statutory responsibilities of the SAB are understood and supported
- Responding to and monitoring the ongoing impact of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as "Cheshire West")

It is everybody's responsibility to report abuse wherever it is seen, suspected or reported. Safeguarding is a vital part of our responsibilities. It is more than just adult protection; it is about protecting the safety, independence and wellbeing of people at risk.

Julie Ogley
Director of Adult Social Care, Health and Housing
Central Bedfordshire Council
Chair of the Bedford Borough and Central Bedfordshire Safeguarding Board

Kevin Crompton
Director of Children's and Adult's Services
Bedford Borough Council

Safeguarding is our Responsibility

1. The Developing Context for Safeguarding

1.1 The Care Act 2014

From April 2015 the Care Act 2014 puts the Safeguarding Adults Board on a statutory footing. The safeguarding policies and procedures have been amended to reflect the changes in law, terminology and culture of safeguarding practice. This briefing note provides an introductory summary of the changes. It is important to refer to the full policy and procedure document for complete details.

The Care Act requires that each local authority must:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom;
- set up a Safeguarding Adults Board (SAB); the statutory members are the local authority, police and clinical commissioning group. Members of the SAB must appoint a designated adult safeguarding manager (DASM).
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. They must be informed of their rights to an independent advocate.
- co-operate with each of its relevant partners (as set out in Section 6 of the Care Act) in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

The Care Act Statutory Guidance can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

A number of resources have been produced by SCIE (The Social Care Institute for Excellence) to support implementation of the Care Act. These include sharing information, undertaking SARs, and practice guidance. This information can be found at:
http://www.scie.org.uk/care-act-2014/safeguarding-adults

1.2 Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end. Information can be found at:
http://www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/6074789/ARTICLE

The Care Act 2014 statutory guidance states that safeguarding should be personal; it should be person led and outcome focussed; it should enhance involvement, choice and control as well as improving quality of life, wellbeing and safety. The person should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. Thinking about outcomes in adult safeguarding means focusing on what people who have experienced the process say, and the extent to which the outcomes they wanted (their wishes) have been realised. It is vital that the views of the

person are sought and recorded. These should include the outcomes that they want, such as feeling safe at home, access to community facilities, restricted or no contact with certain individuals or pursuing the matter through the criminal justice system

The focus of safeguarding work is not about proving an allegation. It is about whether:

- the wishes of the person have been achieved
- risk has been addressed
- a difference has been made

1.3 Sexual Exploitation and Modern Slavery

The Care Act 2014, as well as national cases of child sexual exploitation across the country, and local cases of modern slavery, have heightened awareness of these areas and the impact on vulnerable adults. They have also highlighted the need to develop an understanding of the victims of these crimes, the professional responses, operational effectiveness and strategic partnership effectiveness.

Both local authorities have established child sexual exploitation panels to gain understanding of what is happening in the local area. In January 2015 an independent Bedfordshire wide review of CSE was commissioned which will provide strategic recommendations for improvements in the work of the LSCBs, CSPs and SABs.

Modern Slavery can include human trafficking, forced labour and domestic servitude and coercion, deceit and forcing people into a life of abuse and inhumane treatment. This is a complex area which requires all SAB partners to work closely together and share information. This is an area where it is recognised that all partners would benefit from increased understanding and knowledge.

Information on modern slavery can be found at: https://modernslavery.co.uk

1.4 Self Neglect

The Care Act statutory guidance states that safeguarding partnerships can be a positive means of addressing issues of self-neglect. The SAB is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly. Intervention in self neglect often depends on assessment of mental capacity, as people who have capacity are entitled to make choices for themselves. Interventions that work tend to be based on multi agency multi disciplinary assessments and include building of trusting relationships, consensus and persuasion, and practical support with daily living. Monitoring should focus on outcomes, not only on services provided. In most instances, concerns about self neglect are best supported by the agency responsible for the person's needs, whether they are environmental health, housing, physical health, mental health or other needs. The person should always be at the centre of any decisions made to support them. A safeguarding concern must be made in situations of severe self neglect where here is high risk and it is proportionate to do so – for example where there is no clear lead agency. The role of a safeguarding enquiry in this instance will be to coordinate a multi agency forum to share information, assess risk and establish a lead agency to work with the person concerned.

Information about self neglect can be found at:
http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care

1.5 Prevent

Channel is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorist-related activity. The process forms a key part of the Government's Prevent Strategy. The process provides a mechanism for safeguarding vulnerable individuals by assessing the nature and extent of the potential risk they face before they become involved in criminal activity and, where necessary, provide a support package tailored to an individual's needs. Terrorism is a very real threat to all our communities and terrorists seek to exploit those who are most vulnerable. That is why it is vital that we all work together to support those who are at risk of radicalisation – regardless of faith, ethnicity or background. All Channel referrals undergo a screening process and vulnerability and risk preliminary assessment. Those appropriate for Channel will be referred for assessment by a multi-agency panel which decides how best to support the vulnerability. For further information see the NHS England Protocol for Prevent Referrals.

Information about Prevent and counter terrorism can be found at:
https://www.gov.uk/government/publications/2010-to-2015-government-policy-counter-terrorism/2010-to-2015-government-policy-counter-terrorism

1.6 Deprivation of Liberty Safeguards

Since the decision of the Supreme Court in *P v Cheshire West and Chester Council (& Ors) and P and Q v Surrey County Council* (Cheshire West), there has been a vast increase in the number of people deprived of their liberty by the state. The increase has been ten fold across the country, and there has been a raft of associated guidance and new forms developed. The Law Commission are reviewing the legislation with a consultation starting July 2015. Please see section 4 for details on local activity under DoLS.

The Law Society has issued comprehensive guidance on the law relating to the deprivation of liberty safeguards. The guidance was commissioned by the Department of Health and aims to help solicitors and frontline health and social care professionals identify when a deprivation of liberty may be occurring in a number of health and care settings. The guidance provides a summary of 27 deprivation of liberty legal cases, including seven it advises should not be followed, in a bid to help social workers, best interest assessors and other professionals comply with the landmark Supreme Court ruling. For further information please see: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty

The Social Care Institute for Excellence (SCIE) launched a new online MCA directory in February 2015. The directory is a repository of MCA materials; guidance, tool-kits and information leaflets. Information is accessible for all sectors. For information please see: http://www.scie.org.uk/mca-directory

2. The work of the Safeguarding Adults Board in Bedford Borough and Central Bedfordshire

2.1 An Overview of Safeguarding Improvement Work in 2014/15

In January 2014 a task and finish group of the safeguarding board was set up to review the LGA safeguarding standards and develop a template for partners to review their safeguarding arrangements and those of the Board.

Partners were requested to complete the template to inform their action planning and provide a summary of strengths and areas for development for the Board.

The most common strengths and areas for improvement across the partnership have been summarised below:

Strengths

- Comprehensive safeguarding policies in place within organisations
- Designated safeguarding leads
- Senior management representation at Safeguarding Board
- Comprehensive record keeping by partners about safeguarding alerts
- Established training programmes in place
- Safeguarding policies and processes understood and embedded across all agencies
- Partners hold each other to account through the Board
- Community views are represented in organisations
- Partners have established action plans for safeguarding
- Partners are able to respond to changes in processes
- Awareness raising carried out by all partners

Areas for Development

- Training – for all volunteer, operational, front line staff and managers; use of competency frameworks; ensure consistency; centralised list of available training
- Review and update of policies and procedures
- Mental Capacity Act and DoLS – training and awareness, recording and documentation
- Using internal data to better understand themes and trends
- Development of public information
- Awareness raising within the wider community beyond the partnership
- Improve and strengthen the links with the Local Safeguarding Children's Board
- Consideration to be given to a Multi Agency Safeguarding Hub
- Ensure clear referral pathways between partners
- Domestic Abuse awareness raising and greater understanding of relationship to safeguarding adults
- Expand methods used to support adults at risk to keep themselves safe
- Improvement in use of advocacy support for adults at risk

The SAB has developed a three year vision and strategic plan 2014-2017. This outlines the Board's vision and strategic plan which in turn provides direction and continuity to the business plans of each local authority. The business plan ensures that the achievements of the board are built on year on year and that the achievements drive forward improvements in the safeguarding of vulnerable people. The SAB's strategic objectives are in line with the national priorities and can be found at the back of this report.

In November 2014 the SAB held a development day for the Board. This included guest speakers on key issues such as Prevent, CSE and Self Neglect. The interactive sessions in the afternoon focused on data collection and reporting, focusing on what works and what does not. This informed a review of data and reporting to the operational sub group and the board. This led to proposals for membership, reporting and governance arrangements following implementation of the Care Act being approved in June 2015.

The SAB has adopted a joint protocol between Central Bedfordshire Local Safeguarding Children Board, Central Bedfordshire Health and Wellbeing Board, Central Bedfordshire Children's Trust and Central Bedfordshire Community Safety Partnership. Bedford Borough Council operates the same principles for shared priorities, responsibilities and information sharing with the Bedford LSCB, CSP and Health and Well Being Board and shares a number of common statutory partners. The Bedford Borough partnership boards operate a separate protocol which addresses local shared priorities, responsibilities and information sharing. The two protocols are complementary and have received inter-authority approval. The protocol sets out the expectations of the relationship and working arrangements between the above listed partnerships. It covers their respective roles and functions, membership of the partnerships, arrangements for challenge, oversight scrutiny and performance management. The chairs of the various partnerships have endorsed this document.

2.2 Prevention and raising awareness

- Two meetings of a pilot housing provider sub group which brought together housing providers and mental health services, and has led to this being formally created in the coming year
- Development of safeguarding chapters within the areas Joint Strategic Needs Analyses
- Briefings on the Care Act for Council members, care providers, community safety partnership and the SAB member organisations
- Attendance at provider forums to raise awareness of developments in safeguarding and DoLS
- Awareness raising visits to re-ablement services, day centres and tenants forums, care homes and voluntary groups
- Link work with trading standards including a joint visit to vulnerable adults
- Council-wide mail-out including safeguarding easy-read leaflet and awareness campaign focusing on the changes within the Care Act
- Meetings held on an individual basis with providers where issue have been identified to offer support with improving safeguarding practice
- Providers forums held including a Care Quality Commission led forum on Inspections and Ratings

2.3 Workforce development and accountability

- Review and re-commissioning of training in light of Care Act and MSP
- Ongoing development work with frontline teams including practice surgeries and workshops
- Training and development for BIAs, S12s doctors, signatories and staff on DoLS
- Involvement in Care Act implementation to ensure safeguarding element is understood and communicated
- Meetings held with team managers and seniors on a quarterly basis to update on safeguarding practice and issues, share learning from audits and look at areas of development.
- Task group set up to review safeguarding paperwork to ensure it is aligned to the principals of Making Safeguarding Personal and Care Act Compliant.
- Briefings held with team managers and seniors on the Care Act 2014 and safeguarding.
- Presentation and briefing paper compiled on the changes in safeguarding processes as a result of the care Act 2014, emailed to all provider, partner agencies and teams.

2.4 Partnership working

- Working across Bedfordshire and Luton as part of the Hate Crime partnership – development of a strategy and formation of a new disability related harassment sub group chaired by the disability resource centre.
- Regular meetings with Local Safeguarding Children's Board managers to ensure joined up approach on areas such as Child Sexual Exploitation, modern slavery, domestic abuse and drug and alcohol use.
- Multi agency workshop across health and social care on serious incidents policy and protocol
- Pan Bedfordshire review of the SAB sub group meetings – resulting in new training and case review sub groups
- Pan Bedfordshire alert form amended to incorporate Care Act developments
- Joint work with the Ambulance Trust to reduce and divert alerts made by the Trust
- Multi agency SAB sub group review of the safeguarding policies and procedures in light of the Care Act
- Engagement with the Eastern region Safeguarding Leads group
- Continued engagement with MARAC (multi agency risk assessment conference), SARAC (sexual abuse risk assessment conference) and ASBRAC (anti social behaviour risk assessment conference) Safer Community and Community Safety Partnership Board meetings
- Quarterly information sharing meetings with CQC
- Commitment to set up regular safeguarding meetings with the police and develop shared training events

- In conjunction with Central Bedfordshire, Bedford Hospital, Luton and Dunstable Hospital, Bedfordshire CCG and advocacy procedures were agreed for effectively managing safeguarding investigations within the hospital settings when expert clinical knowledge is required. This has been incorporated into the revised Multi Agency policy and Procedures.
- Regular meetings with the Mental Health Trust to review cases, data and conduct audits

2.5 Quality Assurance and protection

2.5.1 Both Councils are committed to a continued programme of auditing safeguarding activity. Bedford Borough has undertaken two audits throughout the year. An independent audit took place in May 2014 where twelve Bedford Borough Council cases were selected at random. This was followed by an internal audit of ten Bedford Borough Council cases in December 2014, which was supported by the outgoing external auditor(who has undertaken audits within Bedford Borough Council for the last 6 years).The outcomes of the audit were as follows

2.5.2 May 2014

- **One** case was **adequate**
- **Eight** cases were **good**
- **Three** cases were **excellent**

2.5.3 Strengths identified were

- Threshold decisions safe, secure, analytical
- Strategy discussions of a high standard of professional practice
- Mental Capacity Assessments documenting high standards of practice
- Service users exercising choice and control over how safeguarding needs were met
- Initial risk assessments, protection plans and closing reports of a high standard

2.5.4 Area for Development identified

- Case conferences to have a clear conclusion and rationale for reaching the conclusion
- Scope for investigations to be delegated to providers
- More attention to checking with adult at risk that their outcomes have been achieved
- Safeguarding paperwork to include prompts to include the outcomes the adult at risk wants and risk and protective factors
- More emphasis on service user feedback
- Protocol to be developed to cover the interface between hospitals complaints procedure and safeguarding processes
- Protocol to be developed to cover hospital and clinical investigations where complex decisions have to be made about nursing or medial practice
- Review safeguarding threshold and consider the potential for a wider range of pathways and levels of response

2.5.5 December 2014

- **Two** cases were **adequate**
- **Eight** cases were **good**

2.5.6 In relation to the cases audited no significant issues of concern were found and practice was deemed to be safe. The auditor examined the internal judgements in conjunction with some (but not all) of the case recording. This allowed the auditor to reach an independent view about the validity, reliability and safety of the internal audit judgements and to strengthen the capacity for robust internal audit within Bedford Borough Council, and provide consultancy and coaching around the practice of case file auditing. The auditor commented that the internal audit was carried out with 'great care, precision, and a determination to demonstrate an evidence based approach to the case work judgements.

2.5.7 The auditor found the judgements to be safe and reliable and was confident that Bedford Borough Council had the 'analytical skills and knowledge to make sound judgements in the future and to carry out audits in a competent and robust way'. Recommendations included ongoing internal in-depth audits (as distinct from the brief audit at case closure), this to include team managers and advanced practitioners. To ensure future methodology is aligned to Making Safeguarding personal and to commission an external audit on an annual basis. Areas for development in relation to the cases graded at adequate included strengthening of management oversight to ensure momentum and focus with case and that closing reports were completed, better application and consideration of the Mental Capacity Act and better promotion of the individual in the processes with clarity of their views, preferences and desired outcomes.

2.5.8 As part of the 2014/15 Bedford Borough Council Financial Internal Audit Plan, an audit of the safeguarding team has been carried out. The purpose of the audit was to review and test the effectiveness of controls established by management in the following areas to help mitigate the risk in relation to key council or service objectives.

- Governance and legislation
- Policy and procedures
- Safeguarding alerts
- Risk management
- Performance monitoring

2.5.8 The outcome of the audit was 'that the appropriate assessment of control in relation to this audit at this present time is '**substantial assurance'** There was one recommendation to review the current arrangements with the independent consultant who has undertaken recent auditing of safeguarding cases to ensure independency and objectivity is maintained. The next planned audit involving an independent consultant to review safeguarding cases will take on board the recommendations to engage an alternative independent auditor. On completion of all safeguarding cases, the team manager or advanced practitioner undertakes an internal audit using the Bedford Borough audit tool. This allows feedback to be given to the individual worker regarding good practice and area to develop.

2.5.9 Central Bedfordshire Council has undertaken a continuous programme of audits throughout the year with regular case file audits and focused audits on areas for development. 48 case file audits were undertaken of which 16 related to the Mental Health Trust – the themes are outlined below. 60% of cases audited were good or excellent, meaning 40% of cases were adequate or poor. This is a reflection of the Council's emphasis on Making Safeguarding Personal; meaning that good evidence of person centred working is required for a case to be good, regardless of adherence to procedures or timescales.

2.5.10 9 Case files were audited as excellent

- Well planned, documented and evidenced decision making

- Multiagency approach
- Visits with a professional independent advocate present
- Evidences very clear actions and outcomes
- Personalised approach and use of evaluation tools - person's views clear throughout including difficulties with communication.
- All aspects immediately recognised and protective measures implemented.
- Risk assessments are holistic and identify future potential concerns which have been addressed in the protection plan.

2.5.11 20 case files were audited as good

- Good managerial oversight and strategy discussion
- Good working with families and engagement
- Recognised and linked to wider concerns regarding provider
- Good evidence of multi agency working and information sharing.
- Good risk assessment and analysis of safeguarding issues, holistic and person centred
- An area for improvement to evidence that 'lessons learnt' have been thoroughly disseminated.
- Some time delays which did not impact the outcome but may have been avoidable
- Cases may not have required such a robust investigation the actual incident appeared low impact but distressed family members significantly.

2.5.12 13 case files were audited as adequate

- Person safeguarded and good care management
- Detailed assessment of risk and protection planning in case conference not reflected in documentation
- Risk assessment and protection plan basic and lacked analysis, hard to locate documents.
- Profile notes and strategy discussions do not reflect progress of case
- Concern that risk assessment did not include clinical issues and therefore was not a holistic working document
- Limited evidence of involvement of person or family despite this being an action recorded from strategy discussion and a basic requirement in safeguarding investigations
- Protection plan and managerial oversight may have been better, and may have helped coordination and prevention of "drift"
- Limited evidence of communication across multiagency partnership
- Limited person centred working, not clear at strategy and case conference in the management of risk.
- Difficult to comment on strengths beyond the actions to safeguard the client.

2.5.13 6 case files were audited as poor

- Poor timeliness of response and unexplained delay.
- Poor recording in terms of who completed it and what the outcome was.
- Limited understanding or implementation of the Mental Capacity Act
- Risk assessment is not relevant to the safeguarding concern

- Initial safeguarding concern was not considered. Protection plan reflected the needs of the home not the person.
- No evidence of family involvement when family have raised concerns
- No strategy discussion / meeting following initial visit which would have provided focus
- Unable to access case conference minutes or investigation summary.
- Same alert raised less than three weeks after this investigation ended which would demonstrate that issues were not addressed
- Investigation summary does not reflect the outcomes in relation to the concerns raised.

2.5.14 In all cases involving poor audits, assurances are made that the person is safeguarded. In three of these cases the person concerned had moved to a new care home and in the other three no immediate safeguarding actions were required. However it is notable that poor communication is a theme throughout these cases and three cases have resulted in a complaint being made by family members. All poor case file audits are escalated to the Head of Service responsible for that team. Two of the poor audits relate to the same case and worker which was re-audited following an initial audit of poor. The worker concerned has been supported to improve their practice through the Council's formal capability HR process.

2.5.15 Both Councils have undertaken the following activity to reinforce quality assurance activity:

- Both Councils are signed up to Making Safeguarding Personal which has included briefings to staff , dissemination of information and tools, and review of safeguarding paperwork to ensure the views, wishes and opinions of the individual are captured and acted upon. We have undertaken an MSP stocktake undertaken to inform development of work in 2015-16
- Reviews have been undertaken of internal processes within the safeguarding teams to effectively manage the high volume of contacts and ensure a proportionate and most appropriate response to safeguarding concerns.
- Both Councils have undertaken ongoing reviews and audits of Mental Capacity Assessments and feedback to workers.
- Both Councils undertake ongoing audits of Deprivation of Liberty Best Interest Assessments, to ensure a quality and robust assessment in line with legislation. Feedback given to assessors including commissioned independent assessors and section 12 Doctors.
- Bedford Borough Risk Enablement panel meets regularly to consider complex cases and consider further support mechanisms.
- Both Councils hold regular meetings with managers of front line teams to ensure updated on Care Act, MSP and good practice in safeguarding
- Staff development and practice surgeries have focused on MSP and person centred risk assessment, and the link between risk assessment and protection plans
- Focused safeguarding audits on specific parts of the safeguarding process such as risk assessment, personalisation and report writing

2.5.16 Quality of Care and Support

- The Safeguarding teams work closely with the contacts monitoring and care standards teams and meet on a regular basis to share information relating to standards of care delivery and to agree if any monitoring or safeguarding action is required.
- Throughout the year the safeguarding teams and contacts monitoring and care standards teams have undertaken several joint visits as a result of whistle blowing information, to establish the validity of the concerns and assess what action may be needed such as action plans or safeguarding action.
- The contacts monitoring and care standards teams have undertaken a programme of planned and unplanned quality assurance visits and assessments to providers, to ensure that home care agencies and care homes are complying with the Multi Agency Safeguarding Procedures.

