Appendix 1

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 2015- March 2016

Abuse is Everybody's Business
Safeguarding is our Responsibility

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Introduction

This annual report covers the work of the Bedford and Central Bedfordshire Safeguarding Adults Board during the year April 2015 to March 2016.

It aims to inform residents of the two unitary council areas, including those who use social care and health services, their families and carers, elected members of each Council, those who work in social and health care across all partner agencies, about the work of the Board and safeguarding activity across the area. Over the year all partner agencies who are part of the Board continued to work closely together with the aim of ensuring effective safeguarding. Partners have openly shared information on how they have performed, about the issues and challenges that they have faced over the course of the year and have sought to identify areas where closer joint working and co-operation will lead to improved outcomes for people.

During the past 12 months the Board focussed on

1. Embedding the well being principles of the Care Act, including "making safeguarding personal" which ensures that we have a focus on the outcome that the person we are seeking to support is at the fore.
2. Increasing our awareness of sexual exploitation, modern slavery and self neglect.
3. Improving our working arrangements with the Local Safeguarding Children Boards and Community Safety Partnerships
4. Responding to and monitoring the ongoing impact of the Supreme Court ruling on Deprivation of Liberty Safeguards (known as "Cheshire West")

The Board also moved to recruit its first Independent Chair and I came into post in March of this year.

During the coming year the Board will be focusing its activities around four broad themes:

1. Improving Board resilience – ensuring all Board members understand and deliver their roles and responsibilities as Board members;
2. System Assurance – ensuring the Board is confident that arrangements for safeguarding are effective, well managed and performing well and staff have the skills and knowledge required;
3. Challenge – the Board identifies areas where agencies need to improve their service or performance and is assured that action is taking place;
4. Awareness – the Board is confident that partners are aware of the strengths and challenges within the local community and that agencies are effectively identifying and responding to emerging risks.

A business plan with specific actions will build on those themes and will guide the work of the Board in the year to come.

Safeguarding is everybody's responsibility – the Board will do all that it can to support the work of our professional teams across health, local authority, voluntary sector and care providers. We will build on the strengths that currently exist and aim to learn from instances where things may not have been entirely successful. We will keep the Making Safeguarding Personal tenets of well-being and that outcomes people with care needs wish for are at the heart of our work.

Terry Rich
Independent Chair

1. The Developing Context for Safeguarding

1.1 The Care Act 2014

From April 2015 the Care Act 2014 put the Safeguarding Adults Board on a statutory footing. Revised statutory guidance was introduced in March 2016. Some of the more substantial changes reflected learning and feedback through the first period of implementation, including:

- Clarification that ordinarily, an enquiry under Section 42 of the Act is not appropriate where people are failing to care for themselves. Section 42 is primarily aimed at those suffering abuse or neglect from a third party.
- Updated definition of domestic violence to reflect new legislation.
- Additional information in relation to financial abuse to reflect significant increases in internet, postal and doorstop scams and crime.
- Amendments to reporting and responding to abuse to highlight the need for practitioners to consider the need for criminal investigations and take advice if necessary.
- Reporting and responding to abuse and neglect amended to remind local authorities that they have powers even where they do not have duties - adult safeguarding is one area where this may be significant.
- Reinforcement of the principle of prevention (better to prevent abuse than act after the event) and a reminder to practitioners of the importance of identifying and managing risk of abuse and neglect, even where those concerns are not the presenting issue.
- New guidance on allegations about people in positions of trust - emphasising that this is a responsibility of all partner agencies as well as the large and diverse independent provider sector.
- Local authorities encouraged to use existing tried and tested surveys to understand the experience of carers and service users who have been involved in a safeguarding process.
- The removal of the requirement to appoint a Designated Adult Safeguarding Manager (DASM). This was seen to have been confusing and contradictory and distracted from improving practice.
- The role of professional and practice leadership in adult safeguarding strengthened, to recognise the need to have expertise within an organisation where practitioners and their managers can go for advice and guidance. Emphasises the potential role of the Principal Social Worker in this area of practice.
- Section on strategic leadership reworked to articulate clearly the need for a strategic and accountable lead for safeguarding at a senior level in an organisation to ensure action to implement the SAB Strategic Plan.

1.2 Making Safeguarding Personal

The Care Act (2014) defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. Making Safeguarding Personal (MSP) aims to make safeguarding person-centred and outcomes focussed, and moves away from process driven approaches to safeguarding. The approach started in 2009, and has been led by councils. Since then it has grown in scale and momentum, culminating in inclusion in the Care Act (2014).

Rethinking key elements of safeguarding are important to making safeguarding personal, such as:

- Working to individuals' stated outcomes, rather than imposing outcomes. For example, in cases of domestic abuse, safety planning rather than encouraging people to leave the relationship straight away may be a positive outcome
- Agreeing 'desired' and 'negotiated' outcomes with people and spending time at the beginning of an intervention to get this right. This can be helpful to agree on outcomes that are realistic and take account of the broader context (e.g. law, human resources law and public interest).
- Ensuring that adequate time is spent preparing people for meetings, and not making assumptions about people's ability to express their outcomes, involving advocates where needed.
- Gathering feedback as the enquiry is progressing where possible, to avoid 'opening old wounds' by seeking feedback after the enquiry is closed.

In addition it is important to review our processes and ways of working including:

- where meetings are held
- who attends
- what can and cannot be discussed
- who needs to know what
- how data, discussions and decisions are documented
- how and by whom meetings are chaired
- and what skills, training and support people need to participate

While making safeguarding personal has started to become embedded, Recording of outcomes is an area that still needs significant work, despite much time and effort already having been spent on it. Data relating to outcomes is patchy and inconsistent and recording systems are often not set up to support this way of working.

1.3 Exploitation and Modern Slavery

Modern Slavery can include victims that have been brought from overseas, and vulnerable people in the UK, being forced to illegally work against their will in many different sectors, including brothels, cannabis farms, nail bars and agriculture. Sexual exploitation is included within the definition of modern slavery. In Bedford and Central Bedfordshire we have experience of homeless and alcohol dependent people in forced labour on traveller's sites, and domestic servitude experienced by a person with mental health needs.

From 1 November 2015, specific public authorities have a duty to notify Home Office of any person identified in England and Wales as a suspected victim of slavery or human trafficking. If the person consents, the national referral mechanism (NRM) should be used. The NRM is a victim identification and support process designed to make it easier for all the different agencies that could be involved in a trafficking case, for example, police, UK Visas and Immigration, local authorities, and non-governmental organisations to co-operate; to share information about potential victims and facilitate their access to advice, accommodation and support.

From 31 October 2015 there is a requirement for regulated health and social care professionals and teachers in England and Wales to report 'known' cases of female genital mutilation in under 18s which they identify in the course of their professional work to the police.

1.4 Working with Vulnerability

The implementation of the Care Act and its focus on well being has led to an increased focus on issues such as self neglect, hoarding, domestic abuse, and exploitation, as well as on people who may not have accessed adult social care historically but present as being vulnerable. This means there is an increased responsibility for Safeguarding Adults Boards to work in partnership, think creatively about how to respond, and balance the challenges of working with risk. For example, in cases of self neglect using multi agency risk enablement panels or conferences to establish which agency is best placed to support individuals on a longer term basis; ensuring domestic abuse cases are escalated and heard at MARAC; using existing resources in areas such as anti social behaviour and utilising partners skills, knowledge and expertise in challenging situations.

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

Name Of Organisation:	Bedford Borough Council

1. Progress on agency action plan for safeguarding

- The safeguarding team meets with the council Local Authority Designated Officer to share information and improve links with children's services.
- Meetings with representatives from Housing sector, Community and Voluntary sector and care providers to support issues pertinent to the sector
- Joint work within PAN Bedfordshire Group to produce a common template for providers undertaking S42 Enquires including guidance.
- Focus on Dignity in Care Day with displays and publicity to raise awareness.
- MCA awareness exercise relating to unwise decision making to promote greater awareness of the principals of the Mental Capacity Act held on Mental Capacity Awareness day (15/03/16).
- Partnership working by representation at Safer Community meetings, Anti-social behaviour meeting, Hate Crime Partnership, info sharing meeting with Care Quality Commission (CQC)
- 6 weekly meeting with the council Care Standards Team to share information about providers of concern and agree actions
- Attendance at the Pan Bedfordshire meeting to review training at Bedford Borough Council, Central Bedfordshire Council and Luton Borough Council with Workforce development managers as well as sharing case studies and implementing joint pieces of work
- Worked towards implementing the ADASS guidance and paperwork re Deprivation of Liberty Safeguards (DoLS) in relation to senior management sign off of DoLS
- Risk Enablement Panel met on a regular basis to consider complex cases where service users were making unwise decisions
- Work has continued following the investigation into criminal abuse at Winterbourne View Hospital in 2012 which initiated a national response known as "Transforming Care" to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviors that are described as challenging. In 2015 a 'Joint Transformation Plan' for Bedfordshire, Luton and Milton Keynes was drafted in response to the required actions led by the government. The plan been developed in partnership with the organisations identified within a new footprint area (Specified by NHS England), this includes three Clinical Commissioning Groups (CCG) and four Local Authorities, including Bedford Borough Council. A Transformation Board now meets on a monthly basis to oversee progress, this is led by Luton Clinical Commissioning Group and attended by core members of the Safeguarding Board.
- Bedford Borough Council has set up a Board concerning Child Sexual Exploitation and other vulnerabilities. This extends to the PREVENT agenda as well as modern slavery and other known vulnerabilities to enable concerns and intelligence to be shared amongst professional agencies.
- Regular meeting with East London Foundation Trust (ELFT) in relation to mental health services
- Meeting with team managers and advanced practitioners to share good practice and address safeguarding and DoLS issues
- Meeting with managers at an immigration detention centre to discuss safeguarding issues, regular meetings have been set up, which includes a representative from the council's children service
- Ongoing liaison and meetings with Bedford Hospital, the Bedfordshire Clinical Commission Group (CCG) and ELFT in relation to complex cases
- Individual work with providers where practice issues or concerns are identified for safeguarding, mental capacity and DoLS

2. Safeguarding risks and issues related to your agency and action taken

The Care Act 2014 came into effect on 1st April 2015 and enabled local authorities to request that another agency undertakes a formal safeguarding enquiry under section 42 of the Care Act. Bedford Borough Council took the decision not to ask other agencies to undertake a Section 42 Enquiry until training had been offered to ensure agencies and providers had the appropriate skills to undertake such an enquiry. Due to capacity issues for trainers, it was not possible to commission dates until after April 2016. A programme of training has now been implemented with a view to providers and agencies undertaking Section 42 Enquires.

An ongoing risk resulting from the Care Act is the requirement to provide an advocacy support for any individual part of a safeguarding enquiry that has 'substantial difficulty' in understanding and being involved in the process. Because of the pressures upon the local advocacy service, discussions have taken place between the service and the Bedford Borough Commissioning Team around the contract and what services can be provided, but it is likely that there will be a reduction in funding and this may impact on the level of community advocacy services offered for 16/17. Further pressure is resulting from the DoLS Supreme Court Ruling and the involvement of advocates to support this process.

The Bedford Borough Safeguarding Team continues to receive a high volume of safeguarding concerns/contacts and requests for DoLS, which results in the team being stretched at points. Consequently there has been a reduction in the amount of awareness sessions and developmental work that the team has been able to undertake. Team processes are reviewed to ensure the team is working effectively and changes in paperwork have been introduced to speed up processes.