- The contacts monitoring and care standards teams have updated their Benchmark Standards for registered providers in line with the Care Quality methodology
- The contacts monitoring and care standards teams have worked in conjunction with the Clinical Commissioning Group Care Homes Lead Pharmacist and Deputy Head of Medicines and Complex Care Team with initiatives to improve the administration of medicine within care homes, extra care housing and domiciliary agencies, including guidance on polices and initiatives for local pharmacists to complete MAR sheets.
- Regular meetings are held with the Safeguarding Teams, contacts monitoring and care standards teams and the Care Quality Commission to share information and determine any local action.
- A Winterbourne Joint Steering Group attended by managers at a senior level from both Councils and the CCG has been put in place a robust action plan which included reviewing and monitoring placements. This has been audited by the Joint Improvement Programme to build on agreed plans.
- Regular meetings are held with the Clinical Commissioning Group safeguarding lead to share information on safeguarding and services giving concern.

2.6 Involving people and empowerment

- Regular meetings with POHWER to link in with the Voice groups
- Host of Making Safeguarding Personal regional event
- Ongoing promotion of the "network" or "circle of support" or working with the family including the role of the carer
- Promotion of paper based mechanism to record outcomes to promote person centred working
- Development of best practice examples for practitioners
- Development of multi agency guidance for safeguarding meetings to ensure person is at the centre
- "Back to basics'' approach to making safeguarding personal
- Review of "planning a personalised response " training

2.7 Outcomes, improving people's experience and proportionality

- Development of the role of the safeguarding teams to produce a more proportionate risk based response in line with the Care Act
- Focus on outcomes in decision making and the views of the individual, particularly in the responses of the safeguarding teams
- Review of the critical stages in the safeguarding process to ensure the safeguarding team's expertise is fully utilised
- Focus on other investigatory methods to ensure other processes such as complaints and employer investigations are fully considered before implementing safeguarding enquiries

2.8 Use of the Serious Concerns Process

2.8.1 The purpose of the Serious Concerns Procedure is to adopt a consistent and proportionate response when serious noncompliance with minimum standards is raised about a care provider.

2.8.2 Central Bedfordshire Council initiated the serious concerns procedure in the case of three care homes during 2014-15. Activity under this procedure included instigating an embargo on all new admissions to the homes, visiting all residents within the homes to review their care and support, meeting with residents, staff and families to hear their views, and implementing an action plan for improvement. All homes concerned have returned to admitting residents following significant improvements after this process. The following themes were highlighted during these processes:

- Return from respite/ admission to hospital in poor physical condition
- Failure to respond to complaints or concerns about care
- Poor nursing knowledge
- Misuse of sedative medication
- Poor care planning, monitoring of food and fluids and weight loss
- Not adhering to SALT and dietician assessment advice
- Lack of dignity – inaccessible call bell, poor/ dirty environment, people left in bed
- Quality of assessment in relation to discharge from hospital into the home
- Quality of care planning and communication within the home
- Availability of information for new and agency staff to support care provision

2.8.3 Bedford Borough Council implemented the serious concerns procedure for one care home in June 2014. This care home had previously subject to the borough serious concerns procedure in September 2012 to June 2013. The decision was taken in conjunction with the Care Quality Commission to utilise the serious concerns procedure for this provider, when despite intensive support provided to the home by the Care Standards and Review team and the Complex care team, the home was unable to provide a good standard of nursing care including the management and administration of medication and skin integrity in the unit providing nursing care. All nursing care residents were moved to alternative placements. An embargo was placed on the home admitting new residents, an action plan implemented and the home agreed to cease providing nursing care.

2.8.4 The home was re-inspected by the Care quality Commission and found to be compliant, and with support from the Care standards team and Complex care team the suspension on placements was lifted with agreements on how many new residents could be admitted and at what pace. The home has agreed that they will only provide residential care. In February 2015 it was agreed that the home had made improvements to the level where they no longer needed to be monitored under the Serious Concerns Procedure.

2.9 Serious Case Reviews

2.9.1 The purpose of a serious Case Review is to establish the lessons learnt from a case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults at risk. It is used to identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result. As a consequence the outcomes are to improve inter-agency working and better safeguards and promote the welfare of adults at risk. From April 1st 2015 Serious Case Reviews will be replaced with Safeguarding Adults Reviews under the changes brought in by the Care Act 2014. The Safeguarding Adult Board must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2.9.2 Central Bedfordshire Council held one serious case review this year. Mr. A died on 4th November 2013. He was 85 years old. The cause of death was described as Renal Impairment, Urinary Outlet Obstruction and Faecal Impaction and Resolving Pneumonia. His health had deteriorated markedly in the five week period prior to this during which time he had been admitted for planned respite support to a care home, discharged home, been admitted to a residential care home with nursing care and finally transferred to another residential care home where he eventually died.

2.9.3 He had been in regular contact with Central Bedfordshire Council Adult Social Care Services since 2012. Increasing levels of support had been offered to Mr. A and his carers, those being his son and daughter–in-law. This support increased over time to include home care, to assist with getting him up, day care and periods of respite care in a residential care home.

2.9.4 Mr. A's family expressed concern about the quality of care at both the first and second care homes he stayed at during September and October 2013. They were particularly critical of the care he received at the second of these. A report by the manager of the third home Mr. A stayed at also expressed concern about his care at that home and prompted the initiation of a safeguarding alert to Central Bedfordshire Safeguarding Team. As part of that process there was a criminal investigation by Bedfordshire Police which found that there was no evidence of wilful neglect.

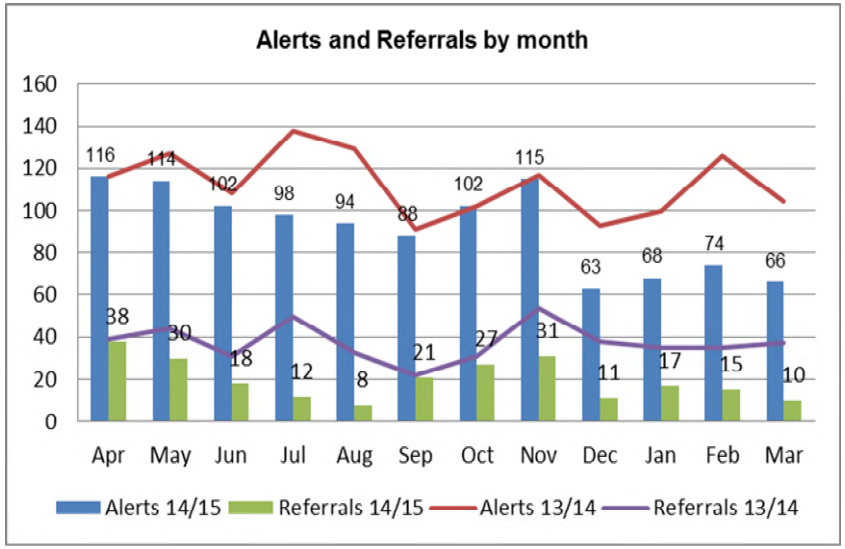
2.9.5 A serious case review was conducted and resulted in 16 recommendations for the partnership, which formed part of an action plan that has been kept under review by the SAB. The report concluded that Mr. A did not receive the coordinated care he had a right to expect. To address the shortcomings identified, the Individual Management Reviews have recommended improvements to their respective agencies practice, policies and procedures. There has also been a considerable focus on the care home both by the Care Quality Commission and Central Bedfordshire Council Contracts Monitoring Team who both suspended new admissions to the home under the serious concerns procedure and required improvements as a condition. Significant improvements have since been made at this home and it has been taken over by a new provider.

2.9.6 There have been no adult Serious Case Reviews undertaken by Bedford Borough Council for 2014-2015.

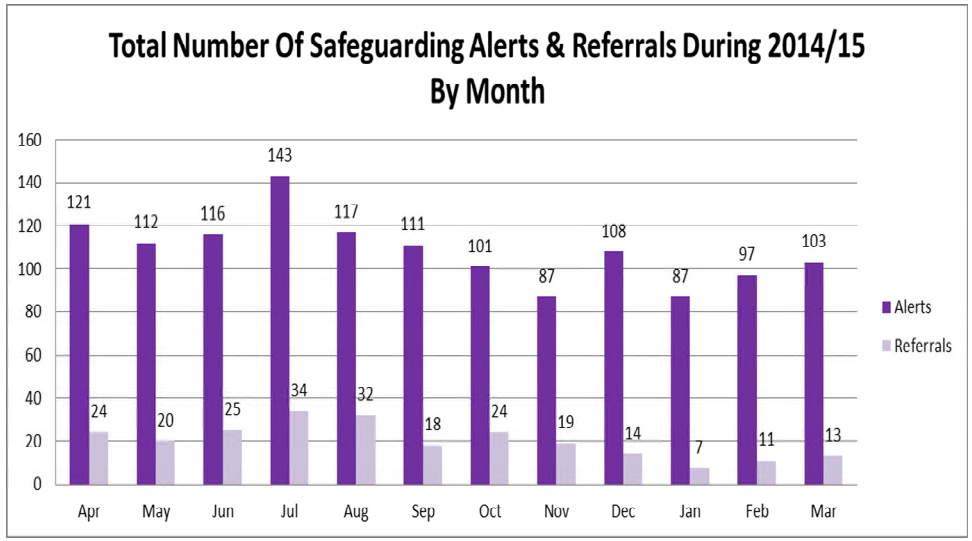
3. Safeguarding Activity April 2014 – March 2015

3.0 Number of alerts and referrals

Central Bedfordshire



Bedford Borough Council



3.0.1 An adult safeguarding alert is the term used, to describe the reporting of suspicions or allegations of abuse, maltreatment or neglect. An adult safeguarding referral is a referral for a safeguarding investigation.

3.0.2 Central Bedfordshire Council received 1,100 alerts during the year, a decrease of 251 from the previous year. 238 alerts progressed to investigation, 22% of the total alerts, which is a decrease from the previous year (33%). This is as a consequence of the external case file audit which prompted the Council to review its use of the safeguarding process and ensure that decisions made to initiate the process were proportionate. In addition to the safeguarding activity, there were 675 contacts made to the safeguarding team, which were not treated as safeguarding alerts as no abuse or neglect was alleged. This made total activity during the year 1,775 contacts. Discussion has been held within the multi agency partnership about the volume of contacts to the safeguarding teams. It has been agreed that while potentially not a safeguarding concern at the point of information being shared, this may be useful intelligence about a vulnerable person and that the safeguarding teams are able to provide a point of contact for this information. Nonetheless, there is still a need to clarify professional referral routes for vulnerable people to receive an assessment of need as the level of contacts does indicate the safeguarding teams are being used as an access route for referral and assessment services.

3.0.3 Central Bedfordshire Council put in place a risk based system to manage the volume of contacts in 2013, which means that the safeguarding data over two years has stabilised, leading to very little change in reporting patterns from the reporting year 2013-2014 and the current reporting year. As reported in previous years, there continues to be a downward trend in the number of alerts and referrals received

3.0.4 Bedford Borough Council received a total of 2038 contacts for 2014- 2015, which includes all safeguarding alerts, information sharing reports, referrals for social care or care management activity/involvement and concerns received by the team. This is an increase of 209 from 2013 – 2014 when 1,829 were

received. Out of the 2038 contacts 1,306 were progressed to a safeguarding response and 241 led to a safeguarding referral/investigation, and 735 were of information nature, community care referral or not a safeguarding concern.

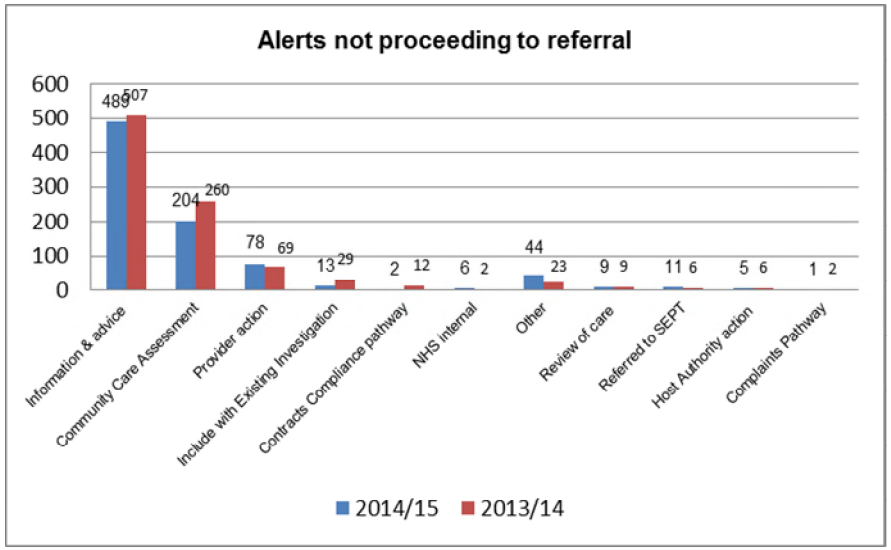
3.0.5 This is the 6th year that Bedford Borough has seen continued increases in the number of contacts received by the team. During 2014-15 the total number of Bedford Borough Council alerts which progressed to referral were 241 which equates to 19% of alerts received, which is down 7% based on the 2013-14 conversion rate. The decrease in the number of alerts progressing to a referral is reflective of the approach the team has taken in ensuring a proportionate response to achieve the best outcome for the individual other than through a safeguarding investigation . This can include care management involvement and action, a provider internal investigation and review and reassessment of services provided.

3.0.6 In the 2013 – 2014 Safeguarding Annual Report, Bedford Borough commented that it had significantly higher amounts of safeguarding alerts per 10000,00 of the population as reported in The Vulnerable Adults Comparator Report 2012/13, than any other local authority in the comparator group. The disproportionately high level of alerts was attributed to Bedford Boroughs policy of recording all contacts received by the team as safeguarding alerts, it was identified that work needed to be done to look at different ways of managing the levels of contacts and alerts received by the team, and re directing concerns that were not a safeguarding nature. The decrease in actual safeguarding alerts for 2014 -2015 from 1,829 in 2013 -2014 to 1,306 demonstrates the difference in approach where concerns did not indicate abuse or potential abuse. These concerns were managed through different routes such as passing information on the relevant social care team/agency, forwarding referrals to appropriate teams, advising providers to use their HR processes and complaints processes, actions for providers to review support plans or re directing to the Bedford Borough commission team or Care Standards and Review team. A combined approach of more robust screening of safeguarding alerts at the point of receiving, and a more proportionate response to safeguarding alerts progressing to referral, will account for the decrease in alerts and referral for the 2014 -2015 reporting period despite the increase in safeguarding contacts received by the team.

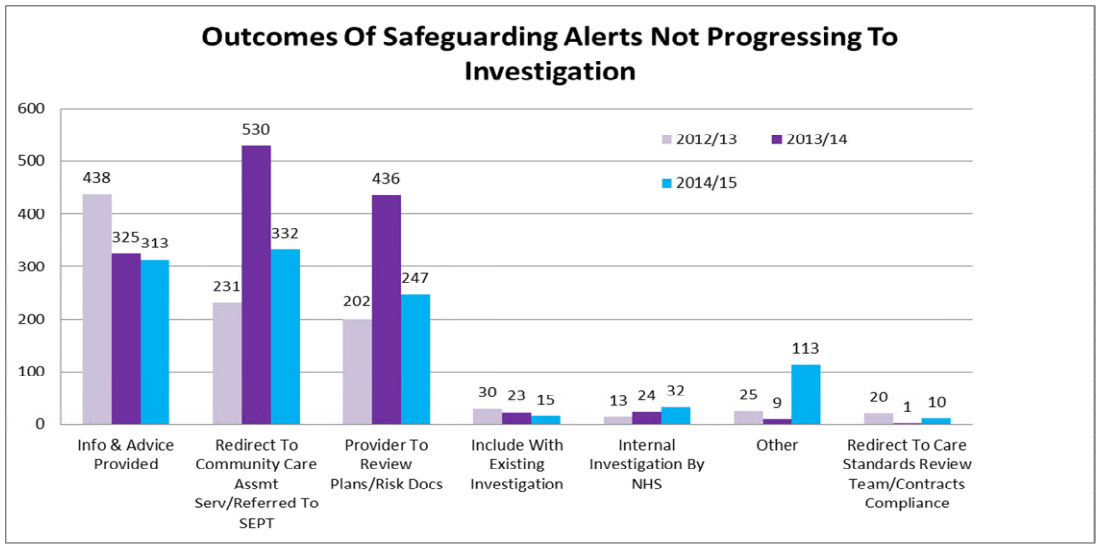
3.0.7 The Health and Social Care Information Centre has not produced a report on data for individual authorities based on the safeguarding adults return so benchmarking data is not available for 2013-2014 or 2014-2015.

3.1 Alerts not proceeding to referral (investigation)

Central Bedfordshire



Bedford Borough Council

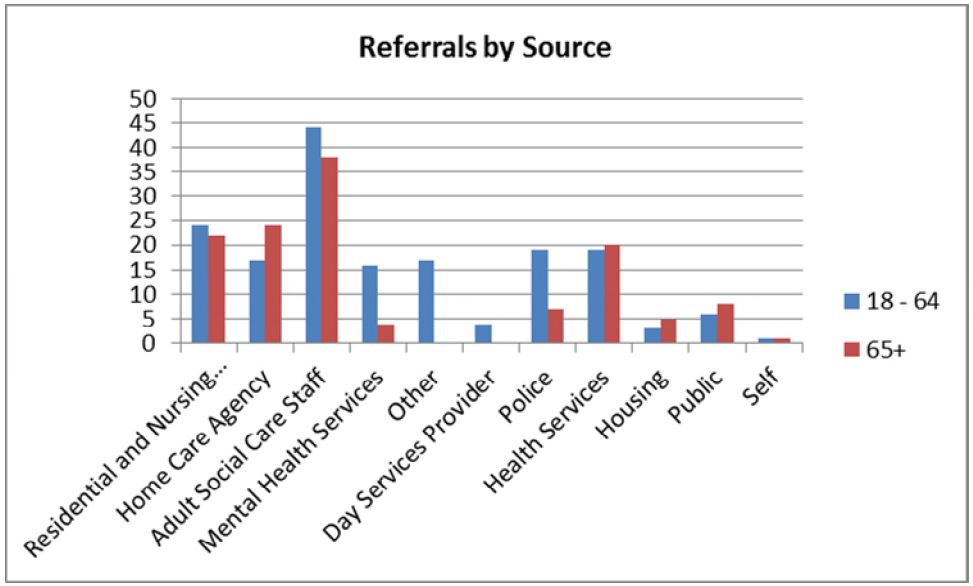


3.1.1 The number of safeguarding alerts in Central Bedfordshire not progressing to safeguarding investigation totalled 862, a decrease of 63 from the previous year. Trends overall are very similar to the previous reporting year. There is a slight increase in responses being information and advice from 54% to 57%. The proportion referred to the community assessment and care management teams for a response which has fallen slightly from 28% to 24%.

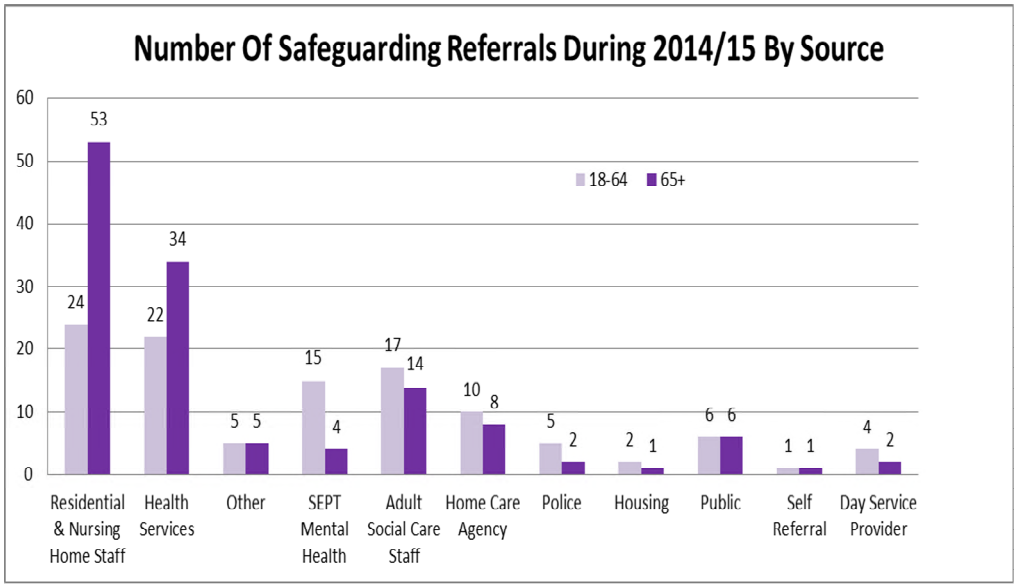
3.1.2 The number of safeguarding alerts in Bedford Borough not progressing to a safeguarding investigation equated to 1062, this is a 286 decrease from the previous reporting year. The decrease is a result of the higher numbers of contacts being made to the team where a safeguarding response is not needed. The majority of alerts not progressing to investigation are managed through information and advice and redirecting to community care teams for action and providers reviewing risk assessments and support plans, which is in line with the previous year's trends. There has been an increase in the number of responses being managed by NHS internal investigations/reports, and this is a result of joint work undertaken with Bedford hospital, the Bedfordshire Clinical Commissioning group, Central Bedfordshire Council and PoHWER, to ensure a proportionate response to concern, identification of the most appropriate route within the hospital and ensuring the person with the best clinical knowledge undertakes the piece of work.