DoLS has had a 29% increase over the year and throughout the year the number of DoLS authorisations that have exceeded time scales had increased. Reasons for exceeding time scales included increase in volume of requests resulting in administrative and process delays and backlogs, and delays in completion of assessments. Additional administrative staff have been employed to support this process and options for more effective and timely sign off of authorisations by senior council staff have been considered. An increased number of Section 12 Doctors and independent Best Interest Assessors have been commissioned by the Safeguarding Team and the team has also employed 2 permanent Best Interest Assessors to deal with the increasing levels of requests. Compared with other local authorities, the team has managed the volume of alerts well and there was no waiting list for assessments during this period.

Bedford Borough Adult services have been involved with a Serious Case Review initiated by children's services which involved the death of a young adult of 17 with a learning disability whose care would have been part of the transitions process. Recommendations have been made which include a holistic approach to Carers assessments and challenges and taking action when families refuse care and support for a vulnerable person.

Bedford Borough Council initiated a Safeguarding Adult Review for a case of suspected modern slavery. An independent reviewer with expertise in modern slavery and safeguarding was appointed to undertake the review and produce a report identifying learning across the agencies involved.

There has been ongoing collaboration with the Bedford Borough Care Standards Team to monitor a residential care home that had previously been under serious concerns. The home was unstable due to lack of management and the company placed a voluntary suspension of admissions whilst it reviewed its management position and put in place an interim manager.

As a result of ongoing concerns about practice issues in an independent hospital, ongoing monitoring and liaison between commissioners, CQC, BBC and CCG has been in place. CQC undertook an announced visit in August which resulted in an inadequate rating. Ongoing monitoring is still in place.

Following covert filming at a care home by family members which highlighted issues of poor care, 6 staff were suspended, and a S 42 Enquiry instigated which up held the concerns. The case was reported to the media and local press. The provider took disciplinary action which resulted in some staff being dismissed. The individual with family involvement was moved to a new care home.

Close working with ELFT and the CCG in relation to levels of safeguarding concerns within inpatient settings.

Following on from the independent audit undertaken, a recommendation was for the Safeguarding Board to consider the case of an individual who was admitted to hospital and concerns raised regarding the treatment, care and decision making that occurred in relation to his mental health needs and proposed use of ECT when the hospital were not licence to give ECT. This was discussed with the chair of the SAB and the case was to be referred to the SAB SAR Subgroup that was to be set up.

Due to capacity issues caused by staff vacancies, the Bedford safeguarding team has faced challenges in responding to all safeguarding concerns within timescales. Particular difficulties have been experienced with the high level of concerns and contacts either of a low level risk, where no abuse has occurred or where support needs where identified. The team has recruited to vacancies and will be fully staffed by September.

Issues in recording outcomes of completed S 42 Enquires have been identified. Regular meetings with the Corporate Performance Team have been set up and information reports are to be sent to the team monthly so any recording issues can be identified at an early stage.

An Easy Read leaflet explaining the safeguarding process to people with care and support needs involved in a safeguarding enquiry has been started, but due to capacity issues within the team issues has not been completed.

3. Outcomes of audit

- Programme of audits of Mental Capacity Assessments implemented, with feedback given to individual practitioner. Themes show that assessments were not evidenced based, not enough steps had been taken to support the person to help them make a decision, and it was unclear in some assessments how the decision as to whether a person had capacity or not was reached.
- Each completed S42 Enquiry is audited by the team manager or advanced practitioner for that team. There is a need to update the internal audit tool to incorporate checks that practitioner are appropriately recording outcomes on the council data base.
- Independent audit undertaken of both completed S 42 Enquires and safeguarding concerns that were screened out by the safeguarding team
- An internal audit planned for Oct with team managers and advanced practitioners. The audit did not take place due to unprecedented levels of sickness and low capacity within teams.

4. Risks and issues related to safeguarding training and policy

- Care providers training to undertake S 42 Enquires have been introduced so that providers have the relevant skills to undertake S 42 Enquires. Courses are well subscribed to and additional courses may have to be considered.

- It has been identified that the basic Mental Capacity training is not run frequently enough to ensure new employees receive the training within a reasonable timescale of starting. The metal Capacity Lead Practitioner is undertaking training to be able to deliver a monthly programme of basic mental capacity training. This training can also be adapted to meet the requirements of a specific team if needed.
- The Eastern Regions Safeguarding Leads Group has identified areas to develop and is working on modern slavery, Safeguarding Adult Reviews guidance, Making Safeguarding Personal and PREVENT
- The Safeguarding Competencies have been reviewed. Implementation of Safeguarding Competencies with teams needs to be undertaken
- Completion and implementation of MCA competencies
- Regular meetings with the Corporate performance team to identify an issues with recording and consideration if training for teams is required
- Review of safeguarding and Mental Capacity Assessment training and meetings set up with trainers for to discuss next year's training needs
- Regular Best Interest Assessors (BIA's) supervision groups including independent BIA's. Programme of training to for appropriately qualified workers to undertake their BIA training.
- Sessions to be set up with team managers and advanced practitioners on how to audit mental capacity assessment's and best interest decisions to ensure quality assessments and decisions.
- Review of the Multi Agency Policy and Procedure

5. Safeguarding risks and issues to prioritise in 2016-2017

- Introduction of safeguarding documentation that is based on Making Safeguarding Personal principals
- Implementation of a tracker and quality monitoring system for S 42 Enquires allocated to providers and other agencies
- Review of ongoing safeguarding training for practitioners undertaking S42 Enquires and review and commissioning of generic training for others
- Partnership working with agencies to identify alternative routes into services for people with care and support needs other than via the safeguarding team
- Ongoing work with providers in relation to appropriate reporting of concerns
- Strengthen links with LSCB and children's services with a focus on
- Review of S42 training for providers
- Training for safeguarding conference meetings minute takers to improve quality of mins
- Eastern Regions Safeguarding Group to focus on areas of modern slavery, Making Safeguarding personal, Safeguarding Adult Review and PREVENT.
- The Mental Capacity training has been reviewed with new trainers commissioned and additional training set up for practitioners managing complex cases which could result in Court of Protection proceedings.

Name Of Organisation:	Central Bedfordshire Council

1. Progress on agency action plan for safeguarding

- Corporate project established to respond to DoLS across the Council including the Coroner and Childrens services
- Revision of the safeguarding recording framework to include a review of person centred outcome and evaluation forms
- Review of risk enablement approach including policy and practice guidance

- Joint Board meetings across the LSCB and CSP are taking place; the chairs of these Boards have met and the Boards leads have been tasked to meet to plan a shared approach to common agenda. Leads for the Central Bedfordshire LSCB, CSP, SAB and HWB produced a paper for the chairs focusing on domestic abuse, mental health, prevent and radicalisation, female genital mutilation, hate crime, modern slavery, substance misuse and child sexual exploitation to support prioritisation of common issues
- Contribution to the Central Bedfordshire Domestic Abuse Strategy following a review by Safe Lives, the CSE strategy and the annual CSP strategic assessment
- Modern slavery and self neglect have been highlighted at the eastern region safeguarding leads meeting. Focus on improving the skills of the safeguarding team - attendance at modern slavery train the trainer event; attendance at self neglect briefing from Making Research Count.
- Safeguarding team awareness raising with a day centre, a housing tenants forum and the full of life older people's festival, carers rights day and day centre. Targeted work has begun with care homes and care agencies where safeguarding reporting patterns are noted
- Central Bedfordshire and Bedford Borough safeguarding teams met to review their approach to responding to safeguarding concerns post Care Act
- Representation at regular partnership group meetings - Police pan Bedfordshire steering group, L&D adult safeguarding board and CQC information sharing group

2. Safeguarding risks and issues related to your agency and action taken

During May a focused piece of work to review the recording of risk in safeguarding was undertaken. This revealed that that there continues to be variability in recording throughout the safeguarding process and throughout teams. A further monthly review of open safeguarding cases is carried out in order to proactively identify where gaps in recording and practice may be occurring.

The safeguarding team audited all cases undertaken by external agencies under S42 of the Care Act. Those with outcome of poor were due to the limited information within the report, and further information was requested from the agency to satisfy the team that a robust response had been initiated. Other results were as follows:

- Good and excellent reports did not require any further additions from the safeguarding team
- Adequate reports were varied in their quality, content and format
- Most adequate reports failed to clearly record involvement of, and feedback to, the individual and or their advocates
- Some adequate reports had outcomes but no real details in relation to how these would be met and within what timescales
- Some adequate reports did not report immediate actions or include comprehensive assessments of risk

Proposed actions:

- The safeguarding team need to be available to people undertaking S42 enquiries to discuss as cases progress, to provide a consistent approach.
- A template or form will be considered to assist and promote consistency
- Awareness of Duty of candour and its relationship to safeguarding needs to be strengthened.

The serious concerns process was initiated in respect of one nursing care home, following 19 safeguarding concerns reported to the Council during the quarter four in April, 9 in May, and four in June. Following CQC enforcement action to remove the registration, this care home was closed on 7th August 2015. Following an appeal the home's registration has been reinstated by tribunal and the home has since reopened under a new name. The serious concerns process continues to monitor progress following the court order.

A safeguarding adults review was initiated in respect of a resident formerly living at Greenacres care home. Abuse or neglect did not contribute to this person's death, however the safeguarding enquiry identified concerns relating to multi agency information sharing and response. A Serious Incident Learning Process was used to review the circumstances.

Two serious case reviews in respect of children were initiated by the Council. In both cases parents were identified as having a learning need and had been known to adult services.

The Council took a case to the Court of Protection following serious safeguarding concerns which resulted in social workers seeking an urgent order to remove an older man from his home to a local care home.

The Council had its first appeal against Deprivation of Liberty taken to the Court of Protection. An order was granted without a hearing due to all parties agreeing that the placement was in the person's best interests.

Mr X was reported to have died in a fire at his own home on 29th Feb 2015. The incident was reported to Bedfordshire police by Bedfordshire fire and rescue service. It has been logged by Bedfordshire police as non suspicious, related to cooking. His death has been confirmed and no further police or fire investigation action is being taken. The Chair of the SAB was briefed on the incident and a decision reached that: while the case raises issues around the role of agencies in safeguarding individuals who are resistant to services and are prone to self-neglect, there are not sufficient issues to warrant an SAR. The Council will initiate an internal management review with a view to presenting a case study to assist the board in considering the general issue of self-neglect and service resistance and the role of statutory and voluntary sector agencies in safeguarding their well-being.

3. Outcomes of audit

Rating	Number of files	Themes
Excellent	2	Well managed with clear documentation and planning. Risks clearly identified. Protection plan robust in its analysis of risks. Good multiagency working. Information recorded relevant to outcomes. Creative, person centred, outcomes focused and holistic with good managerial oversight.
Good	4	Very clear recording of the process and interventions used- Excellent communication with family throughout Good initial assessment and assessment of risk and protection plan. Good person centred working and involvement of person causing harm as appropriate. Could have identified strengths more clearly, would be helpful to pull all risks across to protection plan, Lacked good evidence of planning at strategy and may have discussed risks more clearly at case conference as documented.

Adequate	3	No evidence that family were contacted at the initial visit. May have considered supportive approach with the view to engaging family. Did provide appropriate responses to the concern in regard to protection planning but the risk assessment was limited in terms of its focus. Further ongoing work on domestic abuse support would have been good practice. Risk assessment holistic but fails to identify main risk concerns adequately. Outcomes not recorded
Poor	1	No good analysis of risk or liaison with other professionals, no consideration of strategy discussion to identify risks and close the case.

During October and November 2015 30 open safeguarding cases were reviewed. These have been reviewed through a combination of peer review with the practitioner and desk top review with feedback provided to the practitioner afterwards. Common themes show that the safeguarding recording framework is not being used as live documentation to show actions undertaken, evidence based decision making and protective measures in place. In undertaking these reviews the safeguarding team has been able to have discussions with practitioners about the advantages of recording a case in real time in terms of efficiency and effectiveness. This piece of work will continue in January, with the safeguarding team continuing to review open cases, and undertaking some shadowing of a safeguarding case using real time recording to test the barriers to working in this way.

4. Risks and issues related to safeguarding training and policy

- The pan Bedfordshire sub group has identified modern slavery and self neglect as potential areas where there are training needs. Both of these areas have been highlighted at the Eastern Region
- There is a need to maintain and develop the focus on person-centred safeguarding responses within the adult social care workforce and with those undertaking S42 safeguarding enquiries.
- The multi agency safeguarding policies and procedures are unwieldy as a consequence of covering many areas pertinent to safeguarding adults and the number of cross cutting issues. Consideration needs to be given to an electronic web based version that partners can easily access.
- Low numbers have attended the financial abuse and making safeguarding personal training during 2015. A review of the training offer for safeguarding was undertaken in April 2015
- The MCA DoLS training offer is being reviewed in light of the requirements for social work/ nursing staff to have a sufficient level of competency in relation to DoLS and court of protection.
- The competency frameworks for safeguarding have been updated post Care Act but the MCA competencies require review and updating post Cheshire West.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The disproportionate increase in volume of reports via the safeguarding team that are not of a safeguarding nature or relate to people with care and support needs.
- A review of the training offer and the MCA competency framework

- Ongoing work required with providers who undertake S42 enquiries

6.Bedford Borough and Central Bedfordshire Joint Case File Audit

The annual independent case file audit of safeguarding work in the two Councils was undertaken in February 2016. The auditor undertook audits across both Bedford and Central Bedfordshire Councils. In summary, the audit found that:

- 75% of the Individual case audit was rated “Good”, 25% rated “Adequate”
- 82% of the Threshold decisions audit was rated “Good”, 18% rated “Adequate”
- Case recording demonstrated a high degree of understanding of the need to ensure immediate service user safety
- Response to safeguarding concerns and subsequent enquiry was proportionate in all cases
- All cases demonstrated holistic and robust risk assessment
- All cases demonstrated concern for quality of life issues in addition to the safeguarding concern
- All cases demonstrated a personal approach, concerns regarding well-being and appropriately reflected desired outcomes
- All cases demonstrated an understanding of Mental Capacity Act issues, advocacy provision and Deprivation of Liberty Safeguards (DoLS)

The headline areas of focus for development are:

- Accurate recording. The SWIFT Data base does not support practitioners to achieve excellent due to lack of appropriate tabs which reflect both the Care Act (2014) and the Multi Agency Policy. The updating of data systems can ensure actions and decisions are accurately recorded
- Risk enablement and assessment
- Use of the safeguarding recording framework to evidence making safeguarding personal
- Ensuring close collaboration with Police
- Consistently recording reasons for delay
- Management oversight
- Managing complex meetings so minutes are taken accurately
- The Service User feedback process
- Consistent approach to recording when a decision tool for an alert is not required
- Mental health services and access to SWIFT

The full report has been disseminated to all teams within the two Councils within adult social care. The safeguarding team lead officers will run practice surgeries with all teams to ensure full understanding of the learning within the report.

Name Of Organisation:	Bedfordshire Clinical Commissioning Group

1. Progress on agency action plan for safeguarding

The following actions were identified on the BCCG Safeguarding Adults 2015/2016 work plan;

- The development of an audit tool to understand the training needs for safeguarding adults in primary care. This action was met and enabled a targeted programme to be developed.
- The development of a primary care adult safeguarding training programme. An adult safeguarding training schedule, jointly delivered by BCCG and Luton CCG, is now place incorporating MCA, DoLS and WRAP. 131 delegates have attended to date, 57% of which were from Bedford Borough and Central Bedfordshire.
- The development of a training programme for BCCG staff in relation to Prevent basic awareness and WRAP dependant on role. A training programme is now in place.

2. Safeguarding risks and issues related to your agency and action taken

In acknowledgement of the Supreme court ruling, the BCCG MCA and DoLS lead has been working with the CHC team to identify intensive community care packages that may reach the threshold for DoLS. For those cases identified, capacity assessments are being undertaken to ascertain if the individual can consent to the care package/ regime that is in place. Where appropriate, applications to the Court of Protection will be sought to ensure CHC funded care packages in the community are lawful.

There are currently two Safeguarding Adult reviews, one approaching conclusion and the other awaiting publication. BCCG are working with providers to support and oversee delivery of the single agency recommendations identified. These will be monitored through contractual arrangements to ensure they are being embedded into practice. BCCG will facilitate wider learning across the health economy by sharing lessons learnt with neighbouring CCG's.

3. Outcomes of Audit

A safeguarding audit was undertaken within primary care to establish learning needs. A training programme has subsequently been developed to incorporate the identified gaps in knowledge, namely, MCA, DoLS and PREVENT.

4. Risks and issues related to safeguarding training and policy

- During 2015/2016 a combined, Care Act compliant, Safeguarding Adults and Children's policy was developed. Further policies relating to MCA and DoLS have been developed and are currently awaiting ratification.
- The Safeguarding Adults: roles and competencies Intercollegiate Document, due to be published imminently, will have significant implications in relation to the training that is delivered to health care professionals. Following publication, BCCG will review its current Adult Safeguarding training package to ensure adherence to this document.
- Adult safeguarding training for BCCG staff is provided via an e- learning module and face to face as part of the corporate induction. As of March 31st 2016, compliance for the e- learning module was recorded as 91.86%.
- Additionally, BCCG oversee provider safeguarding arrangements which includes compliance with training and assurance that appropriate policies are in place.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Development of a care home profile for each care home within Central Bedfordshire and Bedford Borough. This will enable improved oversight of issues and/or concerns so that appropriate action can be taken.
- Development of an announced and un-announced visit schedule of all commissioned services, to incorporate care homes.
- BCCG are to be part of the NHSE Midlands pilot scheme to use a standardised, electronic safeguarding data/ assurance tool. Roll out is anticipated for September 2016.
- To work with and support providers, to ensure that the recommendations from the Safeguarding Adult Reviews, commissioned in 2015/2016, are addressed and embedded into practice.

Name Of Organisation:	Bedfordshire Police

1. Progress on agency action plan for safeguarding

- Domestic Violence Protection Notices and Orders (DVPN/Os) continue to be successfully issued in Bedfordshire. The number of DVPOs served and obtained by the force has increased significantly.
- A new offence came into force on 29 December 2015 which sees coercive and controlling behaviour in abusive relationships carry a sentence of up to five years. Over the last six months we saw an upward trend in the conviction rate towards the national average of 75%, with the rolling rate sitting at 73%, up from 70% last year.
- The force has commenced a domestic violence perpetrator panel alongside the Integrated Offender Management that seeks to reduce repeat victimisation.
- Work on Hate Crime has led to the recruitment of the first 3rd party reporting centres for hate crime, there are now 5 spread across the County. Members of these organisations have received specific hate crime training.
- Following a hate crime action week involving the Police and partner agencies over 90 people attended from 50 different organisations, 7 of these have signed up to become 3rd party reporting centres with a further 10 expressing an interest.
- Reports of hate crime have steadily increased year on year, this year has averaged 68 reports per month compared to 64 last year. Conviction rates currently stand at 88% in Bedfordshire compared to the national average of 82%.
- During the last year the safeguarding team have undertaken serious and complex crime investigations including ones of theft committed by carers on their

elderly service users. In March 2016, the force were committed on a county wide operation where officers attended a Bedfordshire travellers site as part of a multi-agency task force looking for victims of modern day slavery. This is the 2nd Operation of a similar nature within the year.

2. Safeguarding risks and issues related to your agency and action taken

- Domestic abuse continues to be under constant review both internally and externally, with HMIC revisiting the Force throughout the year after the HMIC Vulnerability Inspection Report was published in December 2015 and the Force was graded inadequate.
- The Rape Investigation Unit has an improvement plan in place which seeks to improve standards of investigation and evidence gathering, raise awareness and increase knowledge and understanding of sexual abuse, ensure consistent identification and assessment of risk, support and safeguarding and lastly to ensure sufficient training of frontline responders and investigators. The improvement plan includes actions generated from the HMIC inspections and as such the number of Initial Contact Officers across the county has increased to meet demand.

3. Outcomes of audit

- Bedfordshire Police has introduced a feedback process to review and advise frontline officers on the quality of investigations and case handovers to ensure wider improvement across the organisation.

4. Risks and issues related to safeguarding training and policy

- The force is currently providing hate crime training both internally and externally, a hate crime safe-guarding tool kit has been developed for operational Police Officers. Hate crime stalls have been run in Bedford and Luton Town Centres raising awareness and encouraging the reporting of hate crime. Service users from mental health and learning disabilities have also been given hate crime awareness training.
- The Child Sexual Exploitation (CSE) team have attended meetings with Central Beds Local Authority to support training for Hotels and B & B's. The CSE team have attended a training day at the Luton and Dunstable Hospital, with the CSE SPOC for Luton where over 300 health professionals attended three sessions and Chelsea's Choice was performed.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The Force was recognised in the work that has been done to improve the assessment of risk in domestic abuse cases and working closely with partners to safeguard the vulnerable in our society. We are constantly reviewing the way we work and exploring new opportunities to better protect people and we hope our commitment will be reflected in the next HMIC inspection on this priority area for the force in the autumn of 2016.
- The force has committed to funding the training of a critical mass of "first responders" and DA Matters is the training that is recognised to be capable of changing the mind-set of a workforce, endorsed by the College of Policing. It has been agreed that the best option is to train the critical mass as quickly as possible to maximise the cultural change and therefore the training shall take place over an 8 week period commencing January 2017.
- Bedfordshire Police are due to 'go live' with the roll out of Technical SoS (TecSoS) mobile phones which are another tool available to support high risk victims of Domestic Abuse. The aim of the TecSOS project is to introduce a mobile handset that provides high-risk vulnerable people with enhanced access to the police in an emergency.
- A Countywide Sexual Abuse Strategic Group is being considered
- Bedfordshire Police have worked with Mind, Samaritans, ELFT and EAST to introduce Mental Health Street Triage (MHST). This is an all ages, county-wide service which delivers an emergency response to people experiencing a mental health crisis.

Name Of Organisation:	POhWER

1. Progress on agency action plan for safeguarding

- POhWER has remodelled its Safeguarding training to reflect the requirements of the Care Act. New staff must complete POhWER safeguarding training as part of their induction – this must be signed off before staff complete their probation. The Community Manager delivers regular safeguarding briefings and updates during team meetings.
- During this year the Community Manager gave presentations to local social work teams and to the local mental health social work teams with a focus on the Care Act and advocacy. POhWER is a co-opted member of the Safeguarding Adults Board – the Community Manager provides regular updates from the Board to the POhWER Senior Management team.

2. Safeguarding risks and issues related to your agency and action taken

- As the year progressed it became apparent that there may be risks to timely allocation of IMCAs due to the increased rate of referrals (see below). POhWER has managed to continue to meet its internal service standards and is in ongoing discussions with the commissioners regarding the way forward in the future.

3. Outcomes of audit

Bedford Borough Council MCA/DoLS referrals 2015-16

	Q1	Q2	Q3	Q4	Total
39a	8	10	10	15	43
39c	3	2	3	4	12
39d	23	16	4	9	52
ppr	**18**	**34**	**39**	**29**	**120**
safeguarding	3	4	3	2	12
					239

Central Bedfordshire Council MCA/DoLS referrals 2015-16

	Q1	Q2	Q3	Q4	Total
39a	14	8	8	16	46
39d	9	5	8	5	27

ppr	**7**	**28**	**19**	**18**	**72**
safeguarding	6	2	3	4	15
					160

The increase in paid person's representative referrals in both local authorities is evident from the above tables (192 referrals in total).