3.2 Source of referral

Central Bedfordshire



Bedford Borough Council



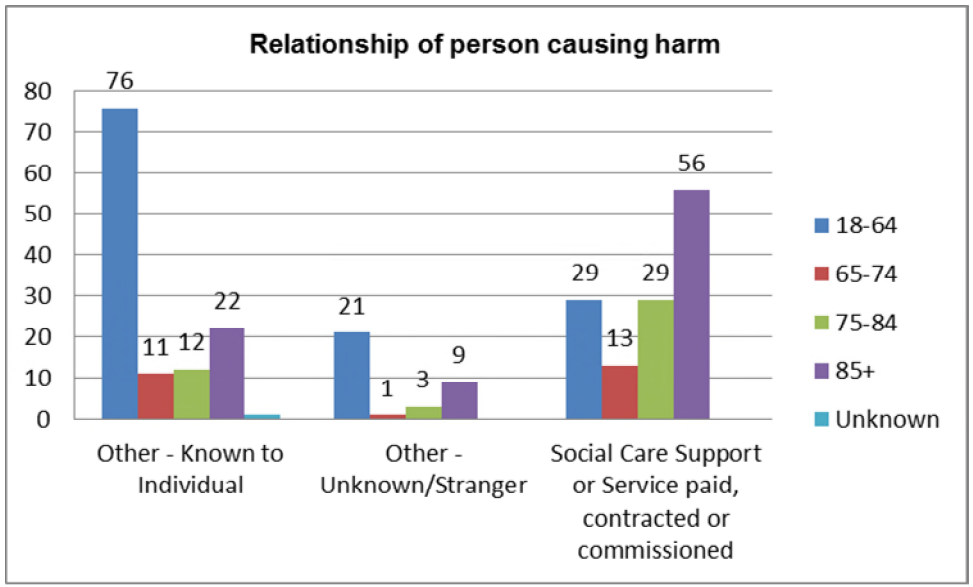
3.2.1 In Central Bedfordshire the majority of referrals relating to older people come from residential and nursing homes (20%) and health services (17%). The majority of alerts relating to people under the age of 65 come from mental health services (22%) and residential and nursing homes (16%). There are a large number of alerts from "other" categories – these are for example from the regulator, voluntary agencies, prison and probation services, which individually account for small numbers of referrals. There has been a considerable increase in referrals from adult social care staff since the previous year.

3.2.2 In Central Bedfordshire a significant figure to note is the large proportion of referrals in relation to people over the age of 65, made by primary or community health care staff. This trend was notable in the previous year's figures. It is likely that community health care workers will be those who come in to frequent contact with older people living in their own homes. Given that there has been an increase in incidents within people's own homes, it is also notable that reports by family members remain low, and have decreased from last year, meaning that safeguarding teams remain reliant upon the community professionals that work with people's homes - adult social care, domiciliary care and health services staff.

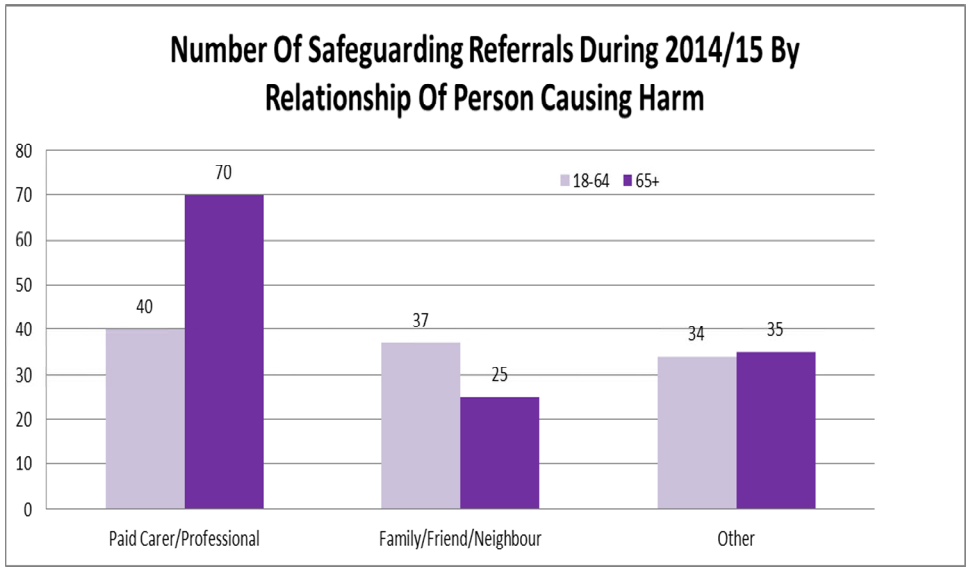
3.2.3 In Bedford Borough referrals for the Residential and Nursing Home category were the main source of referrals (taking over from Health who were the main category in the previous reporting year), with a higher proportion of alerts relate to the over 65 age group. Similarly the Health category has a higher proportion of alerts relating to the over 65 age group, but levels of referrals for this age group have reduced from 84 last year to 34 this year. The reduction is likely to be as a result of the joint work completed around ensuring the most appropriate route of dealing with concerns in the hospital is used and utilising other routes such as the complaints route, Serious Incidents procedures and internal reports. Initiatives such as the hospital discharge lounge in supporting better hospital discharges is also likely have impacted on the reduction in levels of alerts progressing to referrals.

3.3 Relationship to victim

Central Bedfordshire



Bedford Borough Council



3.3.1 In Central Bedfordshire the majority of referrals in 2014-15 relate to incidents where the person causing harm is from Social Care Support or Services paid, contracted or commissioned and accounts for 45% of all incidents, particularly for people aged 85+. This is a change from 2013-14 where most incidents involved a person known to the individual.

3.3.2 For incidents where the person causing harm is known to the individual, these generally involve working age adults and remains at the same level as 2013-14.

3.3.3 For older people, a greater proportion of incidents relate to professional or paid carers (77%) compared to the 38% known to the individual. The number cases where the person causing harm is a professional or paid carer increases as people get older.

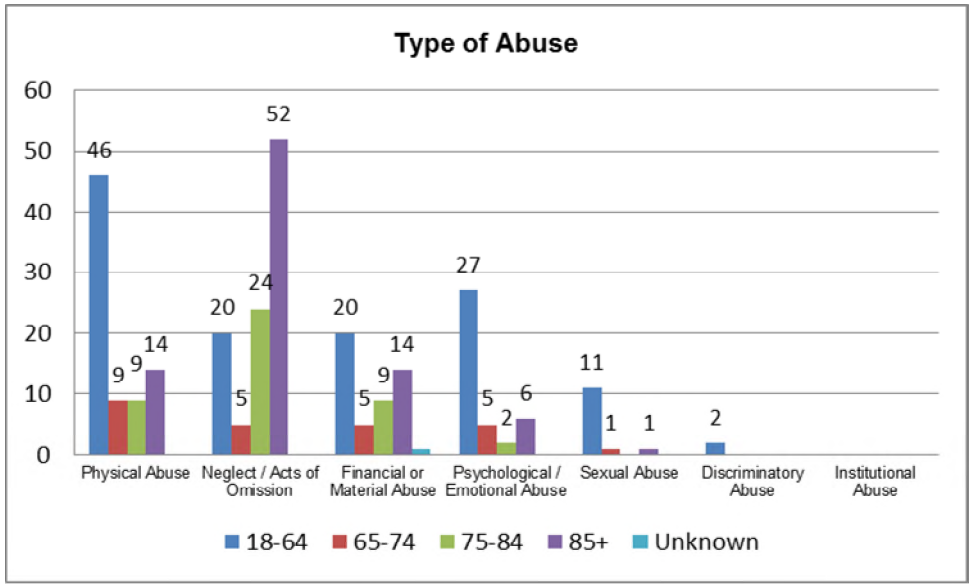
3.3.4 In Bedford Borough the category Paid Carers/Professional continues to be the main relationship between the person causing harm and the person at risk (44%). This will include staff at nursing and care homes, domiciliary care agencies and health staff. Incidents relate to acts of omission such as medication errors, missed domiciliary care call and poor care which have had a serious impact on the individual. The Bedford Borough Care Standards and Monitoring Team continue to work with registered care providers through a programme of announced and unannounced visits, to ensure standards of care are at an acceptable level and implementing action plans where standards of care are not at the required level. Last year the Care Standards team responded to 180 Quality Assurance feedback forms which they had received highlighting an issue with practice or organisation, the majority of these Quality assurance forms where not related to a safeguarding issue but where practice was not at the expected levels.

3.3.5 There continues to be a similar pattern with more people in the 18 – 64 age group being subject to abuse from friends, family and neighbours, and as more vulnerable people are supported in the community or rely on friends family and neighbours to provide support. This particularly relates to financial abuse.

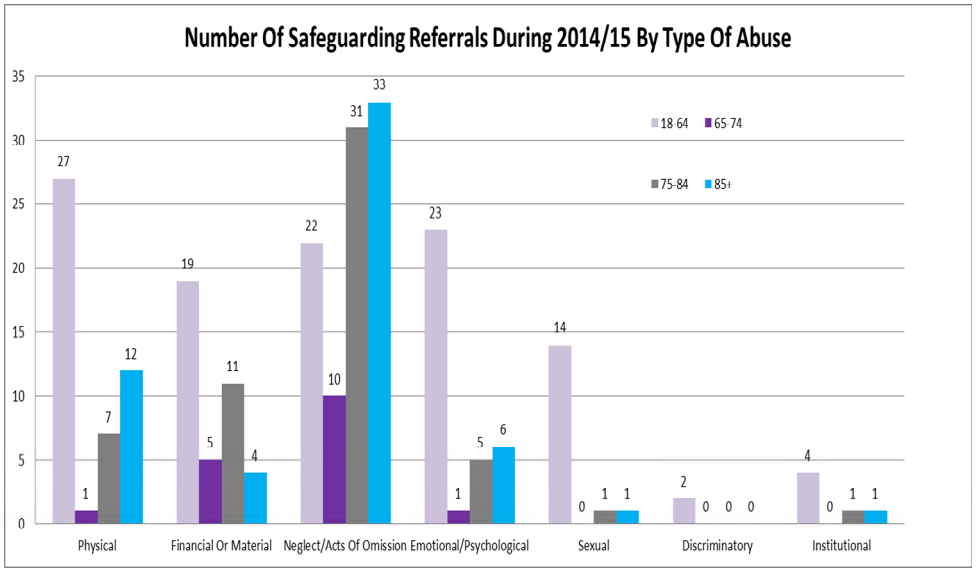
3.3.6 Within the Other group will be incidents which involve service user upon service user, these incidents tend to be within residential settings and more predominate in the 18 – 64 age group.

3.4 Types of abuse

Central Bedfordshire



Bedford Borough Council



3.4.1 In Central Bedfordshire physical abuse remains the most common type of abuse in relation to people under 65 and with neglect being the most common in relation to people over the age of 65. There continues to be a slight decrease in the number of referrals relating to physical, financial, discriminatory abuse. The proportion of referrals for neglect remains constant at 36%. No incidents of institutional abuse were reported.

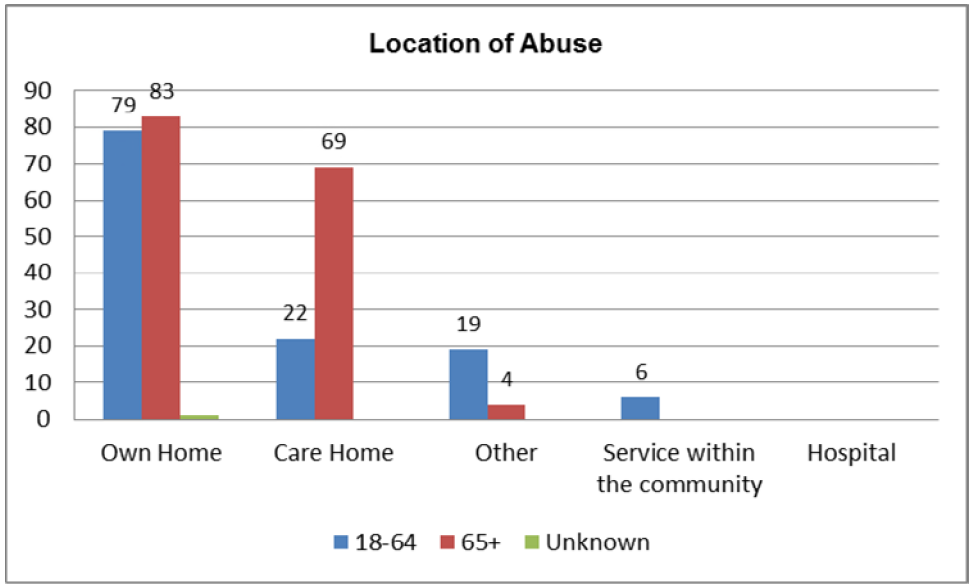
3.4.2 In Bedford Borough the trends and patterns for type of abuse remain similar with Neglects/Acts of Omission as the main category of abuse. As reported previously this will relate to serious medication error, inappropriate care or lack of care, missed domiciliary care calls and poor hospital discharge that has resulted in harm to the person. Within this category the highest proportion of referrals are for the 75 and over age group, who are most likely to be receiving support, residential care or hospital admission and highlights the vulnerability of this group.

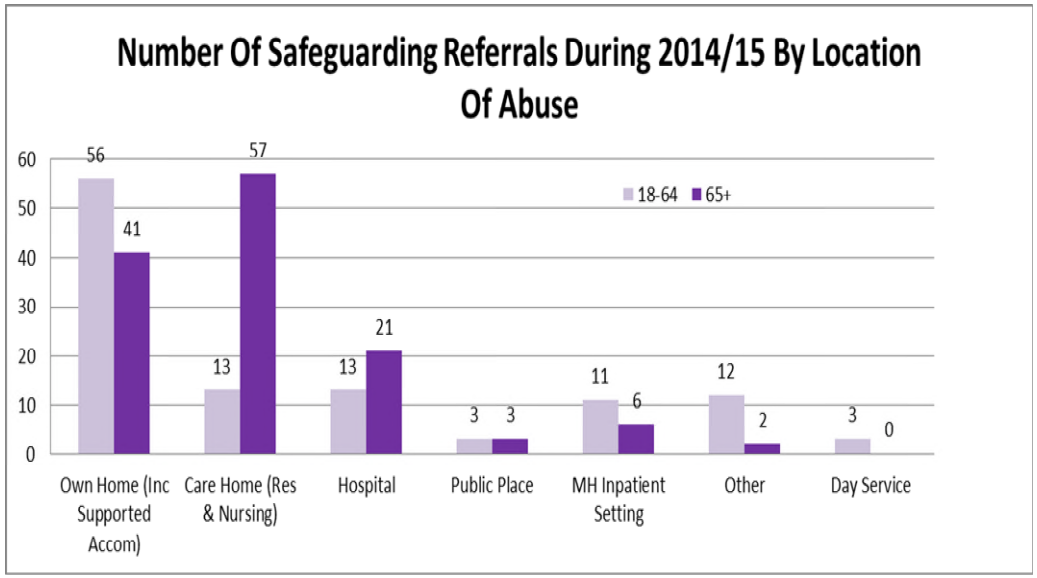
3.4.3 Financial and physical abuse categories show very similar patterns to the previous year with the 18- 64 age group being the predominate age group. Financial abuse tends to place more when the individual is living in the community and usually by someone known to the person, emphasising the importance of robust financial support plans for vulnerable individuals living in their own homes.

3.5 Location of abuse

Central Bedfordshire

Bedford Borough Council





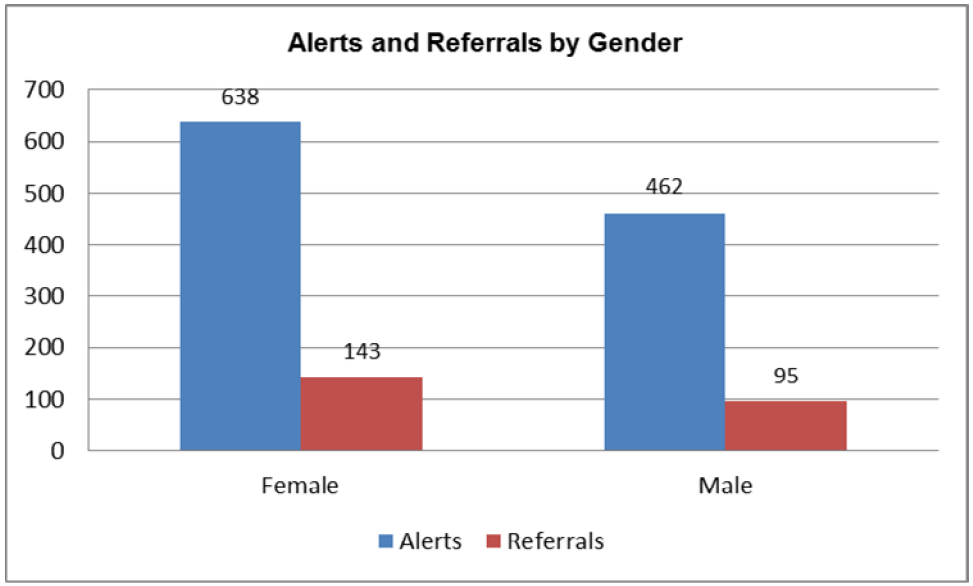
3.5.1 In Central Bedfordshire, there has been a slight increase in the proportion of incidents over the year occurring in the persons own home, from 57% in 2013-14 to 58% in 2014-15 and also a slight increase of 1% in incidents in care homes. No incidents took place in a hospital setting.

3.5.2 In Bedford Borough the highest level of safeguarding referrals relate to abuse taking place within the individuals own home by a family member or paid carer. As more care is delivered in the community in the form of supported living and extra care housing, this is an area that will need ongoing monitoring to ensure measures are in place to safeguard individuals being supported to remain in their own home, through regular reviews and financial support plans.

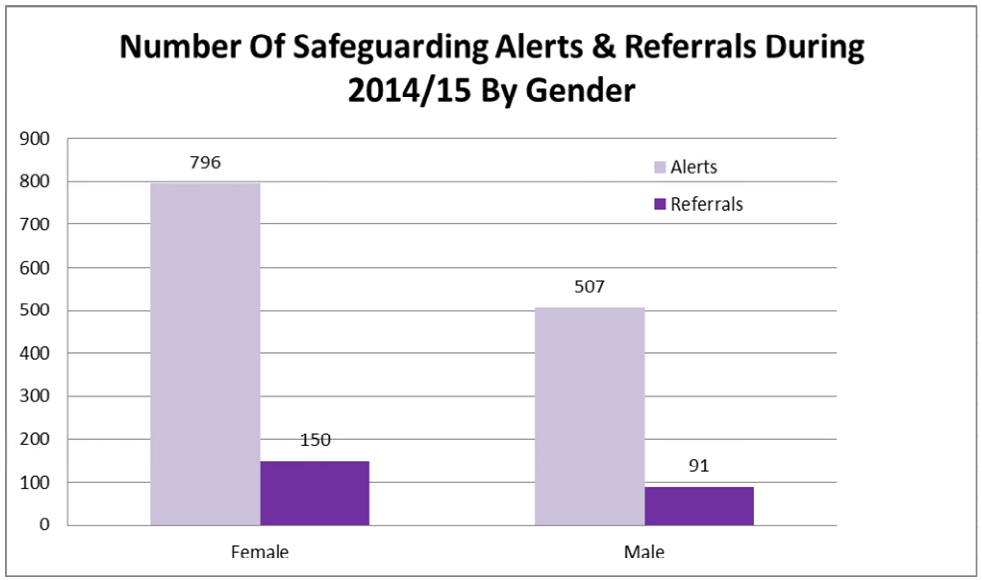
3.5.3 There has been a decrease in referrals for Care Homes (nursing and residential), for both the 18-64 age group and the 65+ age group. This is liked to be as a result of a more proportionate response being taken by the Safeguarding team and where appropriate, actions are managed through care management or the home using their complaints process, HR processes or completing an internal investigation/report.

3.6 Alerts and referrals by gender

Central Bedfordshire



Bedford Borough Council



3.6.1 In Central Bedfordshire the ratio of male to female alerts and referrals is the same as the previous year, with the majority of people at risk being female. This reflects the proportion of people using care services which are mainly female.

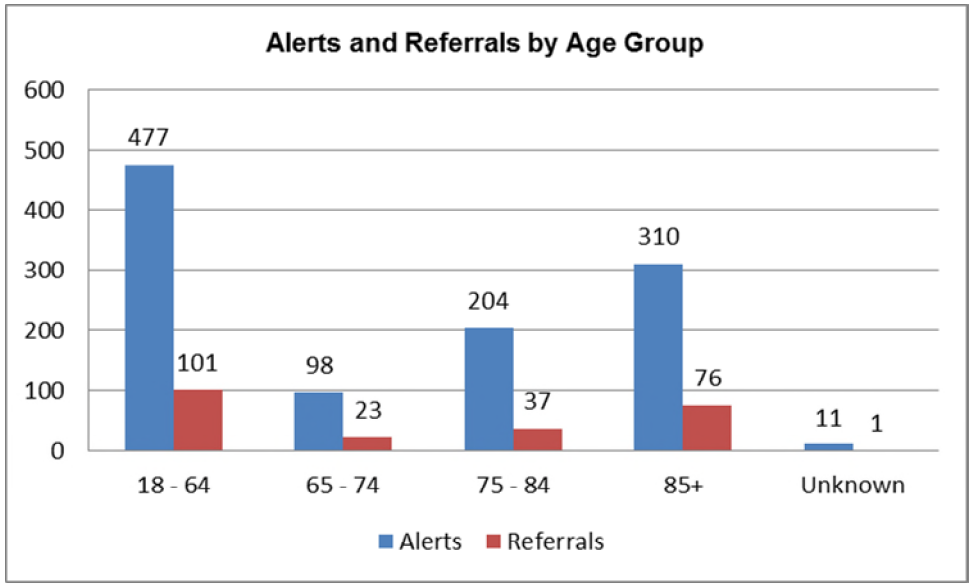
3.6.2 In Bedford Borough Council, as per previous years the larger proportion of alerts and referral relate to women. This continues to reflect the national picture of greater female life expectancy of females and a higher proportion of incidents relating to females being reported.

3.6.3 Approximately 63% of clients receiving a service from Bedford borough are female and this is replicated in the figures above. The overall numbers of alerts for both females and males has only changed marginally during the current reporting period compared to 2013/14.

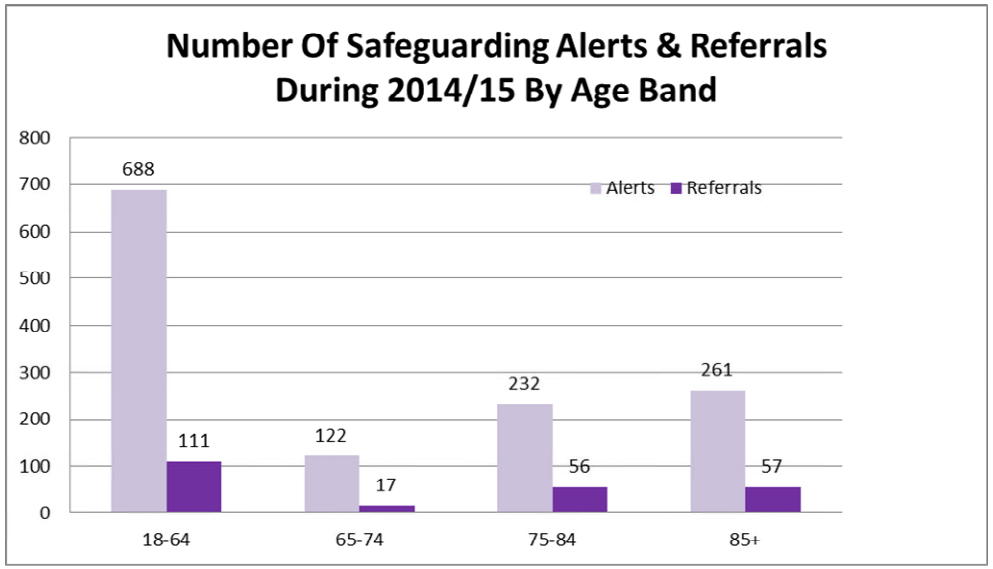
3.6.4 The percentage of alerts progressing to referrals has dropped with 19% for females and 18% for males and this compares with 35% for females and 31% for males during 2013/14. This reduction is likely to be as a result of more proportionate screening by the safeguarding team at the alert stage.

3.7 Alerts and referrals by age group

Central Bedfordshire



Bedford Borough Council



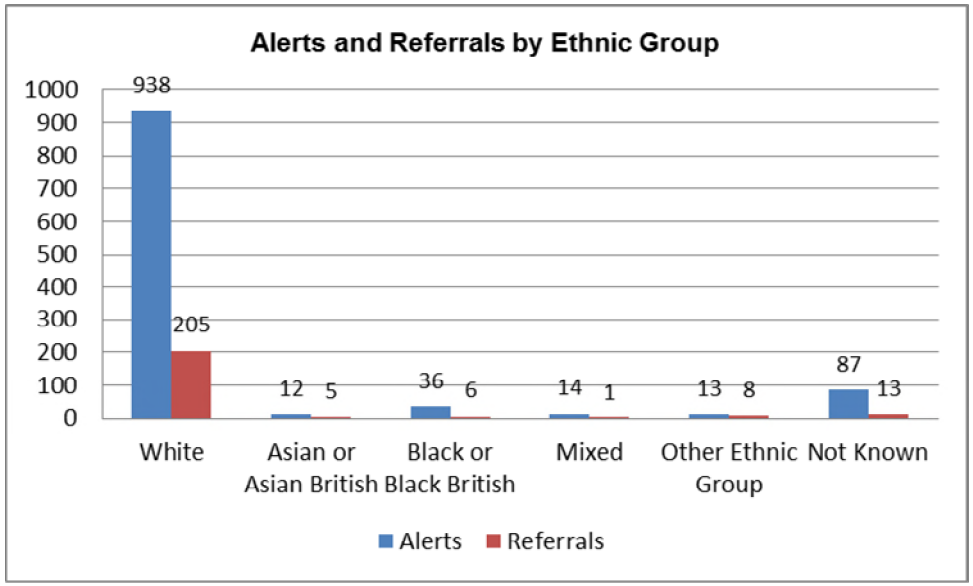
3.7.1 In Central Bedfordshire, the ratio of ages for alerts and referrals has changed slightly from previous years, with an increase in the proportion of alerts for working age adults, from 39% to 43% and a decrease in alerts for people over the age of 75. The proportions of alerts progressing to referral have not changed from last year.

3.7.2 In Bedford Borough, consistent with the previous year the majority of safeguarding alerts and referrals relate to people aged 18-64 with 16% of alerts progressing to a safeguarding referral. This indicates a high number of alerts that do not meet the threshold for an investigation or can be managed in other more appropriate routes.

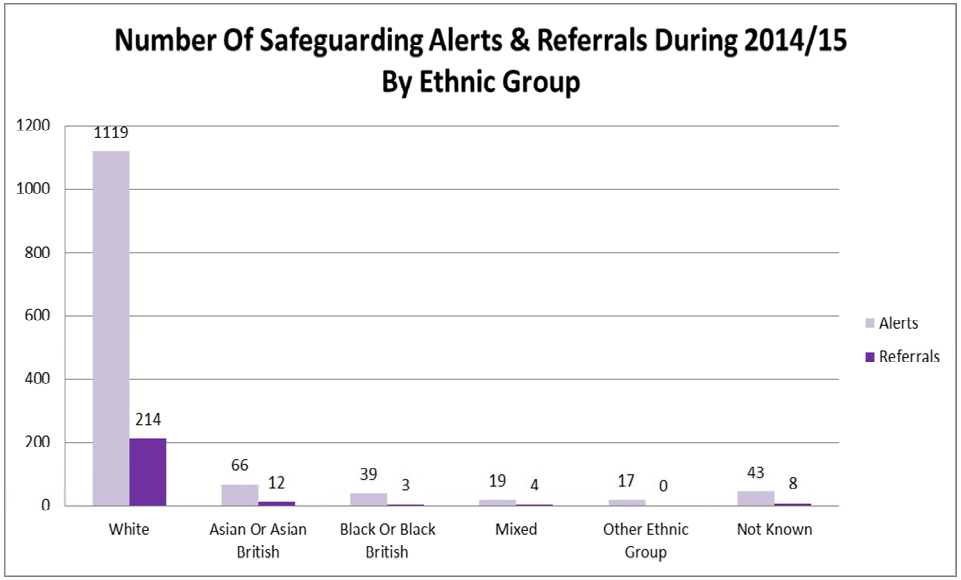
3.7.3 Within the 18-64 age group will also be a high number of service users with a mental health issue or learning disability and where an alert relates to a service user upon service user incident, where no significant harm has been caused and this is reflected in the low proportion of alerts leading to a safeguarding investigation.

3.8 Alerts and referrals by ethnic group

Central Bedfordshire



Bedford Borough Council



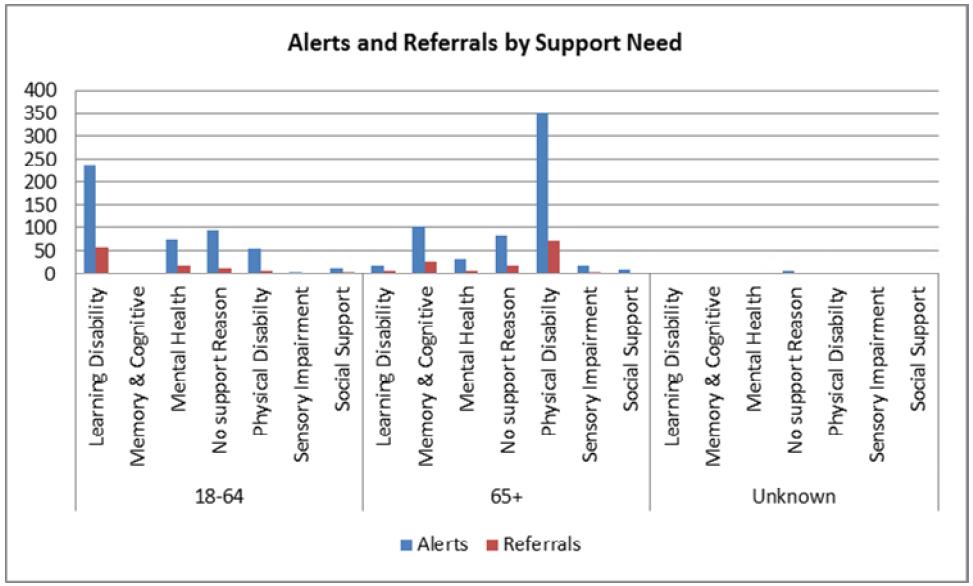
3.8.1 85% of alerts and referrals in Central Bedfordshire relate to White British people. The low number of alerts from the BME communities within Central Bedfordshire is a reflection of the communities within the locality and the presenting population which is predominantly White British. There has not been a change in patterns over the previous three years. The proportion of alerts progressing to referral for White British people is the same as for people of other ethnicities, and there has not been a change over the previous three years.

3.8.2 In Bedford Borough the number of alerts and referrals relating to ethnicity remains in line with the previous reports with the largest category being White British, making up 85% of alerts which is a drop of 3% from 2013/14. The 2011 census shows 84% of adults are white British and this figure is reflective of the proportion of alerts relating to White British people.

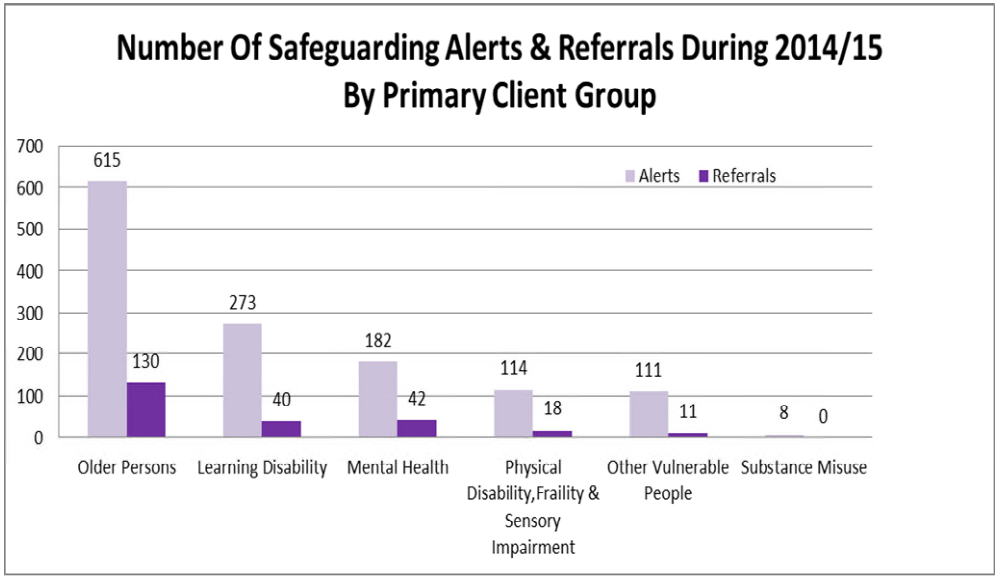
3.8.3 There has been a reduction in levels of alerts and referrals for all groups, with the biggest difference being in the Black or Black British group where there has been a drop in alerts from 71 to 39 with 7% progressing to a referral. There does not appear to be a reason for this drop but this reduced number may be a recording issue as the number of alerts in the Not Known category has increased from 1 to 43.

3.9 Alerts and referrals by support need

Central Bedfordshire



Bedford Borough Council



3.9.1 Central Bedfordshire's statistics are consistent with the previous year, the majority of alerts and referrals relate to older people. The support needs of older people are now being reported to the Health and Social Care Information Centre (HSCIC) and the chart above demonstrates this.

3.9.2 The majority of alerts from working age adults relates to people requiring support as a result of a learning disability, whereas the majority of alerts from older people require support needs due to a physical disability.

3.9.3 Central Bedfordshire's charts above show it is possible to conclude that safeguarding referrals are more common in respect of allegations of neglect and acts of omission, in relation to older white women, living either in their own home or in a care home, receiving paid care and support.

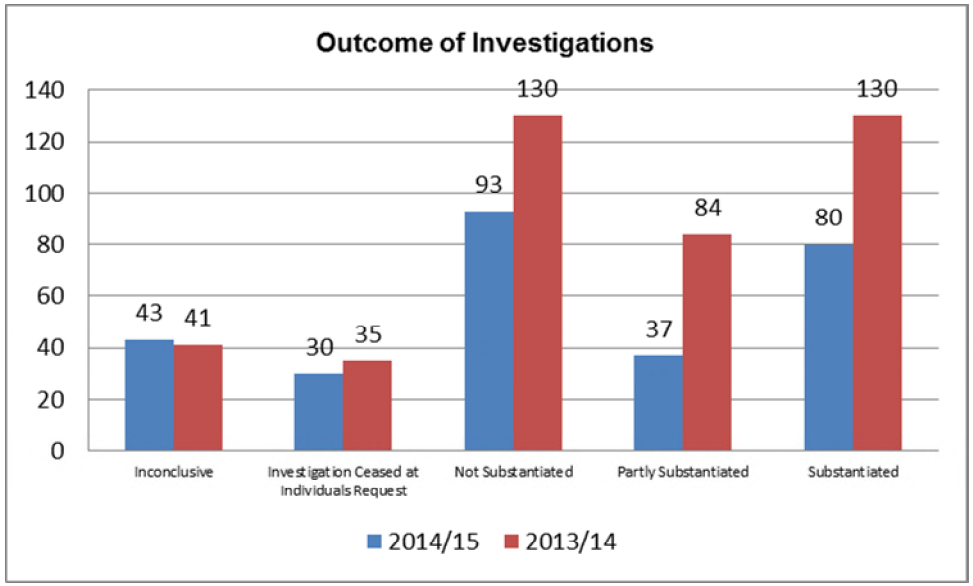
3.9.4 In Central Bedfordshire, safeguarding referrals in relation to people with a learning disability are more likely to involve physical abuse. There is also a higher incidence of reports of allegations of sexual abuse and emotional abuse in relation to people with learning disabilities. The person causing harm is more likely to be a family member, friend or neighbour, but locations can vary across supported living, residential accommodation and the person's own home.

3.9.5 In Bedford Borough Older person continues to be the category with the highest levels of alerts, followed by learning disability and then mental health which is consistent with the previous year's reporting. There has been an increase of 12% in alerts received for older persons, with 24% progressing to referral compared to 23% last year. Often alerts for older persons require an immediate response but often will be of a risk nature as opposed to abuse taking place and action will be passed to the most relevant social care support team to action. The types of alerts for older persons involving paid carers tends to be poor care, medication errors and missed domiciliary care which is similar to previous years. Where financial abuse has taken place, this is more likely to be a family member and the abuse to have taken place within the person's home. Alerts for older persons involving care homes and domiciliary care agencies are monitored to pick up any emerging patterns and themes which can then addressed.

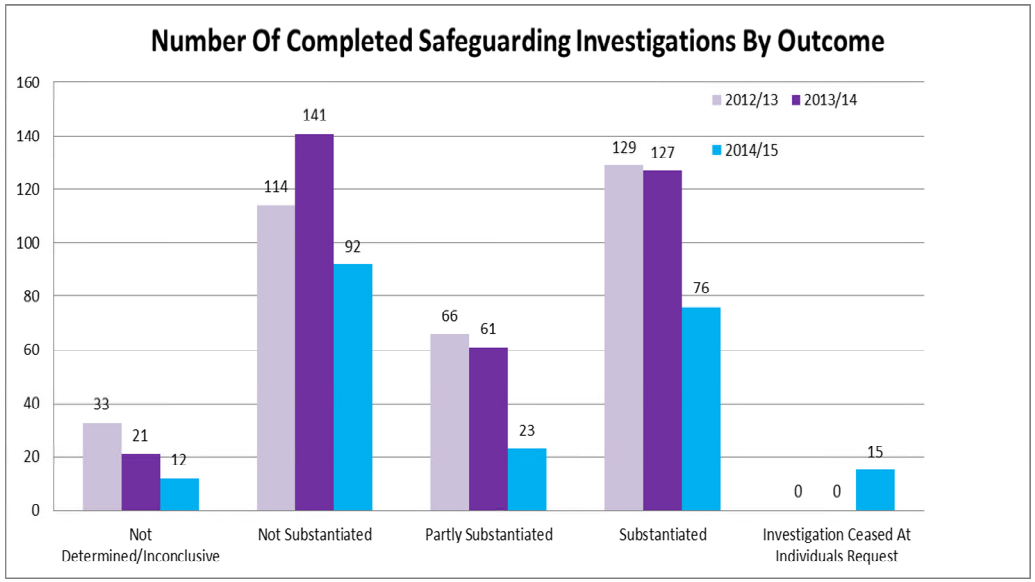
3.9.6 There has been a noticeable decrease in alerts for people with a learning Disability or Mental health issues. This is due to the high number of information contacts received from the police, ambulance and other agencies where a safeguarding response is not required or appropriate but the concern/contact is passed to the community team for action, referral for services or information, which previously would have been recorded under safeguarding.

3.10 Outcomes of investigations

Central Bedfordshire



Bedford Borough Council



3.10.1 In Central Bedfordshire the outcomes of investigations can be broken down as follows:

	2014/15	2013/14	2012/13	2011/12	2010/11
Not Determined / Inconclusive	15%	10%	14%	17%	8%
Not Substantiated	33%	31%	33%	36%	57%
Partly Substantiated	13%	20%	23%	19%	11%
Substantiated	28%	31%	30%	29%	25%
Investigation ceased at individual's request	11%	8%	-	-	-

3.10.2 In Central Bedfordshire, there has been a reduction in both the proportion of cases that have been either substantiated or partly substantiated and an increase in the proportion of cases either not determined or not substantiated since 2013/14.

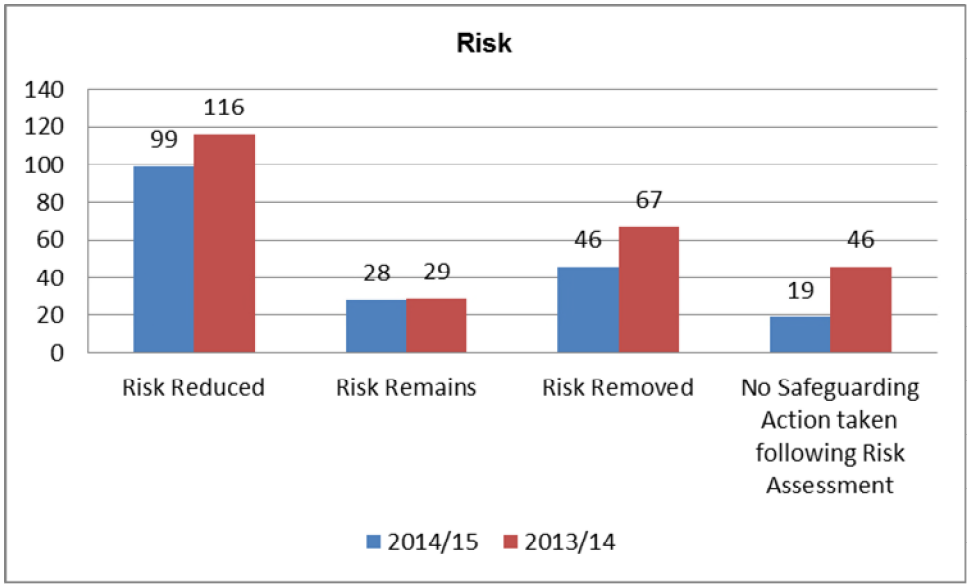
3.10.3 In Bedford Borough the table below shows what the reporting levels for the outcomes of investigations has been for the last three reporting cycles:

	2012/13	2013/14	2014/15
Not Determined/Inconclusive	9%	6%	6%
Not Substantiated	33%	40%	42%
Partly Substantiated	20%	17%	11%
Substantiated	38%	37%	35%
Investigation Ceased at individuals request	n/a	n/a	6%

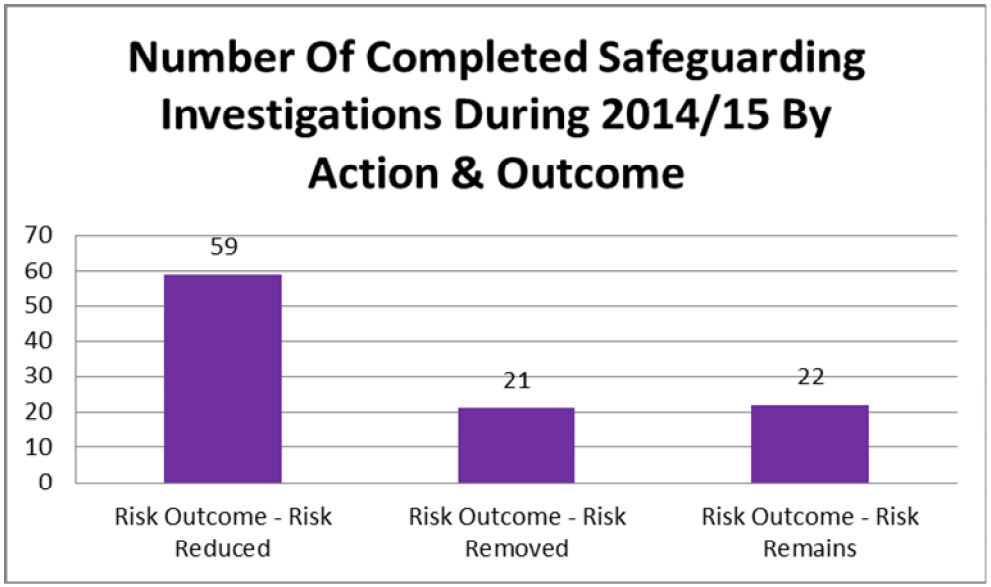
3.10.4 There has been a reduction in outcomes with a substantiated, not substantiated, partially substantiated and not determined outcome. The increase in investigations ceased at individuals request evidences that there is an improvement in numbers of cases where the views of the individual take priority and where appropriate cases are ceased at the individuals request in line with making Safeguarding Personal.