There have continued to be few referrals for community advocacy support for an individual who is subject to a safeguarding enquiry (27 in total in the year 2015-26), with only 3 referrals coming from local safeguarding teams. However, as the Care Act begins to have an impact, a further 9 referrals have been received under this legislation.

POhWER advocacy staff have raised 5 safeguarding alerts during this period:

Emotional abuse	2
Institutional abuse	1
Physical abuse	1
Self neglect	1

4. Risks and issues related to safeguarding training and policy

As well as ensuring the staff have regular safeguarding updates, the Community manager uses published Safeguarding Adult Reviews to deliver further training to staff and to consider where advocacy could have had an impact.

The Community Manager has acted as independent chair in respect of a Safeguarding Adults Review for Bedford Borough Council relating to Modern Day Slavery and will, when the time is right, conduct an internal learning event in respect of this type of safeguarding concern.

5. Safeguarding risks and issues to prioritise in 2016-2017

The pressure on the MCA/DoLS service continues in two particular respects:

Relevant Paid Representative Service (RPR) – this statutory service supports people who are subject to DoLS long-term, by offering a regular visit to check on the appropriateness of the DoLS authorisation. This service applies to people who have had an authorisation for up to a year and whose condition is unlikely to improve, with a restriction likely to continue to be in place. Authorisations are renewed annually unless the client is deceased. Therefore clients accumulate on an advocate's dashboard, increasing pressure on the advocate's workload. Discussions are on-going with Bedford Borough Council to identify alternative models of delivery, where this work can be undertaken by trained community advocates rather than IMCAs.

Litigation Friend support – requests are coming in now for POhWER to provide a litigation friend service where a DoLS authorisation is being challenged at the Court of Protection. These pieces of work are very time consuming and apply significant pressure on the service. A piece of litigation friend work can typically take up as

much as 50 hours of an advocate's time.

Additionally, there is a need for further awareness raising in local health and social care professional teams with the aim of improving the referral rate for supporting individuals through the safeguarding process (making safeguarding personal), either through the IMCA service or through the Care Act advocacy service.

Name Of Organisation:	Healthwatch Bedford Borough

1. Progress on agency action plan for safeguarding

Healthwatch Bedford Borough (HBB) has seen its contribution in focusing on aspects of the SAB Action Plan as follows:

- By involving people who access services and carers in continual service improvements and the management and development of Safeguarding arrangements across Bedford Borough and Central Bedfordshire

Examples of this work are:

Enter and View visits to local Care Homes – where issues such as recommending the use of Makaton – which is a language programme using signs and symbols to help people to communicate. This was seen as a way of ensuring that by its use, that care home residents are better able to understand matters that may affect their wellbeing/safety. We also recommended safety improvements to fixture/fittings in the Care Home, which although not immediately apparent to staff, will reduce/avoid such incidences as trips/falls by residents.

Signposting service – HBB became aware people that people/patients/carers who are D/deaf can be at a serious disadvantage/exclusion from receiving the service which is appropriate to their needs. HBB has worked jointly with organisations such as Access Bedford to use electronic (emails/etc) communications to enable local service providers to engage with members of the D/deaf community as necessary. The pioneering work that HBB has been engaged on in this work has now been replicated in other parts of the Country.

Complaints - HBB has now installed the Contact Relationship Management (CRM) system – this system is managed by Healthwatch England (HWE) on behalf of the local Healthwatch (LHW) network. This enables HWE to correlate items of concern which emerge across the network of 152 LHW`s in England. Whilst HBB does not deal with individual complaints, the trends which emerge from recording data received, can be used to assist commissioners/service providers in preventing/minimising similar occurrences in the future.

HBB also includes the use of the Browsealoud sound system on its website www.healthwatchbedfordborough.co.uk to ensure that "everyone" is included (it has 35 other languages which can also be accessed) – the website also translates into over 70 different languages.

2. Safeguarding risks and issues related to your agency and action taken

HBB seeks to ensure that staff and volunteers are provided with appropriate training in safeguarding matters. All staff and volunteers are required to undertake a Disclosure and Barring Service (DBS) check.

3. Outcomes of audit
As an added precaution - the copy of the outcome of an individual DBS check – HBB requires to be provided with a copy of the outcome report.
4. Risks and issues related to safeguarding training and policy
None identified.
5. Safeguarding risks and issues to prioritise in 2016-2017
HBB will be mindful of the SAB Action Plan and will use that to guide its safeguarding activities during 2016-2017.

Name Of Organisation:	Healthwatch Central Bedfordshire

1. Progress on agency action plan for safeguarding

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 2015/16. Key issues arising during 2015/16 included suspected abuse at an Inpatient Unit; concerns about a disabled resident and the uncaring attitude of staff at a sheltered housing resource.
- 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 2016/17.

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, our Feedback Centre 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 engagement events held throughout 2015/16. HWCB are able to signpost to the Safeguarding team at CBC or other support agencies or organisations that can help.
- An Enter and View visit was conducted by HWCB following the re-opening of a care home after its closure by CQC in the summer of 2015. .

2. Safeguarding risks and issues related to your agency and action taken

- None

3. Outcomes of audit

Enter & View Visits

- Part of the local Healthwatch programme is to carry out 'Enter and View' visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being managed and to make recommendations where there are areas for improvement.
- The Health and Social Care Act 2012 allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, patients and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.
- Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.
- All our Enter & View representatives are fully trained to visit a range of NHS and social care premises to talk to staff, patients, Carers and other service users about their experience.
- During 2015/16 Healthwatch Central Bedfordshire carried out 28 Enter & View visits on services in our area which includes Residential and Nursing Care Homes (for a full list, including a report of each visit, please go to www.healthwatch-centralbedfordshire.org.uk). This year we launched HWCB's 'Enter & View' programme of visits to GP Practices in Central Bedfordshire.
- Each Enter & View report, which includes our recommendations, is shared with the local authority, Central Bedfordshire Council, the Bedfordshire Clinical Commissioning Group, the Care Quality Commission and Healthwatch England. The final reports, of which many include the Provider response, are then published on our website.
- Since the beginning of 2016 we are working even more closely with the Care Quality Commission as we are now sharing a national organisation structure. We hope to continue to be at the forefront of improvements in service provision.

4. Risks and issues related to safeguarding training and policy

Volunteers

- HWCB authorised volunteers who are part of our 'Enter & View' task and finish group completed a series of five pre-requisite training courses during 2015/16, including Safeguarding, Equality & Diversity, Data Protection and Confidentiality and 'Enter & View' in-house training sessions. Further training sessions will be organised as additional volunteers join the team during 2016/17.
- This training is designed to give them a greater understanding and awareness and to be able to identify safeguarding issues if they become apparent during the Enter & View visit. They will also be aware of who to report to with any areas of concern when conducting a visit.

Workforce Development

- Healthwatch Central Bedfordshire staff have all successfully undertaken the Safeguarding Adults Awareness one day course and refresher course. Safeguarding remains an important issue for all HWCB Board members

5. Safeguarding risks and issues to prioritise in 2016-2017

Healthwatch Central Bedfordshire will continue to report issues and concerns to the Safeguarding Board and to Safeguarding Officers at the Council into 2016/17.

Name Of Organisation:	SEPT Community Health Services

1. Progress on agency action plan for safeguarding

- The Trust continues to be active members of the Bedfordshire Safeguarding Board and Operational Group. The Locality Manager of Bedfordshire Community Health Services represents SEPT at the Operational group. This provides clinical knowledge and experience of issues pertaining to a wide range of Community Services and information is cascaded to teams as appropriate.
- The Locality Manager also attends the Trust Safeguarding meeting and provides updates from the Operational Group. The minutes of all Bedfordshire Board meetings are standard agenda items at the Safeguarding group.
- The Trust Safeguarding team continue to work in partnership with the CCG, other NHS organisations, police, advocates and voluntary sector.
- 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. The Trust are exploring how this can be adapted for use with CHS service users.

2. Safeguarding risks and issues related to your agency and action taken

- The Safeguarding team have worked with BBC and CBC to implement the changes since the introduction of the Care Act 2014 and Sec 47 enquiries. The Trust are in regular contact with Local Authority teams to discuss the progress of cases and to provide evidence to support enquiries.
- The Safeguarding team have continued to support staff, advising on robust risk assessments and the least restrictive and intrusive options when supporting service users.

3. Outcomes of audit

- The Trust Learning Lessons Oversight group meets monthly and regularly features a safeguarding case in order to learn lessons and cascade learning
- The Trust received excellent feedback from the Trust wide CQC inspection with regard safeguarding service.
- The Trust has responded to the initial recommendations from NHS England from the Goddard Inquiry which included a checklist for NHS organisations which provides assurance that SEPT have effective arrangements in place for safeguarding.

4. Risks and issues related to safeguarding training and policy

- A series of preventative and awareness raising initiatives continue to be implemented within SEPT. This includes training programmes and the introduction of reflective practice forums where clinical staff meet with the Trust Safeguarding Lead to discuss open safeguarding cases, potential cases and to explore emerging themes.

- The Trust compliance with safeguarding training has been above 90% for 2015/16. Training has been delivered via E-Learning and face to face programmes.
- The Trust Training strategy has been updated and includes Face to Face Prevent training programme where there is an 89% compliance of Bedford CHS clinicians. Prevent training is also incorporated into Level 1-3 safeguarding programmes.
- MCA DoLS training has been introduced this is both E-Learning and Face to Face dependant on staff role.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Good ownership of the safeguarding agenda within Community Health Services staff
- Compliance with staff knowledge and skills continues to improve
- Good partnership working
- Opportunities to discuss, reflect and share lessons learned
- Continue to develop the reflective practice sessions
- Arrange a combined safeguarding child and adult conference
- Continue to improve skills of staff working in Community Health Services

Name Of Organisation:	Bedford Hospital NHS Trust

1. Progress on agency action plan for safeguarding

- The substantive Adult Safeguarding Specialist Nurse commenced her role in August 2015 to support the Adult Safeguarding Lead Nurse.
- Bedford Hospital Safeguarding Board continues to meet monthly, this is a monthly meeting chaired by the Director of Nursing with key stakeholders in attendance including CCG representation.
- The Joint Adult and Children Safeguarding Board commenced meeting quarterly in Q4 of 2015/16. This Board allows both the Children services and Adult services in the hospital to share information and develop joint policies and procedures.
- The Adult Safeguarding Specialist Nurse or Adult Safeguarding Lead Nurse attends the daily operational quality meeting – this includes discussion of emerging safeguarding issues and possible referrals, providing guidance, direction and practical help.
- Matrons and Ward Managers continue with daily quality checks and Site Practitioners have a schedule for conducting quality audits at night with feedback in real time to staff in charge of the area.
- The Adult Safeguarding Lead Nurse meets fortnightly with the Local Authority and Bedfordshire CCG to discuss and follow up on actions that are required in terms of open Safeguarding Investigations to expedite the process. This includes review and monitoring of all open cases/safeguarding Investigations. There are formal terms of reference for this meeting.
- 265 alerts were raised in 2015/16; a decrease of 4 alerts on 2014/15, with 9 alerts upheld against the Trust, a decrease of 11 in the previous year.
- In Quarter 1 of 2015/16 a high majority of alerts related to ‘Harm by Family’ and there have continued to be a high number of alerts in relation to this throughout the year.
- There has also been an increase in regards to alerts raised regarding harm in care-residential/nursing.
- In regards to allegations raised about harm in hospital, the number of alerts has remained consistent throughout the year.