3.11 Risk

Central Bedfordshire



Bedford Borough Council



3.11.1 In Central Bedfordshire, 76% of those cases that recorded the approach to risk had the risk reduced or removed an increase on the previous year (71%). There has also been an increase in the proportion of cases where no action was taken following a risk assessment, from 18% to 46%. The council had undertaken a dedicated piece of work relating to the recording of risk and outcomes. 33 safeguarding investigations (approximately 25% of the total

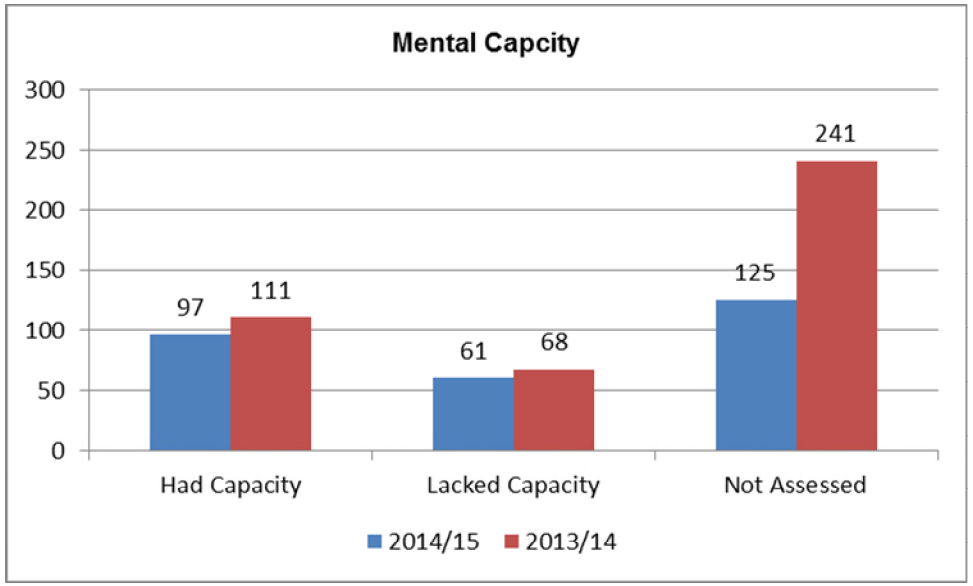
number) closed during 14/15 were identified as not addressing risk. Of the 33, 22 risk assessments were found having been saved incorrectly to the system. Explanations provided for this included the reliability of the SWIFT database for saving work. 11 cases did not have risk assessments available on the system, and these cases were raised directly with the team managers of the teams. This review also identified that the person centred evaluations as part of making safeguarding personal are not being consistently used in order to find out the person's views of the risk to them. This is an integral part of person centred practice in safeguarding work, and a means of assessing whether any difference was made as a result of the intervention. Further practice development work will be undertaken with the teams to support in the understanding and use of the safeguarding evaluations and the recording of risk.

3.11.2 In Bedford Borough during the current reporting period, of the 102 safeguarding cases where an outcome was recorded, 59 (58%) had an outcome of risk reduced, this compares with 68% or 160 during the previous reporting period. This is reduction in the number is partially a result of lower levels of completed safeguarding investigations during the year, but also indicates a recording issue where risk outcomes were not recorded.

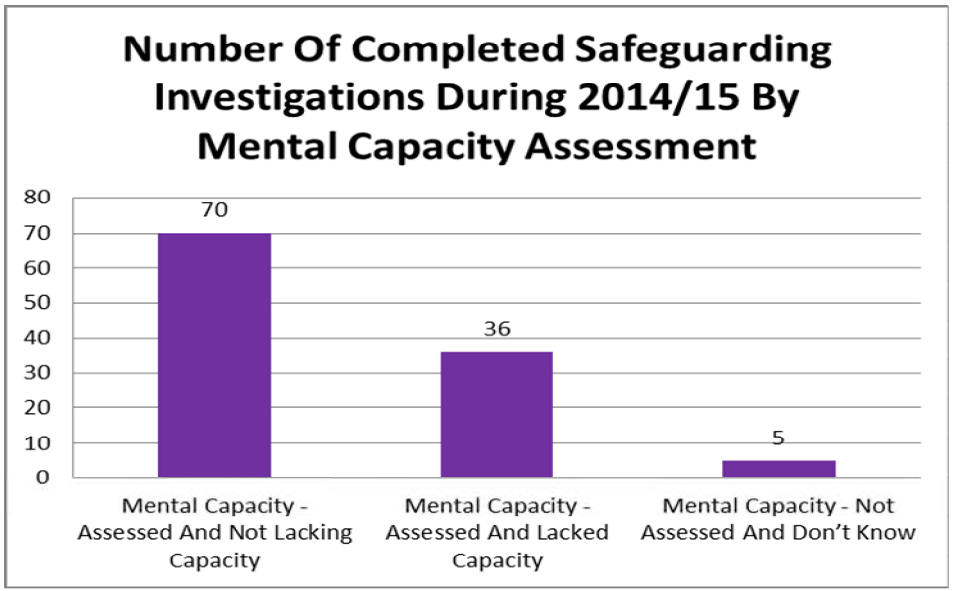
	2013/14	2014/15
Risk Reduced	68%	58%
Risk Removed	23%	21%
Risk Remains	9%	22%

3.12 Mental Capacity

Central Bedfordshire



Bedford Borough Council



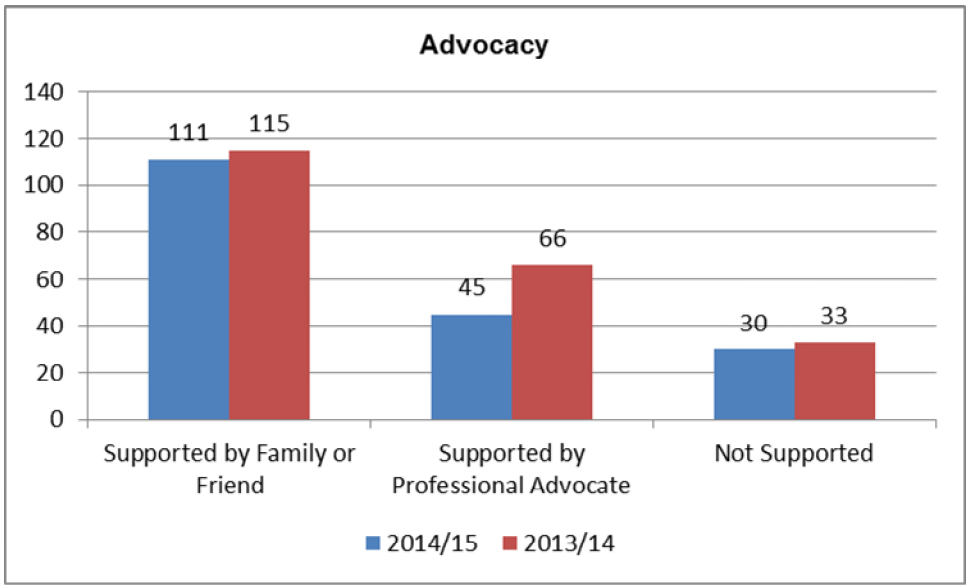
3.12.1 In Central Bedfordshire, 56% of people subject to a safeguarding investigation had their mental capacity assessed, an improvement on the previous year where only 43% of people were assessed. 22% of those people assessed for mental capacity were deemed not to have capacity.

3.12.2 In Bedford Borough during the current reporting period of those assessed 70 (63%) were deemed as not lacking mental capacity this is a marginal increase of 1% on the previous reporting period.

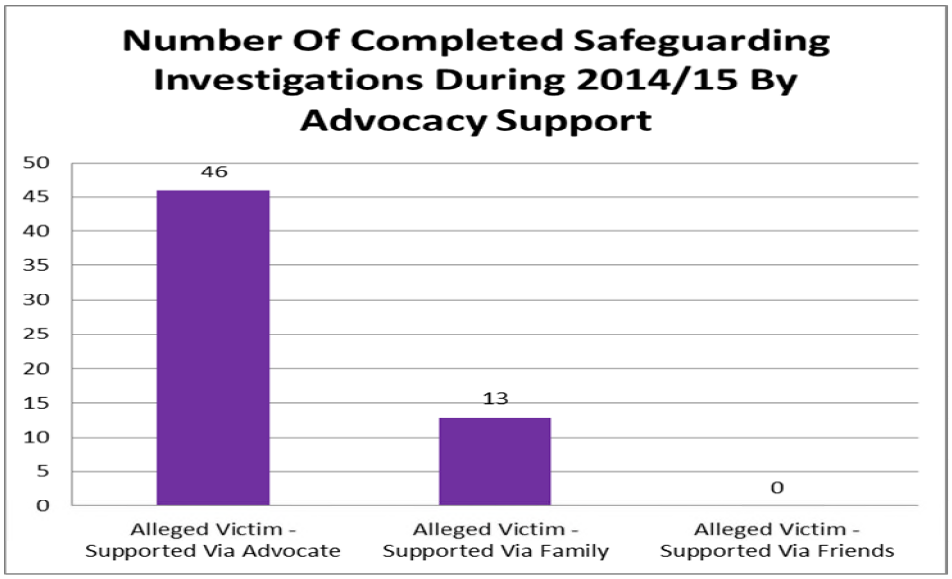
	2013/14	**2014/15**
Not Lacking Capacity	62%	63%
Lacked Capacity	33%	32%
Don't Know	6%	5%

3.13 Advocacy

Central Bedfordshire



Bedford Borough Council



3.13.1 In Central Bedfordshire, 84% of people were supported by an advocate during the investigation, a slight decrease from the previous year (86%). The majority of people were supported by family or friends (60%), an increase on the previous year; the reduction is in the use of professional advocates.

3.13.2 In Bedford Borough during the current reporting period, of the advocacy support recorded, 78% of people were supported by an advocate during the safeguarding investigation; this is a significant increase on the previous reporting period where 66% of advocacy support recorded was provided support by an advocate service. However during the current reporting period we have seen an overall drop in the number of safeguarding referrals and as a result of this we have seen a drop in the numbers of completed referrals where an advocacy support or other support was provided as a result of the investigation.

3.13.3 The table below shows how the reduction in the number of completed referrals has had an impact on advocacy support for these service users:

	2013/14	**2014/15**
Supported Via Advocate	66%	78%
Supported Via Family	27%	22%
Supported Via Friends	7%	0%

4. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards

4.1 Since the decision of the Supreme Court in *P v Cheshire West and Chester Council (& Ors) and P and Q v Surrey County Council* (Cheshire West), there has been a vast increase in the number of people deprived of their liberty by the state. The Latest Official Statistics from The Health & Social Care Information Centre's (HSCIC) report: Deprivation of Liberty Safeguards (DoLS) – Monthly Summary Statistics Quarter 4 2014/15 (January –March) (published May 12 May 2015) highlights for the 116 Councils that submitted data for all four quarters, the number of applications received totalled 113,300 compared to 10,900 in 2013/14. The increase in authorisation requests amounts to a 10 fold increase compared to requests made in 2013/14. While data demonstrates a 10 fold increase for Central Bedfordshire Council (CBC), Bedford Borough Council (BBC) has encountered a 15 fold increase in DoLS activity. In 2013/14, CBC processed 65 requests compared to BBC who processed 59. There are several factors that may explain this variance, including, a higher volume of people in Bedford who are self-funding their placements in care homes.

4.2 **Impact and Numbers:**
In the year 2014-2015 BBC and CBC have processed the following requests in accordance with MCA DoLS:

	BBC	CBC
Number of Applications received	872	605
Requests accompanied with an Urgent Authorisation (assessment to be completed within 7 days)	459	391
Number of extensions granted to Urgent Authorisations (7 day extensions granted)	392	Not collected
Standard Authorisation requests (assessments to be completed within 21days)	413	605
Number of Authorisations granted	701	300
Number of Authorisations not granted	165	41
Number of Authorisations requests withdrawn (these have been withdrawn following a change in circumstances and where assessment is no longer required).	4	108
Number of Authorisation requests that have exceeded statutory timescales since 1st April 2014.	33 (4%)	530 (87%)
Number of authorisations pending allocation	0	156

Number of IMCA referrals made	208	49
Cost of BIA and S12 assessments £000	£405	£325

4.3 The different numbers above account for the different approaches both local authorities have taken towards responding to the increase. CBC took the approach of prioritising the most urgent assessments while utilising a pre-existing informal arrangement with CBC trained BIAs to undertake out of hours assessments, while training more internal staff. An incremental increase over the year meant that a waiting list was created, as CBC BIAs were unable to complete the volume of assessments out of hours. A small team of locum BIAs was utilised to attempt to mitigate this. Towards the end of the financial year 2014-2015 CBC commissioned an agency team of external BIAs to complete the backlog of assessments which stood at 156 at the end of the financial year. The operation of a waiting list has meant that CBC has a higher number of requests withdrawn as people's circumstances have changed over time. While the approach of prioritisation has been recommended by ADASS (see below ADASS priority tool) in order to manage the volume, the risk of such an approach includes failure to adhere to statutory timescales and concerns when someone dies where a DoLS has not been authorised.

4.4 In response to the Supreme Court ruling, BBC took the approach not to use the priority tool recommended by ADASS, but to deal with all authorisations wherever possible and within the statutory timescales. This has meant building up a pool of independent BIAs and also utilising internal BIAs. The consequence of this approach is a significant increase in the need to extend urgent authorisations from 7 to 14 days. This approach has also had a significant impact on the budget as initially independent BIAs were setting assessments fees at high rates. Of the 872 DOLS requests processed by BBC, 79% of authorisations were granted and 19% were not granted. These figures differ significantly from those recorded in the HSCIC report (May 2015), and this is largely due to BBC's compliance with the statutory timescales, which are attached to the assessment and authorisation process (7/14 days for an urgent authorisation and 21days for a standard authorisation). In 2014/15, 4% of requests received by Bedford Borough Council exceeded timescales, with a period of 5 days, being the longest period of unlawful deprivation. The HSCIC report records that 54% of authorisation requests for the 116 Councils were yet to be signed off by the Supervisory Body or were withdrawn, resulting in 36% of authorisations being granted and 10 per cent not being granted.

4.5 80% of authorisation requests for both authorities have come from care home establishments rather than hospitals. These figures are in line with the predictions made by the Department of Health in their 2009 impact assessment (cited in Care Quality Commission: Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14).

4.6 During the year BBC referred 208 cases for an Independent Mental Capacity Advocate (IMCA) to support either the relevant person and/or the nominated Relevant Persons Representative (RPR). This equates to 30% of all cases where an authorisation has been granted. This referral rate is slightly higher than the national average, whereby the average referral rate for an IMCA is around 17-18%, as cited in the Department of Health report, The Seventh Year of the Independent Mental Capacity Advocacy (IMCA) Service 1st April 13 – 31st March 2014. CBC adopted a different approach for referrals to advocacy services, and has not referred for an IMCA for every relevant person's representative unless identified as a need by the Best Interests Assessor. This has resulted in lower referrals for the IMCA service.

5. Learning from Safeguarding Activity

Learning Outcomes	Action To Ensure Learning
Both Councils continue to receive large volumes of contacts which are not safeguarding reports but may be intelligence, information and indications of risk that may require a response. Many result in referrals for assessments of need.	Keep under review the proportionate response to safeguarding contacts, including regular audits of outcomes for all contacts to the safeguarding teams Work with partners to identify those areas where there are frequent contacts for access to assessments services and identify referral pathways for these services.
The SAB development day identified public information as an area for development. Data supports this as referrals continue to be low from members of the public.	SAB to consider community awareness raising and publicity campaign.
The SAB development day identified a need to improve the use of internal data to better understand themes and trends. The quarterly reporting framework has been modified for 15/16 to reflect this.	Keep under review the modified reporting framework for the quarterly reports for the SAB and ensure partners are providing data accordingly Review the annual report template to provide focus on exceptions and enable more detailed analysis of safeguarding activity and cases
The SAB development day identified a need to focus on training – for all volunteer, operational, front line staff and managers; use of the competency frameworks to ensure consistency.	Ensure the training sub group of the SAB addresses the need to review training and consistency and additional needs in light of the Care Act. Offer training to external agencies in undertaking S42 enquiries on behalf of local authorities Review and launch the safeguarding and MCA competency frameworks in light of the Care Act and Cheshire West.
The SAB development day suggested that consideration should be given to a multi agency safeguarding hub	Further research and visits to working MASHs to be undertaken in conjunction with the Police
	SAB to focus on topics of high risk that affect all joint partnership boards, in

The SAB development day highlighted the need to Improve and strengthen the links with the Local Safeguarding Children's Boards and the Community Safety Partnerships. Regular meetings and leads have been identified which has led to improved communication and understanding of overlapping agendas	particular Modern Slavery, Hate Crime, Child Sexual Exploitation and Domestic Abuse.
The Care Act requires the SAB to have an overview of self neglect which includes hoarding. Pathways and procedures have been set out in the updated multi agency policies and procedures	SAB will monitor the volume of self neglect cases and the local, multi agency responses to these.
Audits have identified strengths and areas of weakness in safeguarding practice. Management oversight of cases and recording and assessment of risk have been identified as key themes for development and learning	Both Councils to commission an independent auditor to conduct a piece of work over both authority areas with a focus on S42 safeguarding enquiries, making safeguarding personal, approaches to assessment of risk, management oversight and contacts that do not progress to S42 enquiries.
The Care Act requirements and data form 2014-2015 indicate a need to focus on advocacy support, both professional and through family or friends and the recording of this.	Review the data and recording of use of advocacy in safeguarding, as well as case files to identify whether the use of professional and unpaid advocacy is timely, appropriate and achieving desired outcomes.
Following Cheshire West DoLS activity has had a significant impact on the safeguarding teams in terms of management of resources.	Ensure that appropriate resources are in place to respond to DoLS and do not divert resources from safeguarding developmental work. Respond to the Law Commission consultation by November 2015.
Data is telling us that there are improvements needed relating to the recording of Mental Capacity Act assessments in relation to safeguarding. The majority of MCA resources have been diverted to respond to the high level of increase in DoLS applications.	Review resources within the teams to ensure that support to practitioners in relation to the MCA is maintained, including case audits. Ensure skills within front line teams are developed so that practitioners are equipped to provide the appropriate assessments and documentation for Court of Protection applications.

Appendix 1

Strategic Objectives for 2015-2016

Strategic aims:

1. Prevention and Raising Awareness
2. Workforce development and Accountability
3. Partnership Working
4. Quality Assurance and Protection
5. Involving People and Empowerment
6. Outcomes and Proportionality

Members of the Board must be able to:

- Influence and direct their organisations in ensuring adults are and feel safe and are supported to challenge and change abusive situations.
- Lead and support the development and implementation of safeguarding practice and procedures within their own organisations.
- Take forward any agreed action plans which prevent and minimise abuse, protect individuals and support the delivery of justice and fairness to all.
- Support the development of wider public protection and prevention initiatives as part of embedding the quality and safety agenda.
- Ensure safeguarding activities are monitored and audited.

1 Prevention and Raising Awareness

- Information to be made available identifying the steps individuals and communities can take to keep themselves safe, what abuse means and what everyone should do if they believe abuse may be happening.
- Hate crime, discrimination and harassment of people with disabilities.
- Information will be located in places that the public can access it.
- Access to support for ‘excluded’ people.

- Tackling the causes of abuse.
- Support for families, carers and perpetrators.
- Increasing the understanding of safeguarding in NHS resources.
- Promote awareness and actions to combat hate crime

2 Workforce Development and Accountability

- Staff should be able to recognise and manage risks in supporting and caring for adults at risk of harm or abuse.
- Staff should treat people with dignity.
- Staff should understand how to empower people and enable positive risk taking.
- There should be a focus on achieving outcomes for individuals and evidencing that these have been achieved, rather than processes.
- There should be competency based training to ensure that practice meets good quality standards and targeted training.
- Mental Capacity Assessments and Deprivation of Liberty Safeguards including the use of Independent Mental Capacity Advocates to raise awareness and improve practice within these areas

3 Partnership Working

- Secure electronic information sharing arrangement - receive reports and monitor progress and management of information.
- Tissue viability issues addressed through the Harm Free Care group and actions to be put arrangements and NHS bodies to monitor.
- Mental capacity and unwise decision making – put mechanisms, guidance, training in place.
- Ensuring safeguarding remains a priority and that lack of continuity does not cause risk to vulnerable person through organisational change.
- Ensure links are maintained to the Health and Wellbeing Boards, Community Safety Partnerships, Children's Safeguarding Boards and other strategic partnerships.
- Improvements to out of hours responses.

- Improve multi agency collaboration in respect of people not accessing services.

- Respond to national focus on care quality by continuing to work in partnership with key agencies and commissioners to improve quality in health services, learning disability services and with adult social care providers

4 Quality Assurance and Protection

- Develop more than one means of quality assurance to be able to triangulate information from different sources and evaluate effectiveness.

- Learn from serious case reviews and serious incidents, both locally and nationally.

- Take information from a wide group of partnership members and learn from those experiences to identify local issues.

- Learn from case file audits and what they tell us about the quality of practice improvement and service quality of different agencies.

- Commissioning by the NHS and local authorities in health and social care services builds in assurance that a quality framework is in place and is tested.

5 Involving People and Empowerment

- Ensure the views of people who have used services and their representatives or advocates, who have experienced harm or safeguarding processes, are taken into account.

- Gain feedback following incidents.

- Develop peer support and organisational support for people who have experienced abuse in the way that works for person.

- Develop a range of support and response options to empower people in safeguarding situations.

- Provide case studies to assist with developing services.

6 Outcomes and Proportionality

- Ensure people are empowered to drive safeguarding processes and find effective personal resolutions to harmful or abusive circumstances. The safeguarding team will work with victims of abuse through the personal use of the feedback forms as one means of improving the victim's experience during the safeguarding process.

- Ensure advocacy services are available for people who are unable to challenge or change circumstances that they experience as abusive or harmful.

- Involve service users during the investigation process.
- Continue to promote communication literature to the public via information leaflets about ‘what is abuse’ in different format and languages.
- Build confidence in the process of investigating concerns by making people feel comfortable at the start of a safeguarding process.

Appendix 2

Partnership Contributions to Adult Safeguarding 2014-2015

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Bedfordshire Clinical Commissioning Group (BCCG)
Name(s) Of Person(s) Reporting:	Mel Gunstone (Head of Patient Experience and Safeguarding)

1. Local priority: Prevention and raising awareness

As clinical commissioners, NHS Bedfordshire CCG (BCCG), needs to ensure the health needs of adults at risk / vulnerable adults are met. This includes complying with national and local drivers and requirements.

Bedfordshire CCG Patient Safety Project Nurses have begun to evaluate impact and effectiveness of the Pressure Ulcer training that was delivered to Residential and Nursing homes across Bedfordshire. Early pressure ulcer data indicates a significant reduction in the number of avoidable pressure ulcers.

Information is regularly shared via the CCG Communications team around safeguarding updates, training and revised policies, including the GP newsletter and internal updates.

2. Local priority: Workforce Development

Safeguarding Adults is a standing agenda for BCCGs corporate induction which is mandatory for all staff. In addition, it is mandatory for all staff to complete the Safeguarding Adults eLearning module every 3 years; as of 31 March 2015 94.51% of BCCG staff have completed the Safeguarding Adults Module.

A training programme for 2015/16 is in development to ensure adult safeguarding, Prevent and MCA/DoLS is incorporated and rolled out.

3. Local priority: Partnership working

BCCG continues to strengthen its relationships with the Local Authorities, with membership to information sharing meetings, and regular reporting to these forums. Joint visits with health and local authority continue to be a priority for BCCG both for monitoring quality and safeguarding practices, as well as when there is a service of concern.

4. Local priority: Quality assurance

Safeguarding adults is included in all appropriate strategies, policies and contractual arrangements which are monitored on a regular basis. Monitoring of safeguarding activity of BCCGs key providers is via the Quality Monitoring Contract process.

BCCG is a member of the operational quality assurance groups, and strategic safeguarding board.

Safeguarding is a regular agenda item at BCCGs Patient Safety and Quality Committee (PSQC) where key updates or concerns are discussed. Escalation processes are in place to the Governing Body as required.

5. Local priority: Involving People
Through quality visits undertaken within BCCG, feedback from people using services is sought as part of this, including safeguarding practices. This information is shared through the Patient Experience Group within BCCG and incorporated into safeguarding reports. Where safeguarding issues are identified, th**e**se are raised with the relevant local authority and also the provider.

6. Local priority: Outcomes and Improving Experiences
BCCG safeguarding adult's team are members of the CCG Patient Experience Group. The purpose of the Patient Experience Group is to ensure the voice and experiences of patients and people who use services, are heard and incorporated into the actions and commissioning decisions taken by the CCG. The result of this is to improve the quality of services and outcomes for people within Bedfordshire.

Highlight report of key issues arising during 2014/15, addressing the priorities

Learning from serious case review conducted during the year, with the key points shared within agencies and primary care.

Confusion amongst all partners as to clear role of the CCG within safeguarding matters. This resulted in multi-agency working to establish roles and ensure clearer points of contact /escalation processes when concerns identified. This has considerably improved partnership working within Bedfordshire as a whole.

Improved quality assurance / governance processes to ensure the Adult Safeguarding Board is kept updated with key issues. Improved partnership working as a result of revised processes.

Revision to local and multi-agency policies to reflect new legislation and the Care Act 2014.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Improvement multi-agency working to strengthen safeguarding processes between the local authorities and CCG.

Joint working with local authority contract monitoring teams to ensure early identification of potential risk / quality issues which may result in safeguarding concerns. This to be further strengthened in some areas.

Through multi-agency approach, clear processes now identified for safeguarding, serious incidents and complaints, and how these relate

together when cases involve all three processes.
Improvements planned in adult safeguarding during 2015/16 addressing the priorities
Safeguarding audit within primary care to establish learning objectives and then to develop training around identified areas of learning. GP / primary care briefings /newsletters to provide updates around the Care Act 2014, and developments in DoLS legislation. New MCA/DoLS Lead appointed to raise awareness and deliver training within primary care regarding MCA/DoLS. Development of a training programme for 2015/16 to ensure adult safeguarding, Prevent and MCA/DoLS is incorporated and rolled out.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Bedfordshire Police
Name(s) Of Person(s) Reporting:	DCI Liz MEAD

Highlight report of key issues arising during 2014/15, addressing the priorities

Management Structure and Resources

There has been a balance throughout the reporting year to be made of consistency and stability in personnel versus bringing in to the Department varied experiences to enhance investigation skills.

D/Supt Sharn Basra and DCI Liz Mead are both accredited PIP 3 SIOs with Major Crime Background. DCI Nick Bellingham brings the intelligence and pro-active investigative experience.

2014- 2015 has been challenging for Bedfordshire Police with both financial and resourcing pressures. However, recommendations from the PPU Lean Review continue to be implemented and compliment the FQIP (Force Quality Improvement Plan) that restructures the Force and will continue to deliver a robust service whilst supporting the needs of our communities.

2014-15 saw the first recruitment of police constables in over 4 years and over a hundred are going through at various stages of their probationary period, with further recruitment is planned. In addition there have been transferees with experience recruited direct to the Force and three of these individuals were immediately placed within the PPU.

Domestic Abuse

Domestic abuse investigations and process has seen a number of changes throughout the year with new processes being implemented and new line management. These changes have been challenging but have gone well, with the frontline officers being given further training in domestic abuse and vulnerabilities concentrating on threat, harm and risk to all.

The HMIC Domestic Abuse re-inspection was held in November 2014, this was a brief inspection as new changes had been implemented. It was

acknowledged that the changes were valuable but to ensure the inspection was of value to the force it has been agreed that they will revisit to review the force response to Domestic Abuse.

The new process for the management of Domestic Abuse was implemented in January 2015 in regards to recording, risk management and the investigation processes for domestic abuse incidents. We are reviewing our end to end process in regards to officers investigating crimes and safety planning with the victims.

The first Bedfordshire Domestic Abuse Scrutiny Panel was held on Monday 9th February 2015 at Bedfordshire Police Headquarters. A wide variety of police resources were in attendance and five cases were selected for review. They focussed on the victim pathway and it was facilitated by SafeLives (formally CAADA). A synopsis of the review is due which will highlight any recommendations resulting from the panel alongside a summary of good practice and challenges in each individual case. Further scrutiny panels shall be scheduled in due course and will focus on the end to end process with an emphasis on partnership working.

The HMIC Inspection report from October 2015 has been recently received and is overwhelming positive and reveals good progress against the 17 original recommendations.

The final quarter of 2014/15, saw a 7% increase in DA conviction rate.

DVDS and DVPO'S

The Home Secretary announced a national rollout of Domestic Violence Protection Notices and Orders (DVPN/O's) and the Domestic Violence Disclosure Scheme (DVDS) and Bedfordshire Police introduced both schemes in June 2014.

The Domestic Violence Disclosure Scheme introduced recognised the need for consistent procedures for disclosing information that enables a new partner of a previously violent individual make informed choices about whether and how to take forward that relationship.

A Domestic Violence Protection Notice and Order is aimed at perpetrators who present an on-going risk of violence to the victim with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of Perpetrators.

Both DVDs and DVPOS were used successfully throughout 2014/15 by Bedfordshire Police.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

SPOC Roles were created in the PPU for Adult Safeguarding. Ds Michelle Welsh is the Lead for Bedford and Central Bedfordshire and Ds Richard Eymor is responsible for Luton.

The Care Act places certain responsibilities on agencies and one of these is that the police should have a Designated Adult Safeguarding Manager (DASM) to manage cases involving allegations or concerns raised involving a person in a position of trust. The Act says that Forces should have a DASM who will provide a consistent and dedicated response for our partners to liaise with in matters of concern. The DASM will therefore need to be an officer with sound knowledge of multi-agency working and adults at risk investigations. In Bedfordshire Police, DCI Liz Mead has this role.

Future development

A county-wide MASH is under review and consultation with agencies' looking at their roles within it. The pilot within Bedford is still in its infancy but has shown closer working together between partners.

The referral process for vulnerable adults and the SOVA teams are working well, the agreements made in regards to what constitutes a referral and or an investigation has allowed for the investigation to be referred in a more timely fashion, with officers in the Public Protection Referral Team risk assessing and prioritising the police investigations referring directly to the Safeguarding Sgts for allocation. See the graph below for the numbers of referrals over the past year and subsequent investigations.

Prosecutions/Investigations (Countywide Cover)

Between 01/04/14- 31/03/15 Police received 793 Social Care referrals from all 3 Authorities.
Police completed a significant number of F750s most of which were forwarded on to Adult Social Care. The contrasting figures from 2013-2014 are included for reference and comparison.

Referrals per agency

2013-2014	**2014-2015**
Police 891	Police 1435
Sova 1027	Sova 793
Other 113	Other 70

From the data collated you can see there is a very marked increase in the amount of Form 750s police forms, submitted to Social Services (SSD) in 14/15. This is in contrast to Sova referrals which have seen a marked decrease in the same period.

Staff who regularly deal with VA have also noted this change which is supported by the annual figures.

Break down of VA incidents investigated by SIU

		Physical	Sexual	Financial	Welfare/Neglect

Safeguarding North		14	14	4	14
Safeguarding South		11	10	11	8

Auditing

Qualitative auditing of cases continues to be undertaken by Senior Managers in the PPU on a monthly basis in addition to the Detective Sergeants supervisory responsibility for paperwork checks and auditing of ABE and Suspect interviews.

Weekly crime management/ investigation reviews are being completed by the detective Inspectors. Ensuring our victims and suspects are being kept up to date and the investigations are progressing. This will assist with the implementation of Athena as officers are going to have to use new systems to record their investigations.

Training

The specialist staff, within the Public Protection Unit has continued to receive on-going training on current themes, learning from SCR's and legislative updates at the regular Continuous Professionalism Development days (CPD) including updates in the new legislative changes arising from the Care Act.

NCALT training is also being used to train officers within the service along with access being given by the local authorities to their on line training to support and develop officers within the PPU.

DCI Liz Mead PPU has continued to present at the Crime Seminars with the presentation providing an overview of PPU including vulnerable adult investigations .These presentations are on- going with crime updates being completed on rotation.

Forced Marriage & Force Marriage Protection Orders (FMPO)

These remain static

Missing Persons Unit

The MPU practices have been updated to ensure the correct definition is used, regardless of if the person reached Compact or not, which may have impacted the data if it was broken down into missing compared to absent reports. MPU have will also increase their focus on the appropriate recording of reports relating to MH patients, i.e. absconders are no longer recorded as absent / missing (however this data is

retained for the working group so they can review and address any issues).

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

Future development

The implementation of a Serious Sexual Offences Investigation Team remains on hold. However, longer term the creation of this Team to investigate all serious sexual offences, will enhance the current Rape Investigation Unit.

CSE

The CSE Team continues to gather significant intelligence around young People (YP) who may be CSE victims and also gathering intelligence on possible perpetrators. With the support of partners and the extra training awareness raising we have seen reporting increase with a number of Young people being referred to the CSE Panel. We are continuing to develop processes within the Team to provide a more effective service to the public our partners and internally.

It has been well documented that there are links between the LSCBs and the LSABs relating to CSE and learning and training are to be shared. Bedfordshire Police positively utilised 'The more you see, the more you know' communication poster campaign and opportunities to promote CSE awareness was undertaken on National CSE Action Day on 18th March.

Bedfordshire Police was the subject of a College of Policing Peer Review for CSE over a 3 day period in March 2015. The results of this review were encouraging and the Report will be published early Summer 2015. Comment has been made on the strengths of the clear vision for the Force in relation to tackling CSE and that the vision had been communicated very effectively to police officers and police staff at all levels and across all teams. There was learning identified around effective communication with external partners but recognised the establishment of the Pan Bedfordshire CSE and Missing Panels and CSE/Missing Strategic Group to illustrate the close working relationship that currently exist.

All occurrences of missing and absent are now referred by Bedfordshire Police to each relevant Local Authority. This extensive sharing of information assists in the decision making process around courses of action to be taken such as Strategy Meetings, referrals to the MCYPP or the Child Sexual Exploitation Panel. A CSE co-ordinator for all agencies has been recruited and is due to start in June 2015 providing a county-wide function in developing CSE understanding and practice.

MASH

The development of joint working within a MASH will not only support all agencies allowing for a joint assessment, it will ensure that investigations have a clear lead agency, in regards to Vulnerable adult assessments / investigations this should speed the process and give clear parameters in order for the victim and their families to be up to date with an immediate point of contact.

Domestic Violence End To End Processes.

This is an on-going piece of work which is aimed at having one officer to investigate the crime and support the victim, completing safety planning with them. These investigations will be managed as the safeguarding and Rape investigations are. Allowing for the OIC who is aware of all the facts &risk factors to support the victim and process the crime.

ATHENA

Athena the new investigation tool is due to be implemented in January 2016 which will allow for the crossover of police data. This is likely to affect our data records/ figures for 15/16 they will change.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Luton and Dunstable Hospital NHS Foundation Trust
Name(s) Of Person(s) Reporting:	Chris Harvey, Adult Safeguarding Lead

1. Local priority: Prevention and raising awareness

National priority: Prevention - It is better to take action before harm occurs

The process where safeguarding alerts are raised within the Trust are forwarded to Luton Borough Council (LBC) has been further modified to provide greater efficiency and transparency. Previously alerts were sent from the Safeguarding team to LBC via the discharge administration team via secure email. This has now changed with the safeguarding lead or safeguarding administrator emailing alerts directly to the secure email address. This has also helped to provide greater assurance to the safeguarding lead when attempting to ascertain the progress of investigations.

During the last year occasional difficulties have been experienced with receiving information from LBC in a timely manner. In particular, not receiving alerts, screening tools or risk assessments until after the deadline response dates. After discussions with the safeguarding managers and also the administration teams at both the Trust and LBC this process has improved greatly with alerts being investigated in a timelier manner. However, we will continue to ensure that this improvement is maintained.

Training & Development

The Adult Safeguarding Lead has worked with the Training and Development team to review the statutory training programme for 2015/16. The main aim is to ensure that all staff groups are captured through mandatory training sessions. Also by reviewing all the programmes the training can be tailored for specific groups of staff. In addition to this we are keen to further develop the training provided by the learning disability team with the ultimate aim of combining the Safeguarding, Dementia and Learning Disability sessions on mandatory training.

It has been identified through various nursing audits and CQC peer reviews and practice issues that there is insufficient awareness and knowledge regarding Mental Capacity and Deprivation of Liberty Safeguards. The Adult Safeguarding Lead in response to this has instigated a programme of additional training sessions for all wards and departments ranging from micro training sessions based on the ward to lengthier training sessions incorporated into Ward meetings and training days. The uptake from all these areas has been very good and there is a forward plan to ensure these sessions continue during next year. The

impact of this training and the knowledge and awareness of staff will continue to be evaluated through the Peer CQC reviews as well as audits to be undertaken by the Adult Safeguarding Lead.

In addition to this a thorough review of all Safeguarding was undertaken to ensure that all training delivered is pertinent to the individual staff groups. This has resulted in the training sessions being modified dependent on the target audience. Furthermore, it has identified key training for certain core groups of staff such as all Band 6 and 7 clinical nursing staff will be required to attend MCA/DoLS training in the future and this is to be defined within the updated Adult Safeguarding Policy.
The Trust's Dementia and Safeguarding Leads attended the Virtual Dementia tour - train the trainer training. This training allows staff to experience what it feels like to be a patient with Dementia. It involves the participants to be de-sensitised to sight, sounds and their surroundings. This is very thought provoking training and invaluable if we are to care for our patients in a more empathetic and holistic way. There is a training plan to disseminate this to all staff across the organisation and the sessions delivered thus far have been very well evaluated.

The Adult Safeguarding Lead continues to attend the Channel Panel as part of the Prevent programme and Government's counter-terrorism strategy. The aim of this is to ensure that vulnerable adults and children are prevented from being radicalised by extremist groups into terrorist type activity. With the restructuring of the Prevent programme nationally the Trust is now part of the London region for Prevent whereas previously it had been part of the Midlands and East group. There is a new lead for the London Prevent region - Edward Farrell Pickerill. There are bi-monthly regional meetings which will also include a training focus that we will be required to attend.

Awareness of Prevent is now included in the Induction and Mandatory training programmes. The existing Department of Health's Healthwrap training has been undergoing a period of review and updating. Once released Healthwrap 3 will be delivered to key areas within the organisation such as the Emergency department, short stay wards, Maternity and Paediatrics. In addition to this the Prevent lead attended a workshop and conference as part of the national review into the National prevent guidance. The new Prevent duty is due to be released in July 2015.

2. Local priority: Workforce Development

National priority: Accountability - Accountability and transparency in delivering safeguarding

There is a new Lead Nurse for Learning disabilities. A review of the overall training programme has developed opportunities for combined training and provides greater understanding of individual roles.

The Adult Safeguarding Lead continues to foster a closer working relationship with both the Dementia Specialist Nurse and learning disability team. In addition to this there are now regular meetings with the Chief Nurse to feedback progress and developments on key performance objectives and indicators.

The third Safeguarding Champions course has been completed and comprised of 15 members of staff from the acute setting and 15 members of staff from the community. The course has been very successful with one of the main benefits being the shared learning from different organisations. The programme reviewed and adapted from previous years. This year in particular, included sessions on Domestic violence, communication, leadership and the legal implications and process of safeguarding. The course was run in conjunction with Bedfordshire University and the Clinical Commissioning Group (CCG).

Safeguarding continues to support the Schwarz rounds with a review of a complex Safeguarding case presented in October. Schwarz rounds are a very powerful learning tool and this was a very emotive case with the Schwarz round exploring the learning and emotions that emanated from this particular case. Key personnel that were involved in the case at the time participated and provided insight into how even a year after the case they are still affected by the eventual outcomes.

As part of the preparation for the implementation of the Care Act in April all training sessions included information of the changes that the Care Act is making with regard to Adult Safeguarding. In particular this has focussed on the new types of abuse categories, the requirements for sharing information in the safeguarding setting and the Duty of Candour.

3. Local priority: Partnership working

National priority: Partnership - Local solutions through services working with their communities.
Communities have a part to play in preventing, detecting and reporting neglect and abuse

The Trust's Adult Safeguarding Lead has continued to identify opportunities to further develop professionally and also increase knowledge and skills for the benefit of the Trust as a whole.

Serious Case Reviews

We continue to work with our safeguarding partners as part of the serious case review panel. From the 1st of April with the introduction of the Care Act this group will be known as the Safeguarding Adult review group. In the past year it has reviewed one particular case-Adult G with learning emanating from the investigation. As a Trust although we were not directly involved with Adult G there is still valuable learning in terms of the sharing of information .The final report is due in April 2015.

Serious Case review learning events commenced this year with historic cases reviewed for learning opportunities across all organisations. This was a good opportunity to learn collectively from the lessons highlighted by these cases and ensure we work together more cohesively in the future. Importantly it was also recognised on this day that following these complex cases that there is much improved working relationships across all, agencies.

Multi-Agency Working

The Adult Safeguarding Lead continues to attend the Multi-Agency Safeguarding Leads meetings organised and chaired by the CCG Adult Safeguarding Lead. These are very valuable meetings attended by all safeguarding partners and allow for constructive discussions surrounding current operational issues. From these discussions there is a robust action plan that has been developed to improve practice for all agencies in the future. These meetings are held quarterly.