- The number of alerts raised in regards to discharge issues has remained low, and during quarter 4 at the point of winter pressures this number is very small (3).
- The number of alerts raised in regards to pressure ulcers which have occurred both in the community and in the acute hospital; due to self harm or negligence has decreased in 2015-16 comparison with the previous year 2014-15 (28 vs 36 respectively).
- Increasingly we are seeing more alerts where harm has occurred outside of the trust particularly when the patient is in the care of their family or residential/nursing care. This increase may be associated with patients making allegations when they feel that they are 'safe' within the hospital environment and because staff are more skilled at identifying signs of abuse and are raising appropriate alerts.
- An extensive Registered Nurse recruitment drive has taken place in 2015/16 which has included both the recruitment of overseas nurses as well as the recruitment of local nurses from recruitment initiatives.
- The role of a 'Patient Champion' has been developed; this incorporates Safeguarding Adults, Dementia and Dignity Champions. This was launched in September 2015. There are currently 64 patient champions within the hospital from 39 of the 47 wards and departments. The 'Patient Champions' meet monthly for the opportunity to share good practice and learn lessons from previous Safeguarding concerns.
- 12 nursing staff successfully completed a Safeguarding Adults Champions Course with the University of Bedfordshire.
- The hospital has achieved a 50% reduction in the number of avoidable pressures ulcers reported in 2015/16.
- There is now a link tissue viability nurse on each ward. Quarterly, tissue viability link nurse meetings are held to share root cause analysis and learning and increase their knowledge base. This allows the link nurse to return to their ward bases to share this information.
- Alzheimer's Society have commenced weekly clinics in Quarter 1 of 2015/16 on Elizabeth and Harpur Ward for patients with Alzheimer's dementia and/or their carers for advice, support and signposting to other services.

2. Safeguarding risks and issues related to your agency and action taken

Deprivation of Liberty- Throughout the year and increasingly so, we have had patients who have not received a standard authorisation prior to their urgent authorisation expiring. This is due to a delay in obtaining a Standard authorisation from the local authority due to the processes they are required to follow and is particularly heightened during bank holiday periods. In each of these cases family members were consulted with and they were happy for care and treatment to be provided in the patient's best interests. In each case an Internal Incident Form has been completed. This risk has now been added to the risk register as detailed above and escalated to the Multi agency Safeguarding Adult Board. This was noted by the CQC during their inspection on the 16th December 2015.

Safeguarding Adults- It is recognised that there may be a delay in some Safeguarding Adults Investigations reaching conclusion particularly when there is police involvement and investigations of a criminal nature which Bedford Hospital NHS Trust has no control over, this may attract adverse media attention and complaints from members of the public. Therefore we have added this to the Bedford Hospital Trust Risk Register and maintain open dialogue with both local authorities to help mitigate the risk.

3. Outcomes of audit

At the beginning of Quarter 4 an audit was completed to monitor the use of DNA CPR with 10 patients who have Learning Disability patients in relation to recent changes in guidance on the implementation of DNACPR.

Main Points for Audit:
Was the patient part of the decision making process?

a) If not was Mental Capacity Act used to identify Best Interest and family/friends or Independent Mental Capacity Advocate (IMCA) involved.
b) How long was it from the instigation of a DNACPR form to consultation with Patient or representatives under Mental Capacity Act?
c) What rational was presented for the need for DNACPR, and did this include diagnosis of Learning Disability as a reason for DNACPR.

Findings included:

- No case had Learning Disability documented as the reason for the need or rational for a Do Not Attempt Cardio Pulmonary Resuscitation Decision; this is seen as best practice.
- Family or Independent Mental Capacity Advocate were used, or planned for, on all occasions. There were examples of excellent communication recorded with family.
- The Mental Capacity Assessments and Best Interest Decision practices used were appropriate.
- Quality of written records was often good but not consistently so. This adversely effected data acquisition and identification in records, on occasion, where handwriting or content was difficult to understand.
- Filing of records that may be required to demonstrate the good practice, were not in an order that made this reliable in all cases

Recommendations:

- For this report to support the review of the DNA CPR Paperwork being currently undertaken.
- Continue use of the categories of reason for use of DNA CPR
- Develop clear identification on the form of the need for Mental Capacity Assessment and Best Interest decisions.
- Continue delivery of Mental Capacity Act Training

Additional Action:
To contribute these findings to the revised DNACPR policy in order to reflect best practice in Mental Capacity Assessments. This is due for revision in Quarter 1 2016 / 17.

4. Risks and issues related to safeguarding training and policy

Table ONE: Attendance at Safeguarding Training over a Rolling Three Year Period at the end of Q4 (2015/16)
(Compliance for Adult Safeguarding Training is 90%)

Staff Group	% against target

Add Prof Scientific and Technic	93.28
Additional Clinical Services	93.26
Administrative and Clerical	87.83
Allied Health Professionals	96.59
Estates and Ancillary	93.61
Health Care Scientists	100.00
Medical and Dental	73.96
Nursing and Midwifery Registered	95.04
Total	**90.95**

Adult Safeguarding Training incorporates Mental Capacity Act Training and Deprivation of Liberty Training, alongside Basic PREVENT awareness.

In both Quarter 3 and Quarter 4 of 2015/16 additional Mental Capacity Act Training and Deprivation of Liberty Training was provided for all Consultants, Specialist Registrars and senior nursing staff from Mills and Reeves Health Care Solicitors. This course continues to be very well evaluated by participants.

5. Safeguarding risks and issues to prioritise in 2016-2017

- To continue to recruit and develop the role of the patient champion within the hospital
- Publish Bedford Hospital Dementia Strategy 2016-2019.
- Host a Primary Care and Acute Care Discharge Summit to improve partnership working with community health care providers and improve patient experience of discharge
- It is planned that during 2016/17 a service quality improvement project will be launched involving each of the tissue viability link nurses in their practice areas.
- Strong Partnership working with the Local Authority and CCG to continue.
- The Bedford Hospital Safeguarding Adults Board will continue to monitor and review key publications and national / local directives throughout the year, taking action where appropriate and reporting these through to the Executive Management Committee for assurance purposes.
- Further courses continue to be provided and commissioned in respect to Safeguarding Adults, Mental Capacity and Deprivation of Liberty.

Name Of Organisation:	Luton and Dunstable Hospital

1. Progress on agency action plan for safeguarding

- Full implementation of the Care Act 2014 has taken place. This continues to be discussed at every training session provided by the Adult Safeguarding Lead with specific attention given to the three new forms of abuse introduced by the Care Act 2014 including the abuse indicators.
- Both the Adult Safeguarding Policy and the Mental Capacity and Deprivation of Liberty Safeguards Policy have been updated and fully comply with the new Care Act 2014.

- The Adult Safeguarding Lead continues to represent the Trust at the Channel Panel with support from the Clinical Commissioning Group, as part of the Prevent programme and Governments counter-terrorism strategy. In addition, staff have been advised to raise concerns via the internal safeguarding processes as requested.
- No audits were completed in 2015/16. However 4 audits are planned for 2016/17.
- The Care Quality Commission visited the Trust in January 2016 to assess its compliance against the standards required. During the visit there was a strong focus on Adult Safeguarding as well as compliance with Mental Capacity (MCA) and Deprivation of Liberty safeguards (DoLS). The final report has been released and the trust was given an overall rating of good with some areas of practice deemed outstanding.
- Monthly meetings have been arranged between the MCA/DoLS lead and the Trusts Adult Safeguarding Lead which gives opportunities to discuss new legislation/guidance alongside gaining advice on complex cases where needed.
- The Adult and Paediatric Safeguarding teams continue to work more closely together and foster greater working relationships. As well as working on joint work streams such as Domestic violence and Prevent both teams now attend joint meetings and both Trust safeguarding boards. In addition to this IT access has been given to the adult safeguarding team to retrieve safeguarding information on children when required.
- Furthermore, the Adult and Children's Safeguarding Team have liaised with Luton Food Bank to become referrers. To raise awareness, both teams have arranged a Food Bank Drive within the Trust which will commence on the 18/07/2016 for five days. All donations will be given to Luton Food Bank in time for the school holidays. They have stated this will help support them during a time that increased activity is noted due to school holidays.
- The Safeguarding lead continues to attend the multi-agency Safeguarding Leads meeting which is chaired by the Head of Adult Safeguarding from the LCCG and the Operation sub-group meetings for Central Bedfordshire Council. The meeting is held quarterly with all the appropriate safeguarding leads from providers, managers and social workers from LBC and NHS England. This meeting is to discuss any issues and concerns and to support each other. This has been extremely useful and interesting with a robust action plan in place with good input from all the MDT.

2. Safeguarding risks and issues related to your agency and action taken

On review of the statistics it is noted out of the alerts raised against the Trust approximately 50% (34/66) had an issues or concerns relating to discharge. When assessed in further detail most of the concerns relating to discharge showed themes such as lack of communication, medications, pressure damage, restarting of care and discharge paperwork. This is an area that is being reviewed regularly with a view of improvement which includes the following:

- Currently an Audit is taking place looking at all discharge paperwork but in particular the Discharge Checklist.

- All training sessions incorporate learning around previous safeguarding alerts with a discharge theme and staff are informed of the importance of completing a safe and effective discharge. This includes learning from the recent SILP (Serious Learning Incident Process).

- Discharge planning highlight any delays from their PTL (Patient Transfer List) relating to Safeguarding to ensure a safe but effective discharge. This allows for both the Adult Safeguarding Team and the Discharge Planning Team to voice any concerns and share information which will aid in a safe discharge from hospital.

- Regular discussions take place with staff on Ward 19b to discuss any current or new safeguarding concerns on the unit. This ward is currently being used as a delayed discharge unit within the trust and therefore is responsible for discharging some of the trusts most vulnerable patients.
- Presentation completed at the sisters meeting looking specifically at discharges.
- Chief and Deputy Nurse arranging a meeting with one of the departments highlighted in relation to discharges.
- The Safeguarding lead will continue to meet with the CCG lead for Safeguarding as well as the Trusts Integrated Discharge manager to review all Discharge related alerts. These meetings continue to be successful with a resultant action plan that is also shared with the CCG.

3. Outcomes of audit

- From April 2015 to March 2016 the Trust has raised 312 safeguarding alerts and received a total of 66 alerts against the Trust. There is a slight increase in the number of alerts from 2014/15 (299 to 312) and a marked decrease in alerts raised against the Trust (80 to 66). The alerts discussed cover various areas such as LBC (Luton Borough Council), CBC (Central Bedfordshire Council) and HCC (Hertfordshire County Council).
- DoLS (Deprivation of Liberty Safeguards) applications have also increased significantly from 4 applications in 2014/15 to 107 applications in 2015/16.
- In relation to alerts raised by the Trust, the main theme identified was neglect/Acts of omission, shortly followed by alerts raised for self-neglect. This particular abuse domain has seen an increase each quarter which could be in conjunction with the new care act and an increased awareness. Other themes identified were Domestic Violence, Modern Day Slavery, Financial, psychological and physical abuse.
- In addition to this, themes identified within the alerts raised against the trust consisted mainly of neglect/Acts of omission. This was followed by alerts raised for Physical and sexual abuse.
- 4 alerts have been substantiated between April 2015 and March 2016. 2 of which were discharge related.
- The Trust has been involved in 2 SARs throughout the year 2015/16.One of which is near completion and the actions and recommendations are currently being put into place.
- Training compliance for Adult Safeguarding is currently at 86% for the Trust.