There are now quarterly meetings with the nursing home managers in conjunction with the Integrated Discharge Manager and organised through the Head of Adult Safeguarding for the Clinical Commissioning group. These meetings are again very useful and beneficial for all and aim to discuss relevant issues from both the community and acute Trust perspective. Issues recently discussed include the standardising of times for patients to be discharged by from the hospital and improving the communication prior to and at the time of the patients being discharged back home.

The Adult Safeguarding Lead attended both local authority business development days to establish the onward robust safeguarding strategies for both Safeguarding boards.

Dementia Care

We have continued to work with our partners to promote and improve Dementia care. We actively took part in Dementia awareness week and had stands to promote this within the Trust. The Dementia friendly sessions facilitated by the Alzheimer's society and aimed primarily at non clinical staff continue on a monthly basis.

The Adult Safeguarding Lead continues to work closely with the Dementia Specialist Nurse to support both the Safeguarding and Dementia objectives. In particular to ensure that we actively participate in Dementia awareness week in May and also to identify an action plan for attaining the challenging CQUIN targets for 2015-2016. This in addition to the combined training programme that continues to be delivered.

As part of the Dementia awareness week there will be a tea party for inpatients and their careers, Virtual Dementia Tour training and Dementia awareness displays within the Trust.

Both the Adult Safeguarding and Dementia Lead Nurses continue to have an active role across the Trust by disseminating safeguarding mental capacity and Deprivation of liberty advice to medical and nursing staff in particular in relation to complex medical and discharge cases. They both continue to attend best interest meetings at the request of medical and social work teams and always work as the patients advocate.

Dementia CNS offering phone advice to carers has increased over the past few months. Carers taking the opportunity to have

updates and seek advice using the contact details provided in carers leaflet, hospital website & ward posters.

The Delirium guidelines have now been developed and will be disseminated to Medical and Nursing staff through training. This in turn will meet the required CQUIN improvement goal specifications.

The Dementia Care pathway was launched in November 2014 at the ward managers meeting. The Dementia lead requested that it was disseminated to all staff in their departments by using an education board or having a dementia awareness week/month. She suggested the ward managers consider discussing the pathway at safety briefings daily with all staff becoming aware of the pathway. This is audited by the CNS.

Dementia carer feedback is crucial for improving the service. The phone calls to carers will now be supplemented with questionnaires to encourage more feedback. The predominant focus of feedback refers to carers receiving adequate updates on the wards. The Carer's expectation is to be approached and updated daily or each time they visit the wards.

Right Care initiative (2012) *'Dementia –friendly hospital charter'*. This outlines the contributing principles and standards for a Dementia friendly Hospital with the Trust being invited to become part of a National support network to improve hospital care for the person with dementia It requires self-assessment and intends to build a peer to peer support network, which includes sharing examples of good and best practice.
The Dementia Lead Nurse is attending relevant meetings to promote the need to include Dementia friendly design where possible. PLACE assessments now include Dementia Friendly design standard requirements and actions are being discussed and agreed.

Learning Disability Care
The Adult Safeguarding Lead is working with the Lead Learning Disability Liaison Nurse to review and revise the pathways for all inpatients and outpatient clinical areas. Once complete these will then be disseminated to the clinical teams.

The Lead Learning Disability Liaison Nurse continues to facilitate the Patients Learning Disability Coffee morning. Former patients are invited to attend to discuss their experiences in the hospital and ways to improve the service were explored. The meetings have been expanded with patients from other community groups joining the meetings. The Lead Learning Disability Liaison Nurse also working with both PowHer and the Bramingham Day Centre, Luton to develop specific tours of the hospital for autistic patients.
The Lead Learning Disability Liaison Nurse alongside the Adult Safeguarding Lead is developing:

- A hospital welcome pack for learning disability patients who are admitted to hospital. This will provide them with details of who their key links are while in hospital and what to expect while they are here.

- ❖ Liaising with the Out Patients department to construct Easy read appointment letters and information for patients and carers.

The Adult Safeguarding Lead meets with the other Learning Disability (LD) Champions at meetings co-ordinated by the Lead Learning Disability Liaison Nurse. The aim of these meetings is to raise awareness of the challenges that LD patients experience when visiting the hospital. It also identifies key improvements and new ways of working to improve the patient's experience.

A CQC peer review was undertaken into the LD services provided within the Trust. The official written feedback is yet to be received however, the verbal feedback was very positive. It was felt that the overall patient experience was very good and the service and support provided by the Learning disability team to patients extremely good. An action plan has been developed to address the minor issues that this visit highlighted. The official feedback once received will be disseminated appropriately.

The Lead Learning Disability Liaison Nurse co-ordinated the care and management of a very complex case regarding a patient with extreme challenging behaviour who required urgent and invasive treatment. This required extensive liaison with the Trust staff especially in Theatres, Ward 21, the Consultant Surgeon, the Court of Protection, the Community Learning disability teams as well as the patient's residential home. The excellent communication and cross organisational working ensured that this patient had an excellent and positive experience. In addition to this it also had an impact on his future care as it was felt after this positive experience the patient could be seen in the hospital setting for his outpatient appointments rather than in an independent setting. This excellent example of communication and team working will be disseminated across all organisations via training from the LD team.

4. Local priority: Quality assurance

National priority: Protection - Support and representation for those in greatest need

Last year 299 safeguarding alerts were raised by the Trust and 80 against the Trust. The number raised by the Trust was a slight reduction in the previous year whereas the number against the Trust showed a slight increase.

The emerging themes from the alerts raised against the organisation were related to discharges and specifically medication and communication, issues relating to pressure damage, alleged neglect of care and poor communication and documentation. We have worked and continue to work with our external partners to address the issues highlighted by these alerts to improve the outcomes and experience for all our patients.

All discharge related alerts are reviewed at quarterly meetings between the Adult Safeguarding Lead, The Safeguarding Lead for the Clinical Commissioning Group and the Trusts integrated discharge manager. An action is developed from these meetings and any developments or findings disseminated to clinical teams. Similarly we are working with our commissioners and local authority

partners to support any developments that have arisen out of the safeguarding alerts raised by the Trust and subsequent investigations that have taken place.

Common themes for the alerts raised by the trust are neglect of care, psychological and physical abuse, domestic violence, financial abuse and self-neglect. The action points from safeguarding investigations is communicated back to the relevant departments via the Nursing Midwifery board, Ward Sisters meetings, Clinical Governance meetings and locally through individual ward and team meetings.

5. Local priority Involving People:

National priority: Empowerment - Presumption of person led decisions and informed consent

MCA and DoLS

In order to improve awareness and knowledge regarding Mental Capacity and Deprivation of Liberty Safeguards resulted in the instigation of a programme of additional training sessions for all wards and departments ranging from micro training sessions based on the ward to lengthier training sessions incorporated into Ward meetings and training days. The uptake from all these areas has been very good and there is a forward plan to ensure these sessions continue during next year.

The Adult Safeguarding Lead and Dementia Nurse Specialist have been actively involved in Best Interest meetings and case conferences in complex cases and particularly complex discharges. Both act as the patients advocate where appropriate and ensure appropriate decisions are made in the best interests of the patient and also relatives.

Making Safeguarding Personal

The Luton & Dunstable Hospital NHS Foundation Trust is committed to the principles of **Making Safeguarding Personal,** a project developed by the Local Government Association and the Association of Directors of Adults Social Services. The aim of Making Safeguarding Personal is to ensure that safeguarding is person-led and focused on the outcomes that they want to achieve. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that embraces involvement, choice and control as well improving quality of life, wellbeing and safety.

We will:

- Work with adults (and their advocates or representatives if they lack capacity) at the beginning to identify the outcomes they want to achieve.
- Review with the adult at the end of safeguarding activity to what extent their desired outcomes have been achieved.
- Record and monitor the results in a way that can be used to inform practice and account to the three respective Safeguarding Adults Boards.
- Develop a range of robust and appropriate responses that focus on supporting adult to meet their desired outcomes and

reduce the risk of or recurrence of abuse.

6. Local priority: Outcomes and Improving Experiences

National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

The Trust will monitor safeguarding outcomes and patient experience by the implementation of Making safeguarding personal and by obtaining patients views of the safeguarding process.

Further outcomes and experiences will be monitored by the Dementia Specialist Nurse and Learning disability team for their respective patient groups. All learning from safeguarding investigations will be used to ensure that we constantly strive to improve the patients experience and ensure improved outcomes for all.

Highlight report of key issues arising during 2014/15, addressing the priorities

Implementation of the Care Act 2014-
All training presentations for adult safeguarding have been reviewed to include the main changes relating from the Care Act to Adult Safeguarding.

Mental Capacity and Deprivation of Liberty Safeguards-
From nursing audit and through practice related issues we identified that there was a poor level of awareness of the Mental Capacity Act and Deprivation of Liberty safeguards. A robust training programme was developed and delivered to wards and departments and this work will continue.

Process and information delays-
Difficulties were experienced by the Adult Safeguarding team in receiving alerts, screening tools and risk assessments from Luton Borough Council in a timely manner. After discussions with safeguarding managers and also the administration teams at both the Trust and LBC, this process has improved greatly and alerts are now investigated in a more timely manner. However, we will continue to ensure that this improvement is maintained.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Prevention and raising awareness –
The process where safeguarding alerts raised within the Trust are forwarded to LBC has been further modified to provide greater efficiency and transparency. This has also helped provide greater assurance to the Adult Safeguarding Lead when attempting to ascertain the progress of investigations.

Workforce Development-
The introduction of administrative support for the Adult Safeguarding team and Dementia Nurse specialist has allowed the Adult Safeguarding Lead more opportunity for training and providing support in the clinical area. It has also meant that safeguarding information is shared with the wards and departments as well as external organisations in a timelier manner.

Partnership Working-
The Safeguarding lead continues to attend the Multi-Agency Safeguarding Leads meeting organised and chaired by the CCG Adult Safeguarding lead. These are very valuable meetings attended by all safeguarding partners and allow for constructive discussions surrounding current operational issues.

There are now quarterly meetings with the nursing home managers in conjunction with the Integrated discharge manager and organised through the Head of Adult Safeguarding for the Clinical Commissioning Group. These meetings are again very useful and beneficial for all and aim to discuss relevant issues from both the community and acute Trust perspective.

Quality Assurance-
On-going review of all discharge related safeguarding alerts by the Trusts safeguarding lead as well as the Safeguarding Lead for the CCG and the Integrated discharge manager has produced a robust action plan and various improvements to ensure discharges are facilitated more smoothly.

Training and Development-
A review of the Adult Safeguarding training programme has identified key training priorities for the next year. In particular greater emphasis on Mental Capacity and Deprivation of Liberty training and the implementation of Healthwrap 3 training in the next year. It has also enabled us to focus on what specific training is required for individual staff groups and this will be further outlined in the revised Adult Safeguarding Policy.

Virtual Dementia Tour-
The Trust is now implementing the Virtual Dementia Tour training following the acquisition of the training package and both the Adult Safeguarding lead and Dementia Nurse Specialist attending the train the trainer training. This has resulted in greater awareness of the patients experience for someone who has Dementia. This is an extremely powerful learning tool and will continue to be disseminated across the organisation.

Improvements planned in adult safeguarding during 2015/16 addressing the priorities

- A review of the Adult Safeguarding policy to incorporate changes implemented with the Care Act 2014.
- A review of the Mental Capacity Act and Deprivation of Liberty safeguards policy to ensure this is compliant with new changes in legislation.
- Increase establishment to support role of Dementia Nurse specialist
- Development of safeguarding handbook for staff
- Development of Safeguarding newsletter to be produced quarterly
- Review and updating of Safeguarding resource folders to ensure they are compliant with the Care Act
- Improved monitoring of Deprivation of Liberty safeguards administration
- Prevent Healthwrap 3 training for target areas
- Implementation of Making safeguarding personal

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014115

Name Of Organisation:	Bedford Hospital NHS Trust
Name(s) Of Person(s) Reporting:	Nichola Keer, Adult Safeguarding Lead Nurse Nina Fraser, Director of Nursing Tracey Brigstock, Deputy Director of Nursing

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality - Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

Delay in the completion of Safeguarding Adult Investigations-this has been now been added to the Bedford Hospital Trust Risk Register. Following the Supreme Court Judgement Regarding Deprivation of Liberty Safeguards on 19th March 2014, Deprivation of Liberty Applications have increased within Bedford Hospital. This has led to an increase in demand in the need for assessments to be completed. This has not always been possible to meet and for these cases we have had to apply for an extension to the local authorities involved in regards to the Urgent Authorisation to allow more time for these to be completed Different local authorities have in place different processes for DOLS authorisation applications- which can be problematic when training staff. All staff understand the basic principles of Deprivation of Liberties and are being guided the trust lead dependent on the local authority processes.
Improvements made in adult safeguarding during 2014/15, addressing the priorities
Continual quality assurance monitoring Internal Audit compliance
Improvements planned in adult safeguarding during 201$^{4}/_{1}$5 addressing the priorities
Adult Safeguarding Nurse Specialist- BAND 6 to commence employment in July 2015. Mental Capacity Act and Deprivation of Liberty Training commissioned for all Doctors in Q2 and Q4 in 2015. CQC Preparation. A further Safeguarding Champions Course facilitated by the University of Bedfordshire has been commissioned to commence in October 2015

Signed , Date ..... Page 1 of 1

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	POhWER
Name(s) Of Person(s) Reporting:	Glenda Tizard, Community Manager

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

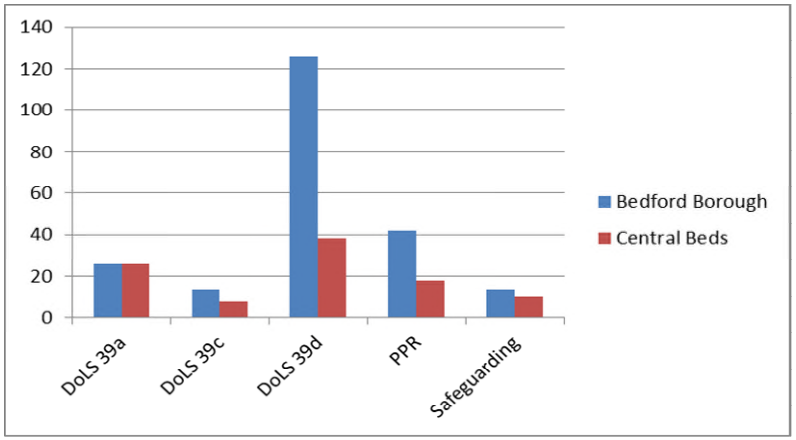
4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

The impact of the Cheshire West ruling on Deprivation of Liberty Safeguards (DoLS) was the outstanding issues during this year. The IMCA service responded to a total of 403 referrals (273 from Bedford Borough Council and 130 from Central Bedfordshire. Of these, 208 referrals from Bedford Borough and 90 referrals from Central Bedfordshire were referrals directly relating to Deprivation of Liberty Safeguards. **(Priority 4 and 6)**



The community advocacy service also receives referrals to support individuals who have been subject to a safeguarding alert. Advocates additionally raise safeguarding alerts where disclosures have been made to them. During 2014-15 community advocates closed 32 safeguarding issues.

(Priorities 4 and 6)

Advocacy Case Study

Client: JW

Presenting issue: JW has learning difficulties and is 21 years of age. JW was residing with her PA as a result of Safeguarding allegations involving her mother's boyfriend. Her family and friends live in Cambridge and JW attends college and day opportunities in Cambridge.

Case action: The CAMHS Social Worker requested Advocacy support to provide independent support, particularly as the Advocate had no involvement or knowledge of the JW's previous situation. The overall aim was to enable the client to voice her views and wishes, specifically in relation to where she would like to live in the future.

Advocacy action:

- Rapport built with JW in a range of settings
- Advocate created safe place for JW to share her views

- All options identified and explored, this included checking back over a couple of meetings to check consistency in what was said
- Supporting the JW to feel more confident in saying what she wants to family and other professionals
- Feeding back the clients wishes to Social Worker

Outcome: JW was supported to move into her brother's home for a short period whilst supported living options were explored and placement confirmed.

Advocacy value:

- JW was empowered and given confidence to share and assert her views and wishes
- JW was able to share her views with someone neutral and independent.
- JW able to engage in the discussions about her long term future and participate in planning/timetable

(**Priorities 4, 5 and 6)**

Improvements made in adult safeguarding during 2014/15, addressing the priorities

The substantial increase in DoLS referrals this year necessitated a remodelling of POhWER's team to enable the team to cope with this demand. A number of community advocates agreed to take POhWER's internal IMCA/DoLS training in order to support the 0.6 IMCA already in place. In December 2014 the Commissioners agreed to provide funds to support the recruitment of an additional 0.4 IMCA. Two members of the Bedfordshire team were successful in their applications, resulting in 3 individuals now providing IMCA support. **(Priority 2)**

As part of POhWER's community engagement programme, the Community Development Worker continues to engage service users with learning disabilities in raising their awareness and understanding of safeguarding issues, through active dialogue in the Voice groups. Through this engagement a substantial amount of work has been done on the issue of hate crime and the need to report it, in conjunction with Bedfordshire Police. **(Priority 3)**

POhWER continues to deliver training to small groups of people under the generic title of "keep safe". This training is delivered to individuals who have been subject to safeguarding alerts and whom it was thought would benefit. 28 individuals have benefitted from one or more of the following modules:

- Assertiveness and confidence
- Communications
- Relationships

Regular reviews with service users are held to confirm what they have learned from the experience.
(Priority 1, 4, 6)

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

Those members of staff who were successfully appointed to IMCA posts in December have now commenced the formal IMCA module of the National Independent Advocacy Qualification (NIAQ) and expect to achieve this in the next 3 months**. (Priority 2)**

Staff have been trained in Care Act advocacy in order to respond to the anticipated influx of safeguarding referrals under the Care Act commencing April 2015. **(Priority 2)**

The Community Manager for Bedfordshire is had the lead role in PoHWER's Care Act Project Group, to ensure that POhWER's Safeguarding policies, procedures and training are compliant with the Care Act**. (Priority 1, 4)**
A member of the Bedfordshire advocacy team has had the responsibility of revising POhWER's internal safeguarding training package. **(Priority 2)**

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE
SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Healthwatch Bedford Borough (HBB)
Name(s) Of Person(s) Reporting:	Anne Bustin – Chair HBB

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

1 Local priority: Prevention and raising awareness

Study of Hospital Discharge - 'Unsafe discharge' can have the biggest impact on people who are already vulnerable.
The need for this study had been identified as a major issue of concern at an earlier public meeting that Healthwatch Bedford Borough had arranged. Co-incidentally Healthwatch England (HWE) had decided to carry out a Special Inquiry covering the same topic area. HWE encouraged all local Healthwatch (LHWs) organisations to support them in the gathering of information to feed into the Inquiry**.**
Three groups of the population were specifically identified as most vulnerable: the homeless, the elderly and mental health patients. HBB`s aim was to gather patient views and use the evidence to share learning and good practice across organisations and to identify areas where things could be improved**.**
This was a major piece of work for the Enter and View team and involved visits,
distribution, completion and analysis of patient questionnaires and Focus Group meetings.
The report was then presented to influential groups of local commissioners, MP's and stakeholders on November 5th 2014. The findings have been taken by providers to develop and improve local services.

2 Local priority: Workforce Development
HBB seeks to ensure that its Directors, paid staff and volunteers who undertake Enter and View visits are adequately trained and supported in Safeguarding awareness and related issues. Everyone who works for HBB (paid staff or volunteers) has undertaken a DBS check.

3 Local priority: Partnership working
It is essential that the local community and network of organisations in Bedford Borough supports,

promotes and informs the work of their local Healthwatch to be a strong independent voice for local people.
As indicated in last year`s report to the Safeguarding Board, HBB has engaged with a Network of Networks approach to community involvement.

The Healthwatch Reference Group (HRG) provides the network, experience and out-reach to not only promote the work of Healthwatch as Healthwatch Ambassadors, but to strengthen the collective voice of local people. It uses its collective knowledge drawn from the needs of the local community to help the Board of Healthwatch Bedford Borough to influence local commissioning strategies and health and social care delivery.

Members of the reference group represent Healthwatch Bedford Borough in a variety of different forums and meetings across the Borough and in the East of England. HRG has also been involved in supporting local consultations and reviewing and responding to proposals about changing health and social care models.

In terms of local safeguarding the HRG is an essential conduit in ensuring the prevention, early detection and reporting of situations where neglect and abuse may be/are occurring.

4. Local priority: Quality assurance Yarlswood IDC

HBB was involved in ensuring that the Care Quality Commission was able to secure its own inspection rights in respect of Yarlswood.IDC.
Along with the existing involvement of HM Inspectorate of Prisons and the Ministry of Justice, this has greatly improved the inspection regime at the IDC. The prime concern of HBB is now to ensure that health and social care services were

accessible to IDC detainees as may be appropriate and necessary.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE
SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Healthwatch Central Bedfordshire
Name(s)	Diana Blackmun, CEO

Healthwatch Central Bedfordshire (HWCB) has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

We engage and consult with all sections of the local population so that a wide cross section of views are heard, understood and acted upon. Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience.

Healthwatch Central Bedfordshire is one of three local Healthwatch in the County of Bedfordshire and we all belong to a network of local Healthwatch. Healthwatch England leads, supports and guides the Healthwatch network which is made up of the national body and local Healthwatch across each of the 152 local authority areas in England.

Healthwatch is the only body looking solely at people's experience across all health and social care. As a statutory watchdog our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

Healthwatch Central Bedfordshire also has the responsibility of being responsive to what we find out in our local area. This includes identifying causes for concern or areas of good practice and feeding back information to the Care Quality Commission, local commissioners, through the Health and Wellbeing Board and Overview & Scrutiny Committee and Safeguarding Boards.

Healthwatch Central Bedfordshire has the power to carry out 'Enter & View' visits and report on poor quality care or service failings, to local commissioners, and to highlight services that are keeping people safe. In this role key themes and trends can be identified and reported directly to the Safeguarding Board.

Healthwatch Central Bedfordshire is an independent organisation; a company limited by guarantee and a registered charity. We play an important role as the consumer champion which includes ensuring that staff, working in health or social care, know where to report safeguarding issues and also where whistle blowers can be listened to and action taken on their concerns

Highlight report of key issues arising during 2014/15, addressing the priorities

Healthwatch Central Bedfordshire is a full member of and is represented at the joint Adults Safeguarding Board. HWCB prepare quarterly reports for the Safeguarding Board which detail current issues and concerns.

Safeguarding Alerts
As part of our signposting service we have referred service users, who contacted us with particular concerns, to the relevant organisations and officers to assist with their anxieties and distress. This has highlighted areas of general concern in relation to safeguarding issues which was reported to the relevant safeguarding officers during 2014/15. Key issues arising during 2014/15 included:

Safety of Carers son
Healthwatch Central Bedfordshire received a safeguarding alert in the first Quarter. This referral was received via Carers In Beds who approached HWCB as their client did not feel that her concerns for her son were being taken seriously and she felt intimidated by the social worker. The situation may have been further complicated as English was not the clients first language.

The incident was logged and escalated to the Head of Safeguarding and Quality Improvement at Central Bedfordshire Council. The alert was immediately referred to the Safeguarding team who recommended that, as this was a complex case, formal strategy planning was needed to assure a robust investigation.

HWCB monitored the outcome of the investigation and were advised that Carers in Beds were continuing to provide support to the family throughout this process.

Serious Complaint
HWCB received a serious complaint, in the second quarter relating to an alleged ultimatum, placed on a relative of a patient, to take a suggested course of action if they wished to avoid a SOVA being raised against their relative. The relative felt under pressure to agree to the suggested course of action and the way in which the SOVA was used to force their hand. HWCB requested additional information about the issue, raised the complaint with the Safeguarding team at CBC and continued to monitor the circumstances surrounding the incident.

HWCB will continue to refer service users and carers, who contact us with general concerns in relation to safeguarding issues, to the relevant organisations and officers to assist with their concerns, into 2015/16.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Prevention

Prevention is at the forefront of the Healthwatch agenda. In addition to gathering the views and understanding the experiences of patients and the public, one of HWCB's key roles and priorities is to signpost people to local health and social care services and to support people who may need to raise a safeguarding issue.

It is important that local residents have access to the information they need at the time they need it. There are many occasions when people are unaware of help and support services available to them and HWCB are here to help.

In addition to enquiries received via telephone, email and face to face, HWCB also provide information and signposting for people who use health and care services via our outreach project, 'Just Ask' and events held throughout 2014/15. HWCB are able to signpost to the Safeguarding team at CBC or other support agencies or organisations that can help.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	SEPT
Name(s) Of Person(s) Reporting:	Elaine Taylor Associate Director Safeguarding

1. Local priority: Prevention and raising awareness
A series of preventative and awareness raising initiatives have been implemented this year within the Trust. This includes service user interviews, competency framework for staff and the distribution of lessons learnt cases. Audits have evidenced that staff awareness and response to Safeguarding issues has improved in the timeframe process and quality of investigations.

2. Local priority: Workforce Development
The Trust compliance with safeguarding training has been above 90% for 2014/15. Training has been delivered via E-Learning and face to face programmes. Compliance with timeframes for investigating safeguarding cases has remained above 91%.

3. Local priority: Partnership working
The Trust continued to be active members of the Bedfordshire Safeguarding Board, Operational Group and other sub groups. The Trust Safeguarding team have regularly worked in partnership with other NHS organisations, police, advocates and voluntary sector.

4. Local priority: Quality assurance
The Safeguarding team have worked with BBC and CBC to complete quarterly audits. The outcomes have been consistently of a high standard. SEPT internal audit programme show continued improvement in the quality or safeguarding and engagement with service users and family members.

5. Local priority: Involving People
The Trust continues to use a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Service user interviews involved meeting with a person subject to an investigation to ascertain their views and experiences. Feedback has been mainly positive; areas of improvement include ensuring the

person is informed along all steps of the process. These lessons learnt are fed back to clinical teams and service managers

6. Local priority: Outcomes and Improving Experiences
The Safeguarding team have continued to support staff and advising on robust risk assessments and the least restrictive and intrusive options when supporting service users.

Highlight report of key issues arising during 2014/15, addressing the priorities

- Good outcomes from internal and external audits
- Compliance with staff knowledge and skills continues to improve
- Good partnership working

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

- Raise awareness of the safeguarding guidance within the Care Act 2014
- Continue to improve skills of staff working in Community Health Services
- Ensure smooth transition of safeguarding services to East London Foundation Trust who will be taking over Mental Health Services in Luton and Beds (Except Robin Pinto and Woodlea units)

Elaine Taylor June 2015

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Bedfordshire Fire and Rescue Service
Name(s) Of Person(s) Reporting:	Thomas Warner Prevention Support Manager

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

Partnership Working and Outcomes and Improving Experiences

During 2014/15 BFRS made 3 Adult Safeguarding Referrals in Bedford Borough and Central Bedfordshire. They were classified as follows:

2 – For Neglect
1 – For Neglect and Emotional Abuse.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Local priorities: Prevention and raising awareness and Workforce Development
During 2014/15 a new classroom based Safeguarding training package was developed and delivered to 80 managers and key personnel.

Prevention and raising awareness

Bedfordshire Fire and Rescue Service (BFRS) continues to deliver a programme of Home Fire Safety Checks (HFSC's). The checks are delivered by Specialist Community Safety Staff, Operational Fire Crews and partner agencies. During 2014/15 4501 HFSC's were completed across the County by BFRS. A further 807 were completed by our partner agencies. The board should note, that whilst vulnerable adults form part of the target audience not all HFSC's are delivered to vulnerable adults.

BFRS is the enforcing authority of the Regulatory Reform (Fire Safety) Order 2005 on the majority of premises covered by the order in Bedfordshire. The Service conducts a risk based audit programme, this includes auditing Residential Care Homes. The number completed and the frequency of audits completed on Care Homes is determined by the risk associated with each Care Home.

Partnership working
Bedfordshire Fire and Rescue Service continues to refer cases that have been highlighted as a safeguarding concern using relevant processes and procedures laid out in the Services Safeguarding Policy. The Service's safeguarding policies have been drafted to compliment that of the SOVA Board.

Quality Assurance

Bedfordshire Fire and Rescue Service will continue to monitor the number of referrals received each quarter to ensure the correct procedures are followed.

Involving people

No relevant activity.

Outcomes and improving people's experience
Prevention / raising awareness

Bedfordshire Fire and Rescue Service (BFRS) continues to deliver a programme of Home Fire Safety Checks (HFSC's). The checks are delivered by Specialist Community Safety Staff, Operational Fire Crews and partner agencies. During 2014/15 4501 HFSC's were completed across the County by BFRS. A further 807 were completed by our partner agencies. The board should note, that whilst vulnerable adults form part of the target audience not all HFSC's are delivered to vulnerable adults.

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Workforce development

The Service has completed the initial delivery phase of its Safeguarding training package with the majority of Managers completing the course. We have identified staff that did not receive during the first phase of delivery and have arranged additional training courses for these staff members during the first half of 2015/16. Once this process has been completed we will roll out the e-learning package for staff that do not require the classroom based sessions.

Partnership working
Bedfordshire Fire and Rescue Service continues to refer cases that have been highlighted as a safeguarding concern using relevant processes and procedures laid out in the Services Safeguarding Policy. The Service's safeguarding policies have been drafted to

compliment that of the SOVA Board.

BFRS made 1 Adult Safeguarding Referral this quarter to the Adult Safeguarding team at Bedford Borough Council for Neglect and Emotional Abuse.

Quality Assurance
Bedfordshire Fire and Rescue Service will continue to monitor the number of referrals received each quarter to ensure the correct procedures are followed. The Service has not been involved in any Safeguarding Adult case reviews this quarter.

Involving people in development of safeguarding services

No relevant activity.

Outcomes and improving people's experience
Bedfordshire Fire and Rescue Service refer cases in line with the Services policies and procedures. It is considered that the outcome of these referrals will ensure peoples experiences are improved by offering support and assistance where appropriate.

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Improvements planned in adult safeguarding during 2014/15 addressing the priorities

Local priorities: Prevention and raising awareness and Workforce Development

Extra classroom based Safeguarding training courses will be delivered for managers who did not complete the training with aim for all relevant staff to have received this training by September 2015. In addition a bespoke e-learning package will be delivered to all staff (including Firefighters) who do not require the more in-depth classroom package.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Voluntary and Community Action
Name(s) Of Person(s) Reporting:	John Gelder

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

Prevention and raising awareness
We continued to highlight the need to raise awareness of safeguarding issues with voluntary organisations and community groups and

for organisations/groups to have in place adequate Safeguarding Policies so as to improve practice within the sector, particularly in smaller groups that are run by/involve volunteers. During the year we were able to highlight progress made in raising awareness among smaller voluntary and community organisations as a result of the safeguarding awareness sessions commissioned by Central Bedfordshire Council (see below).

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Prevention and raising awareness

We highlighted to voluntary and community organisations the need to ensure their staff and volunteers were aware of safeguarding issues and of the need to have in place adequate safeguarding policies.

We continued to deliver a programme of half-day safeguarding awareness sessions to smaller voluntary and community organisations, previously commissioned by Central Bedfordshire Council. 18 sessions were delivered in partnership with Community and Voluntary Service. The programme reached 123 delegates from 42 voluntary and community organisations across Central Bedfordshire. At the end of the year a new programme of sessions was commissioned for 2015/16.

Workforce development

Four new members of staff from Voluntary and Community Action have attended a Safeguarding Awareness session.

Five staff attended sessions on the Prevent Strategy and its links to safeguarding during the year.

Partnership working

We attended and contributed to all Adult Safeguarding Board meetings held during 2014/15.

We contributed to the revision of the Safeguarding Policy for Bedfordshire Adult Skills and Community Learning.

Quality Assurance

We undertook a review of our safeguarding work in line with the Safeguarding Board's Partnership Review template.

Improvements planned in adult safeguarding during 2015/16 addressing the priorities

Prevention and raising awareness

We will deliver a programme of 20 half-day safeguarding awareness sessions to smaller voluntary and community organisations throughout 2015/16, in partnership with Community and Voluntary Service. The programme is expected to reach about 200 delegates

across Central Bedfordshire.

We will continue to highlight within the sector the need for staff and volunteers to be aware of safeguarding issues and of the need to have adequate safeguarding policies in place. We need to review and update our *Better Care* resource pack to ensure that it is consistent with current practice.

Workforce development
All newly appointed staff will undertake Safeguarding Training. Once arrangements for the endorsement of Safeguarding Training are agreed/in place we will submit our Safeguarding Vulnerable Adults training workshop for endorsement.

Partnership working
The Adult Safeguarding Board has agreed a new structure that will now exclude the VCS Infrastructure Organisations from membership of the Board itself. Voluntary and Community Action very much regrets this decision, believing that the voluntary and community sector has an important role in contributing a strategic perspective to the work of the Board.

ANNUAL REPORT TO BEDFORD AND CENTRAL BEDFORDSHIRE SAFEGUARDING ADULTS BOARD 2014/15

Name Of Organisation:	Community & Voluntary Service
Name(s) Of Person(s) Reporting:	Martin Trinder/Jane Owen

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Highlight report of key issues arising during 2014/15, addressing the priorities

1. Prevention / raising awareness

Community & Voluntary Service has worked over the last year to raise the overall awareness within local voluntary and community sector organisations of the adult safeguarding agenda. Hundreds of local community group and charities work with or come into direct contact with adults who are vulnerable. Many more organisations may have indirect contact with vulnerable adults as they deliver their services in the local communities.

Community & Voluntary Service continued to deliver Safeguarding Awareness workshops to local voluntary and community organisations. These courses are aimed at organisations working with children and adults. During the period of this report, we ran a total of 13 workshops which trained 90 people from 39 organisations. We have mapped the course contents to the Adult Safeguarding Board's safeguarding competencies.

In order to enable volunteers to attend, 6 workshops were run in the evening and a variety of locations across Central Bedfordshire and Bedford Borough were used (Moggerhanger, Biggleswade, Flitwick, Lidlington and Bedford).

Most of these courses were part of a programme of workshops being delivered in partnership with Voluntary & Community Action though funding from the Adults Safeguarding Board. The Bedford courses were scheduled to meet demand from groups and we delivered this using our core resources. All these courses are free for Voluntary and Community Sector organisations to attend and are targeted at small community groups.

We are continuing to signpost individuals from voluntary and community sector organisations to carry out their own bookings of the Local Safeguarding Children Board (LSCB) e-learning. Whilst the LSCB focus on safeguarding children, some of the e-learning they provide includes safeguarding adults e.g. "Safeguarding Everyone". We also signpost individuals to the Adults Safeguarding training provided by the local authorities where appropriate.

Many of these organisations also received one-to-one advice on safeguarding issues, including policies and safer recruitment. Our funding and development service provided one-to-one advice to hundreds of organisations, providing an opportunity to discuss safeguarding arrangements and offer support to frontline organisations as required.

We have also promoted safeguarding in our regular email updates, on our website and in our development work with frontline organisations.

2. Workforce development

See information under 1 above – during this period we trained 90 people from 39 organisations.

3. Partnership working

See information under (1) above regarding training delivered in partnership with Voluntary & Community Action though funding from the Adults Safeguarding Board and Quality Assurance of CVS's Safeguarding Awareness workshop by Bedfordshire Local Safeguarding Children Board.

We work closely in partnership with other organisations within the Voluntaryworks Consortium to ensure voluntary and community groups have access to information and advice on matters relating to safeguarding. In particular, Voluntaryworks member Bedfordshire Rural Communities Charity continues to provide a DBS checking service and high quality advice to organisation in relation to DBS requirements and safer recruitment. We also work closely with VOCypf (Voluntary Organisations for Children, Young People & Families) a network of voluntary and community organisations who work with children, young people and families in Bedfordshire.

4. Quality Assurance

We have reviewed and updated the content of the workshop to reflect changes, in particular the Care Act 2014. Bedfordshire Local Safeguarding Children Board will be carrying out a multi–agency panel review of our workshop and we aim to be able to state that our workshop meets their Quality Assurance.

5. Involving people in development of safeguarding services

See information under 3 above.
Bedfordshire Local Safeguarding Children Board will be carrying out a multi–agency panel Quality Assurance review of our Safeguarding Awareness workshop.

6. Outcomes and improving people's experience

No relevant activity

Improvements made in adult safeguarding during 2014/15, addressing the priorities

1. Prevention / raising awareness

The number of individuals from voluntary & community organisations who access our safeguarding training remains high and we are finding that we are attracting the harder to reach groups. Requests for one-to-one advice have increased and feedback from groups shows that they are better able to put adequate safeguarding measures in place in their organisation.

The safeguarding course content is regularly adapted to reflect changes to guidance and local practice and includes updated toolkits and resources available to Voluntary and Community Sector organisations. We have also listened to feedback from groups to ensure that the training enables them to put practical measures in place that are appropriate to their particular settings.

2. Workforce development
See information under 1 above

3. Partnership working
We work closely in partnership with other organisations within the Voluntaryworks Consortium to ensure voluntary and community groups have access to information and advice on matters relating to safeguarding. Our new website (www.voluntaryworks.org) continues to develop and now enables us to regularly send email newsletters to voluntary and community sector organisations. These include information and resources relating to safeguarding and the website enables voluntary and community groups in the local area to access a single portal for advice and information, including safeguarding.

4. Quality Assurance
No relevant activity

5. Involving people in development of safeguarding services
See information under 3 above.

6. Outcomes and improving people's experience
No relevant activity

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

1. Prevention / raising awareness

To continue to promote our training to individuals from voluntary & community organisations in order to ensure they have the knowledge and skills to put adequate safeguarding measures in place in their organisation.

To continue to update safeguarding course content to reflect changes to guidance and local practice and include updated toolkits and

resources available to Voluntary and Community Sector organisations.

To undergo a multi–agency panel review of the Safeguarding Awareness workshop, through Bedfordshire Local Safeguarding Children Board and ensure that our workshop meets their Quality Assurance.

To continue to promote safeguarding in our email updates, on our website and in our development work with frontline organisations in order to increase awareness and also enable more people to receive training.

2. Workforce development
See information under 1 above.

3. Partnership working
To continue to develop links with Local Authority Safeguarding Teams and other local support and development organisations.

To work with Bedfordshire Local Safeguarding Children Board to undergo a multi–agency panel Quality Assurance review of the Safeguarding Awareness workshop.

4. Quality Assurance
To undergo a multi–agency panel review of the Safeguarding Awareness workshop, through Bedfordshire Local Safeguarding Children Board and ensure that our workshop meets their Quality Assurance.

5. Involving people in development of safeguarding services
To undergo a multi–agency panel review of the Safeguarding Awareness workshop, through Bedfordshire Local Safeguarding Children Board and ensure that our workshop meets their Quality Assurance.

6. Outcomes and improving people's experience
No relevant activity

ANNUAL REPORT TO ADULT SAFEGUARDING BOARD 2014/2015

Name Of Organisation:	Bedfordshire Care Group
Name(s) Of Person(s) Reporting:	Andrea Thasan

1. Local priority: Prevention and raising awareness
National priority: Prevention - It is better to take action before harm occurs

All providers have a duty to prevent and raise awareness concerning safeguarding and this is done by training provided to staff, by completion of the safeguarding competencies, updates at provider forums or at the Bedfordshire Care Group Meetings. Any awareness or prevention issues raised at Pan Bedfordshire are shared at the Bedfordshire Core Group Meetings e.g., issues around the Care Act and implications for providers.

2. Local priority: Workforce Development
National priority: Accountability - Accountability and transparency in delivering safeguarding

Staff knowledge around safeguarding is demonstrated through the SOVA competencies, regular updated training being provided which is monitored by CQC and the Local Authority, quality monitoring teams, which includes random questioning of staff.

3. Local priority: Partnership working
National priority: Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

By providers continuing to work in partnership with the Local Authority's and having a representative on the Board, and attending Pan Bedfordshire Meetings relevant and pertinent information relating to safeguarding can be shared alongside updates at provider forums via email, and at meetings of the Bedfordshire Care Group. Also issues and concerns this year about incontinence supplies and increased

attendance at Coroners Courts were able to be discussed.

4. Local priority: Quality assurance
National priority: Protection - Support and representation for those in greatest need

Each provider has their own QA systems but the Local Authority quality monitoring teams and CQC will also feed into this process of checking training provided, competencies completed and by randomly talking with staff.

5. Local priority: Involving People
National priority: Empowerment - Presumption of person led decisions and informed consent

Service users should always be consulted to seek consent with respect to any decision taken and there continues to be an emphasis on the MCA and where capacity is lacking decisions being made in service users best interest, involving advocates where appropriate.

6. Local priority: Outcomes and Improving Experiences
National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

Providers would feedback any concerns relating to people's experiences to the SOVA leads.

Highlight report of key issues arising during 2014/2015 addressing the priorities

Increase in DoLS applications, and Coroners inquests as a result, implications of Section 42 and the Care Act, securing ongoing supply of incontinence products so as not to increase the risk of pressure sores.

Improvements made in adult safeguarding during 2014/2015 addressing the priorities

Continued emphasis on MCA and its interaction with safeguarding.
Improvements planned in adult safeguarding during 2014/15, addressing the priorities
Focus on any changes required as a result of the Care Act 2014 and ongoing DoLS legislation

Abuse is Everybody's Business
Safeguarding is our Responsibility

Safeguarding Adults is about protecting vulnerable people from abuse, maltreatment and neglect and preventing avoidable harm

If you **see something** that concerns you, you must **report it today**

Tell

If a person is in immediate danger, call the police or ambulance straightaway on 999
If you are unable to report your concern or you don't feel that your concerns have been acted upon **say something** to the Adult Safeguarding Team or report your concerns to the

BEDFORD BOROUGH COUNCIL
Central Bedfordshire

The Adult Safeguarding Teams
Bedford 01234 276222
Central 0300 300 8122
adult.protection@centralbedfordshire.gov.uk
adult.protection@bedford.gov.uk
(0300 300 8123 for out of hours emergencies)

CareQuality Commission

on 03000 616161
Fax 03000 616171
enquiries@cqc.org.uk

We can all **do something** to promote dignity and respect for vulnerable people by becoming a dignity champion and making a pledge to do something practical. Visit www.dignityincare.org.uk for free or call 0207 972 4007

SAFEGUARDING ADULTS

Published by the Bedford Borough and Central Bedfordshire Safeguarding Adults Board. For further copies of this poster, to find out more about adult safeguarding and to see our policies, procedures and practice guidance including training and competency materials visit www.bedfordboroughpartnership.org.uk/adultsafeguarding

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