4. Risks and issues related to safeguarding training and policy

- Due the increased safeguarding activity and with the introduction of the intercollegiate document for Adult Safeguarding training, a business case for additional support was developed and funding has been agreed for a 1 year fixed term administrator and a Band 7 Vulnerable Adults Nurse Specialist. Job

descriptions have been completed and this is currently being advertised.

- Although there are still areas that require work to ensure Making Safeguarding Personal (MSP) is embedded in practice, there has already been some changes made to ensure compliance which includes the changing of our internal database to capture this information and the teaching of MSP within all training sessions and the commencement of the new provider led section 42 enquiry forms.

- An increased responsibility has been given to the Trusts Safeguarding Champions with a detailed job description written within the Adult Safeguarding policy. In addition to this a link email has been set up alongside a quarterly meeting to disseminate new and relevant information to each ward and department. These meetings also include teaching from internal and external groups and organisations.

5. Safeguarding risks and issues to prioritise in 2016-2017

- The Adult Safeguarding Lead is currently working in partnership with the Community Safeguarding Lead and the CCGs Designated Nurse for Adult Safeguarding in relation to the future introduction and implementation of the NHS England's Intercollegiate Document for Adult Safeguarding Training. This will ensure compliance within all training sessions provided within the Trust alongside ensuring training sessions are parallel to that of other health organisations. This work will also incorporate the Local Authority's framework as well as the core skills for heath document.

- The Trust will also continue to incorporate emerging themes into all training sessions such as Forced Marriage, Female Genital Mutilation, Honour Based Violence and internet/social bullying.

- In introducing Making Safeguarding Personal (MSP), we aim to develop an outcome focus to adult safeguarding work which should result in safeguarding being done with, and not to people and also aim to shift the emphasis from processes to a commitment of improving outcomes for people at risk of harm. This could prove difficult within a trust setting as the supervisory body would be in most cases leading with the enquiry. However, the Adult Safeguarding Lead has adjusted and added to the current safeguarding database to allow for this data to be collected where appropriate. The Adult Safeguarding Lead is also reviewing the DATIX AP1 forms with the aim of MSP compliance commencing with the initial referral. In addition, the introduction of the Provider Led Section 42 Enquiry forms will also ensure safeguarding enquiries are MSP compliant and person centred.

- The introduction of a full time administrator and a Vulnerable Adults Specialist Nurse will help support the Adult Safeguarding Team within the next year. This added support will concentrate on supporting wards and departments but also help with training staff within the Trust on Mental Capacity and Deprivation of Liberty Safeguards.

Name Of Organisation:	ELFT

1. Progress on agency action plan for safeguarding

- ELFT Adult Safeguarding Practitioners continue to support operational teams in giving support and guidance around adult safeguarding concerns.
- The ELFT Adult Safeguarding Team continues to record and monitor adult safeguarding activity within ELFT and report such both internally and externally.
- ELFT Adult Safeguarding Practitioners carry out audits of adult safeguarding enquiries to ensure quality and a person centred response. Action plans are developed where improvement is required.
- Meetings have been held with teams since the implementation of the Care Act 2014 to explain the changes impacting upon adult safeguarding and the importance of 'making safeguarding personal'.
- The ELFT Adult Safeguarding Practitioners have continued to provide adult safeguarding training to all levels of staff. Where possible this has included lessons learnt from practice.
- The ELFT Adult Safeguarding Practitioners meet with their respective local authority adult safeguarding managers to discuss/monitor/quality assure practice.
- ELFT Safeguarding Practitioners attend the Safeguarding Adult Operational Board and the Pan Bedfordshire Group.
- ELFT have set up a Safeguarding Assurance Group internally to review strategic safeguarding matters and operational issues.
- The ELFT Safeguarding Team continues to work with our commissioners and practitioners meet with the CCG Adult Safeguarding Lead.

2. Safeguarding risks and issues related to your agency and action taken

Local Safeguarding Management

- The Associate Director for Safeguarding Adults in ELFT was based in London and was also overseeing Safeguarding Adults in London Borough's which meant that she had limited time to manage safeguarding in Bedfordshire and Luton. ELFT have agreed a short term post for Associate Director for safeguarding Adults locally but have been unable to recruit to this position. The Associate Director in London finished in her position at the end of June 2016.
- Knowledge and compliance with multi-agency policy and procedures:
- The safeguarding thresholds for adult safeguarding differs greatly from London and the way ELFT respond to safeguarding adults in London is very different to how local arrangements are made. It took some time for managers and staff that moved from London to Bedfordshire to understand the differences in policies and procedures and action was taken to write a policy that will be able to amalgamate London, Bedfordshire and Luton.
- The local risks identified were where London staff were transferred to Bedfordshire without being aware of the differences in how adult safeguarding was being managed. This resulted in some safeguarding alerts not being done and concerns managed internally through Trust procedures. This was picked up quickly and we rolled out a training program for staff around local procedures. One-to-one training was offered and the safeguarding team attended team meetings and away days for wards to update staff on local procedures.

Incident Reporting

- The Trust safeguarding team will now be screening more incidents to ensure that safeguarding alerts are done appropriately and to ensure that training is targeted to the right audience.

Safeguarding Cover

- Owing to unforeseen circumstances (road traffic accident) two of the three ELFT Safeguarding Children Practitioners were absent/on phased return for three

months during the period. Cover was provided by the remaining Practitioner across all ELFT services in Bedfordshire and Luton.

Safeguarding Champions Meetings

- The re-introduction of Safeguarding Champions meetings on a quarterly basis was undertaken during the period. This involves a nominated lead from each ELFT service representing their team as a lead in the field of safeguarding.

3. Outcomes of audit

- In Central Bedfordshire and Bedford Borough, the Trust took part in an external audit commissioned by the local authorities. The outcome for all the cases was good.
- Joint audits have been undertaken within Central Bedfordshire for ELFT cases within the period. Of the four cases chosen two were rated 'good' one rated as 'adequate/good' and the remaining case was rated as 'poor'. The issues identified have been addressed and shared for learning.

4. Risks and issues related to safeguarding training and policy

Safeguarding Policy

- The ELFT safeguarding policy that was in place prior to ELFT acquiring services in Bedfordshire and Luton was not suitable as it was not compliant to the multi-agency safeguarding policy for the Safeguarding Adults Board. A new policy was written to integrate local processes and procedures, but this was a difficult task and it was clear that Bedfordshire and Luton will need their own procedures. The policy has been ratified and the procedures are in the process of being ratified.

Safeguarding Training

- As with the safeguarding policy, ELFT had different levels of training and a different relationship with London local authorities. The initial risk was that all internal training was stopped as the expectation was that local authorities would provide this training. The levels of training also did not match what was agreed locally in the past.
- ELFT safeguarding team have now resumed internal training and training compliance is now at 92%.
- ELFT has also agreed to return to the levels of training as recommended in the intercollegiate document for 2016. We are also in the process of developing a new safeguarding adults training strategy to ensure that we are able to deliver effective training but also that we are able to measure outcomes from the training effectively.

5. Safeguarding risks and issues to prioritise in 2016-2017

- Ensure all ELFT staff have safeguarding training at the level appropriate for the role that they are in and measure outcomes through the safeguarding competency framework.
- Ensure that staff relocating from the London Boroughs have local safeguarding adults procedures training as part of their induction.
- Continue to monitor the progress and quality of safeguarding enquiries through internal audits.
- Improve joint working process with serious incidents investigations and complaints investigations where it overlaps with safeguarding adults.
- Ensure robust management structures for safeguarding adults in the Trust.

3.1 Data Analysis

For the 2015/16 reporting year, the Bedford Borough safeguarding team received 2,193 contacts, which includes all safeguarding concerns, information sharing reports, referrals for social care or care management involvement and general incidents. Of these 1,115 received a safeguarding response with 152 proceeding to a Section 42 Enquiry. Overall the level of contacts to the team has increased from 2,038 in 2014/15 and from 1,829 in 2013/14.

The amount of contacts to the team compared to last year , which resulted in a safeguarding response has decreased from 1,303 to 1,115 with a lower level of 152 safeguarding initial enquires compared to 241 going to a S 42 Enquiry. There has been an ongoing increase in the levels of contacts to the team not requiring a safeguarding response which has increased from 735 to 926.

The Central Bedfordshire safeguarding team received 2,935 contacts during 2016- 2016. Of these 817 received an initial safeguarding response with 330 proceeding to a Section 42 enquiry. This is compared to the previous year when Central Bedfordshire Council received 1,100 alerts during the year, which was a decrease of 251 from 2013-2014. 238 alerts progressed to investigation in 2014-2015. The number of safeguarding enquiries has increased by 39% but is a much smaller proportion of total reports compared to the previous year (11%). This reduction is in response to the significant increase in incident reporting and the result of the teams taking a proportionate approach and considering other options such as care management involvement, reviewing of care packages and providers taking action such as dealing with complaints, taking HR action or reviewing care plans.

The difference between the numbers of initial safeguarding response and enquires is due to the ways the teams process and record information. The same initial screening and risk assessment tool is used in both teams. The recording differences have been addressed which should result in more comparative data next reporting year.

Of the safeguarding concerns that did not progress to a section 42 Enquiry there is a similar pattern to the previous year with information sharing and advice being the most common outcome.

Within the ethnicity category the “Not known” category has increased which is likely to be as a result of the number of concerns involving people not previously known to the council, where at point of contact, this information is not provided. Again this is reflected the category “Primary support reason” in the high number of people that concerns are received for where there is no identified support as they have not been previously known to the council and may not have any apparent care and support need. There continues to be a low level of reporting from ethnic groups which highlights that additional awareness raising may improve this position.

Reporting patterns for other areas show a similar patter to the previous year with Social Care Support (which includes providers and any agency providing social care support), being the main source of reporting concerns leading to a S42 Enquiry, and the main source of persons causing harm. In types of abuse, Neglect/Acts of Omission remains the largest category, followed by Physical Abuse. Location of abuse has a similar pattern to the previous year with ‘Own Home’ and ‘Care Home’ being the two main categories of where abuse has been reported, with a low level of the concerns reported leading to a S42 Enquiry. This is reflective of the high number of concerns that are received that are the reporting of an incident or the risk is very low or the incident is not of a safeguarding nature.

Graphs on p40 – 43 show a high level of enquires where the source of risk is unknown to the individual, this is because the category is based on the Department of Health reporting criteria for the Safeguarding Adult Collection (SAC) and includes health care staff, social care assessment staff, police, regulator and other, where not known to the person. The data for Central Bedfordshire shows a higher proportion of 'source of risk known to individual' because there are a higher number of incidents in peoples 'own home'. Bedford Borough has a higher number of social care providers which means greater numbers where 'source of risk is social care support'.

Reporting on mental capacity and outcomes continues to be a concern due poor recording of these outcomes. Audits show that this work is completed and that the issue is with the updates to the IT systems following the implementation of the Care Act.

3.2 Data – focus on incident reporting

In the year 2015-2016, Bedford Borough Council and Central Bedfordshire Council safeguarding teams received 3961 reports that were not considered to be of a safeguarding nature. This means that they were treated as one of the following:

- complaint
- referral for assessment/unscheduled review
- quality assurance information for contracts management
- care planning/ risk management/disciplinary process for provider
- information sharing about a vulnerable person
- inappropriate contact

This number represents a significant increase form the previous year and in both Councils the trend over the year is upwards.

Data analysis of these contacts to the teams shows that the majority of concerns related to younger adults (under 65) whose care and support needs are not known. By far the greater response (between 50 to 75%) to these concerns is to log them as "information sharing".

The police (Bedford 49%, Central Bedfordshire 34%) and ambulance service (Bedford 42% and Central Bedfordshire 16%are responsible for making the majority of these reports. On the whole reports from the ambulance service relating to people who live in their own home are reporting concerns about people who may not be coping, as opposed to concerns about abuse or neglect. In Central Bedfordshire the East of England Ambulance Service reports are sent via the Council's contact centre, which accounts for the lower proportion compared to Bedford Borough. Despite this, the reporting trend is upwards.

The upward trend of "Information sharing" that results in minimal outcomes is having a significant impact on the ability to focus on safeguarding reports of high risk, and on other partners who are also contacted as part of the information gathering stage. 77-81% of reports by the police are recorded as "information sharing". Consent is not sought from individuals before sending through to the local authority. This means that in the majority of cases an adult social care record is created and people are contacted directly. In 44-58% of cases referred by the police the person did not have identifiable care and support needs. Where the person does

have care and support needs, a significant proportion of these have mental health needs which may require assessment. 43% result in reports being shared with ELFT.

The two Councils continue to receive a significant proportion of reports from care homes where risk is identified but is not of a safeguarding nature. This frequently results in advice and information or the provider is requested to review care planning/ risk management/disciplinary process or documentation.

A priority for 2016-2017 will be to work closely with parters to ensure that safeguarding reports are proportionate and clearly identifiy whether a person is experiencing abuse or neglect, and to identify where there are opprtunities for alternative referral routes.

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

The impact of the Supreme Court judgement *P v Cheshire West and Chester Council (& Ors) and P and Q v Surrey County Council* (Cheshire West) has continued to challenge and evolve causing an ongoing increase in the number of people requiring statutory assessments and subsequently being considered as deprived of their liberty.

The previous reporting year of 2014-2015 data showed a 10% increase in the number of DoLS applications for Central Bedfordshire Council (CBC) received (when compared with before the Supreme Court judgment, March 2014) and 15% increase in Bedford Borough Council (BBC). This year's data reveals yet again a further increase.

Impact and Numbers BBC and CBC have processed the following requests in accordance with MCA DoLS:

	CBC 2015-2016	BBC 2015-2016
Number of Applications received in reporting year	954 (compared with 605 in 2014-2015)	1123 (compared with 872 in 2014-2015)
Number of Applications completed in reporting year	821 (compared with 449 in 2014-2015)	1072 (compared with 870 in 2014-2015)
Number of Authorisations granted	565	848

Number of Pohwer IMCAs/PPR referrals made (including 39a,39c,39d and PPR)	145 (compared with 49 in 2014-2015)	227 (compared with 208 in 2014-2015)

Update on significant changes cited in last year's annual report:

- ADASS priority tool - Neither Central Bedfordshire nor Bedford Borough are currently using the ADASS prioritisation tool however it is available if needed.
- Revised ADASS DoLS forms - Both Central Bedfordshire and Bedford Borough are using the revised ADASS DoLS forms. They have proved overall a positive move assisting Best interest Assessors (BIA's) and supervisory bodies.
- Law Society Practical Guide to Deprivation of Liberty Safeguards (2015) - The Law Society guidance produced in 2015 has shown to be helpful assistance in giving guidance to case law and application in practice. An example of this is around 'respite' placements and Intensive Care Units (ICU).
- Re X procedure – Both Central Bedfordshire Council and Bedford Borough have started taking community cases to the Court of Protection for consideration and subsequent authorisation where needed. In both Supervisory Bodies this is being lead by care management with support by legal departments.

Government updates

Law Commission review of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards:
The original Law Commission proposals – put out for consultation on 7 July 2015 have been revised following significant response to the consultation.

- a 'more straightforward, streamlined and flexible scheme' focused solely on authorising deprivation of liberty
- the responsibility of establishing the case for a DoL to be shifted from the provider of the care to commissioner (i.e. usually the local authority or CCG), using where possible the same assessments already in place for care planning
- there will still be rights to reviews, legal proceedings and advocacy
- there may be 'a defined group of people who should receive additional independent oversight of the DoL' by an Approved Mental Capacity Act Practitioner
- The proposed amendment to the Mental Health Act will not go ahead

Judicial review

Nottinghamshire, Richmond, Shropshire and Liverpool councils have lodged a judicial review against health secretary Jeremy Hunt, arguing he has created "an unacceptable risk of illegality" by leaving councils without adequate funds to meet their statutory duties to vulnerable service users. The local authorities say government funding for DoLS has been maintained at around £34m a year. The Local Government Association has argued at least an additional £172m a year is needed to meet the costs of the Cheshire West judgment in relation to DoLS. The Law Commission has estimated between £405m and £651m is needed annually to fully comply with the ruling. This estimate includes both DoLS cases and the applications to the Court of Protection required to authorise deprivation of liberty in community settings, such as supported living.

http://www.communitycare.co.uk/2016/06/07/government-face-legal-challenge-deprivation-liberty-safeguards-funding/

Potential Risks

- Increase in appeals and challenges under s21a – There is an increase in the number of cases going to court as S12a appeals and challenges. This involves the cost of taking cases to court as well as potential damages. In an example case in Essex http://www.bailii.org/ew/cases/EWCOP/2015/1.html the district Judge approved awards of between £3,000 and £4,000 per month in damages for the unlawful deprivation of liberty of incapacitated person.
- A continued increase in applications received is likely - This year has shown further increases for both Central Bedfordshire and Bedfordshire Borough. It is anticipated that there remains care homes that have not yet started sending new requests and or renewals. CQC appear to be taking a more assertive approach in their inspections around MCA and DoLS which will hopefully address this. Example of CQC reporting that a care home was illegally depriving residents of their liberty for failing to request further authorisations when they expired: http://www.mancunianmatters.co.uk/content/260575925-stockport-care-home-found-guilty-depriving-people-their-liberty-illegally-damning#.V1KK6JIBH_s.twitter
- Legal ramifications of not meeting timescales – It is evident from the data that both Supervisory Bodies have a number of applications that failed to meet the required legal timescales resulting in a period of unauthorised deprivation of liberty. If these were challenged than it is possible that the Supervisory Bodies would incur substantial penalties for breaches in article 5 rights.
- Quality of assessments – There is an identified risk around the ongoing substandard quality of some assessments and that it may continue to prove difficult to improve due to the volume and output of assessment undertaken by assessors. In both Supervisory bodies this has resulted in a number of concerns raised and remedial action has been necessary.
- There is a local and national lack of IMCA support / PPR - Pohwer is the provider for both Bedford Borough and Central Bedfordshire. Pohwer report a significant increase in the volume of IMCA and PPR requests in the last year which is reflected in our data. The consequence of this appears to be less frequent visits, by nominated IMCA/PPR, and delays in the initial visits. In addition to the difficulties with Pohwer, there is a national shortage of IMCA and PPR's which is resulting in problems accessing IMCA / PPR in other areas. Both authorities have experienced out of county IMCA services refusing to provide IMCA services citing a need to prioritise the residents commissioned by their host Local Authority.

5. Learning from Safeguarding Activity

Learning Outcomes	***Action To Ensure Learning***
Increased volumes of reporting that identify risk but are not of a safeguarding nature and that could be managed trough other routes	A priority for 2016-2017 will be to work closely with parters to ensure that safeguarding reports are proportionate and clearly identifiy whether a person is experiencing abuse or neglect, and to identify where there are opprtunities for alternative referral routes
Pressure on advocacy services resources to respond to the requirements for IMCA and PPR	Consideration of alternative models for the PPR role; ensuring DoLS data is included in contract reviews
Law Commission draft Bill on DoLS expected December 2016	Keep abreast of legislative changes for DoLS and planning for response.
An ongoing focus on making safeguarding personal is required.	Review practice development and quality improvement opportunities that promote a more person centred approach in safeguarding
An ongoing focus on agencies other than the local authorities undertaking S42 enquiries is required.	Continue to audit and review the outcomes and quality of enquiries

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

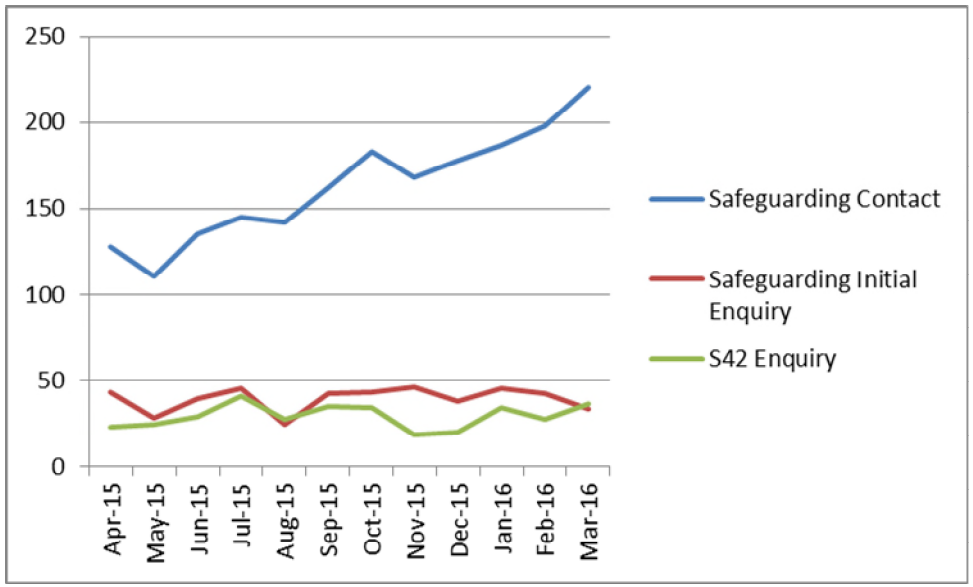
- Ensure people are empowered to drive safeguarding processes and find effective personal resolutions to harmful or abusive circumstances. The safeguarding team will work with victims of abuse through the personal use of the feedback forms as one means of improving the victim's experience during the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

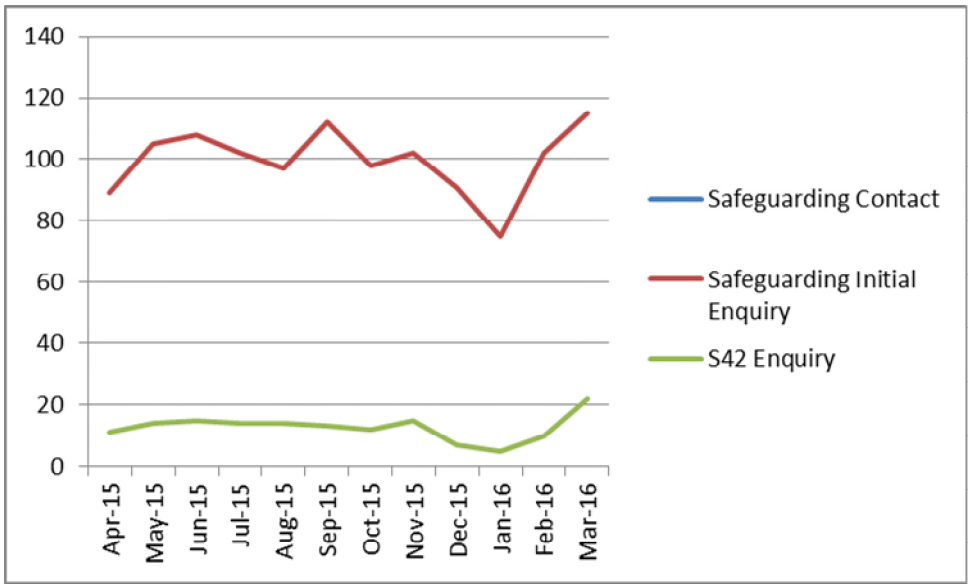
Safeguarding Activity April 2015 – March 2016 Based on the Safeguarding Adults Collection National Data return 2016 – 2017

Activity Data over time

Central Bedfordshire

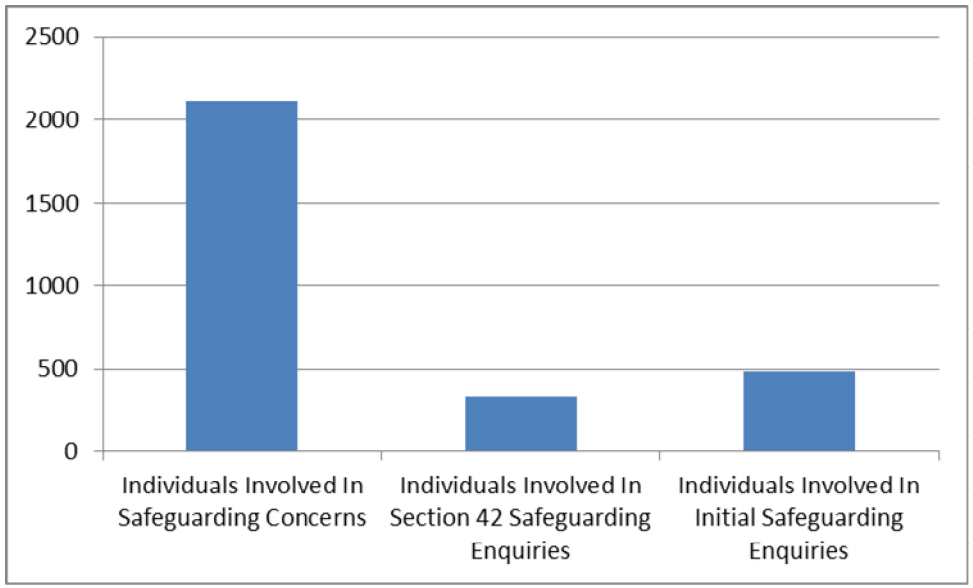


Bedford Borough

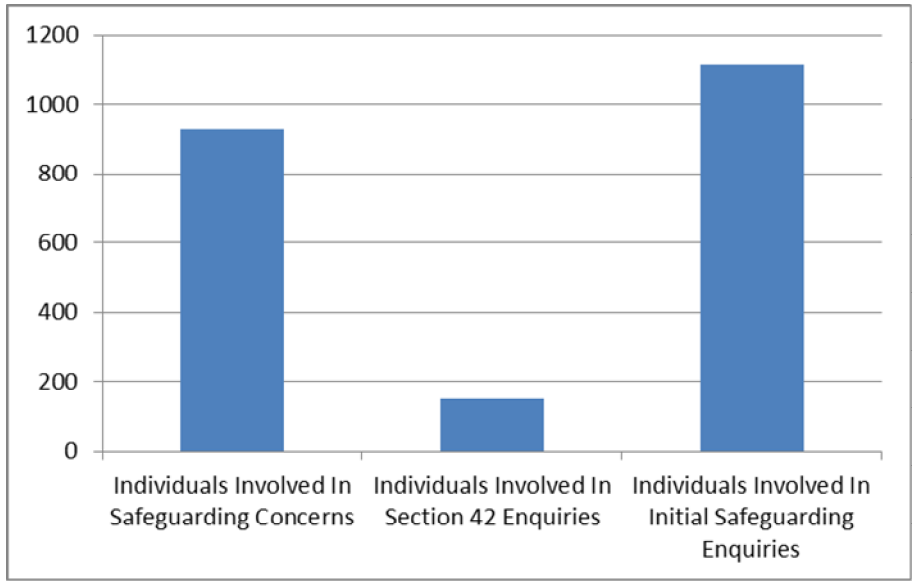


Individuals Involved in Safeguarding Concerns and Enquiries

Central Bedfordshire

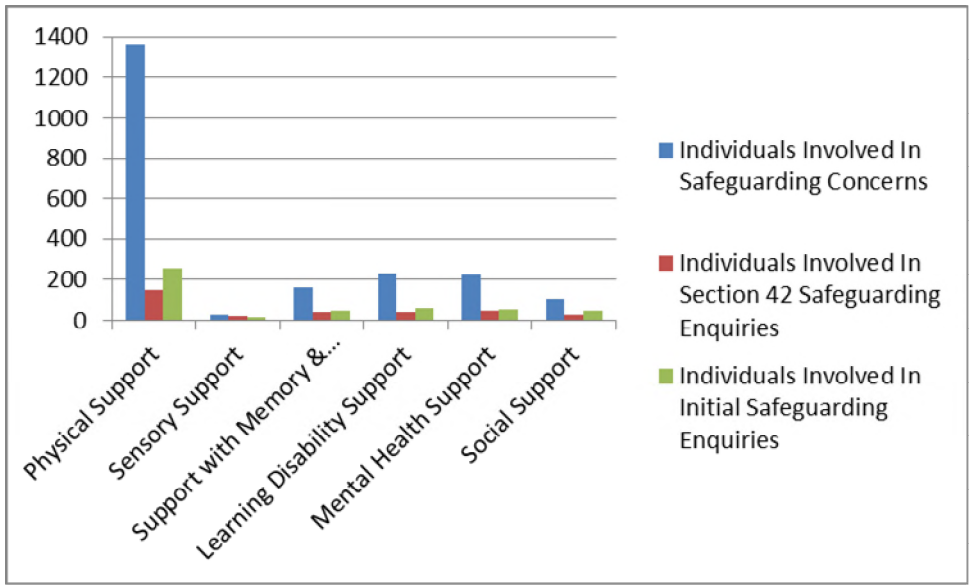


Bedford Borough

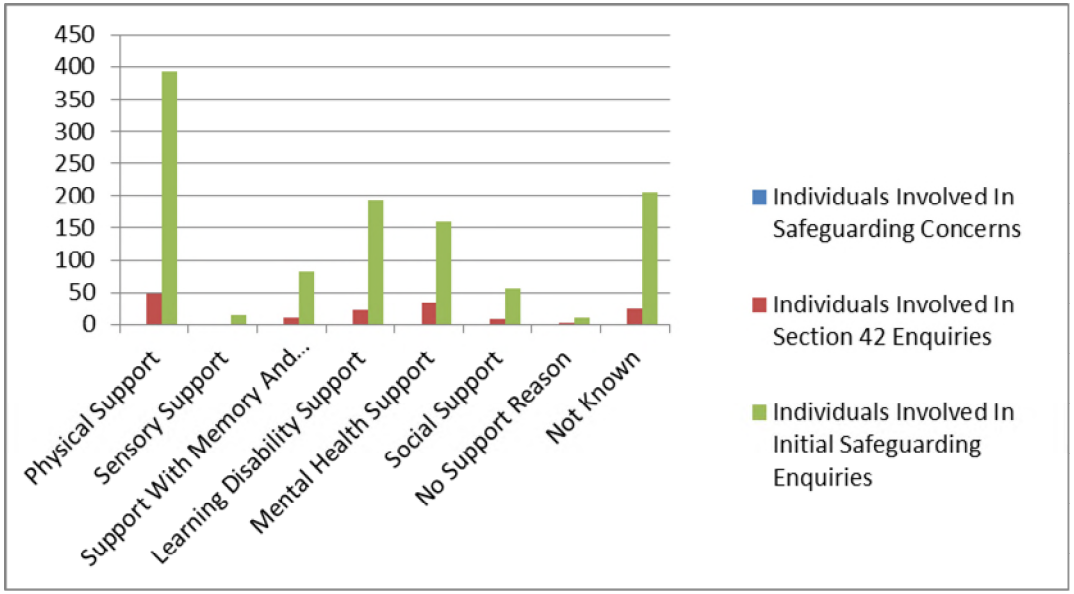


Safeguarding Enquiries by Type of Support Need

Central Bedfordshire

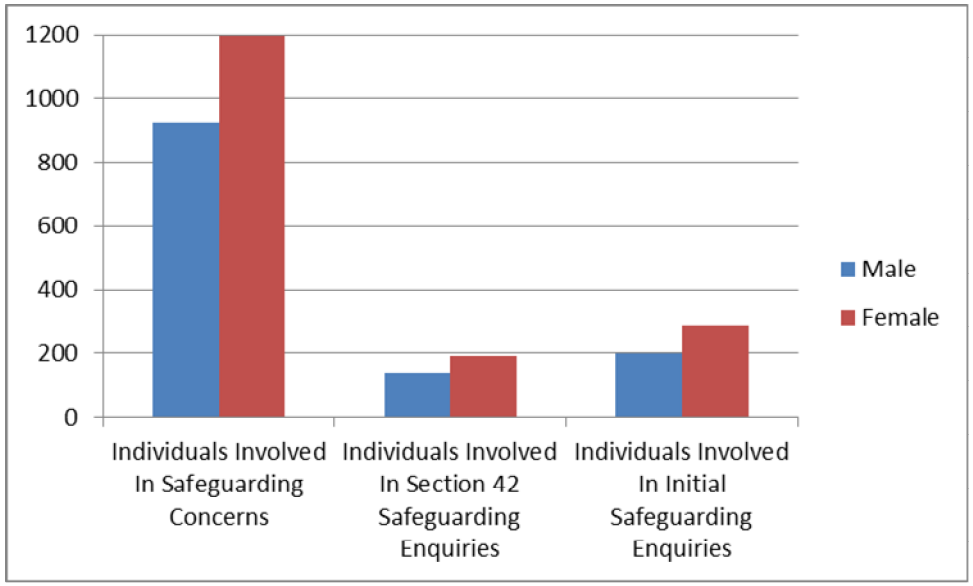


Bedford Borough

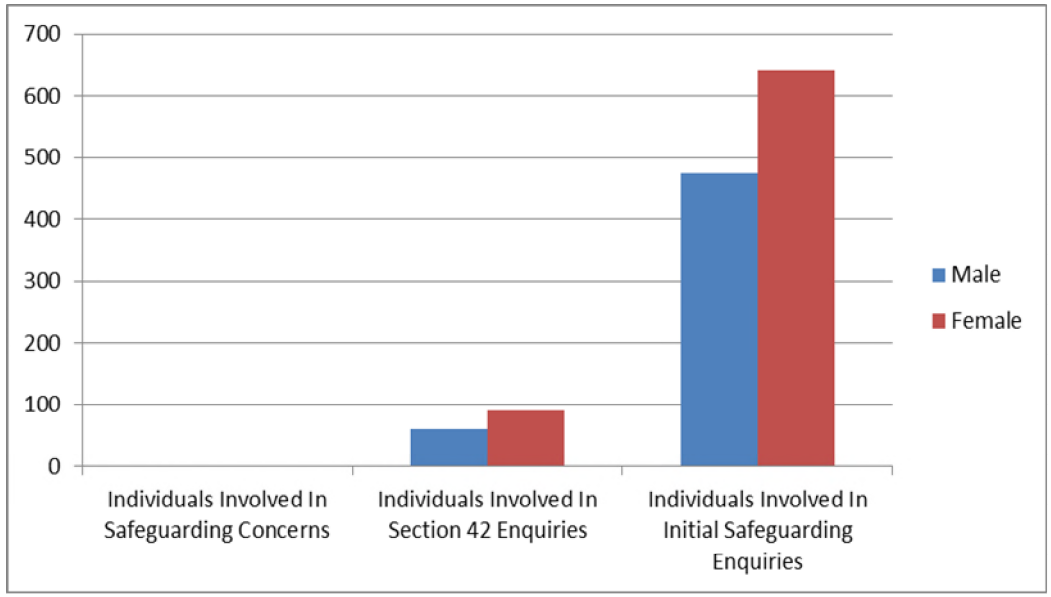


Safeguarding Enquiries by Gender

Central Bedfordshire

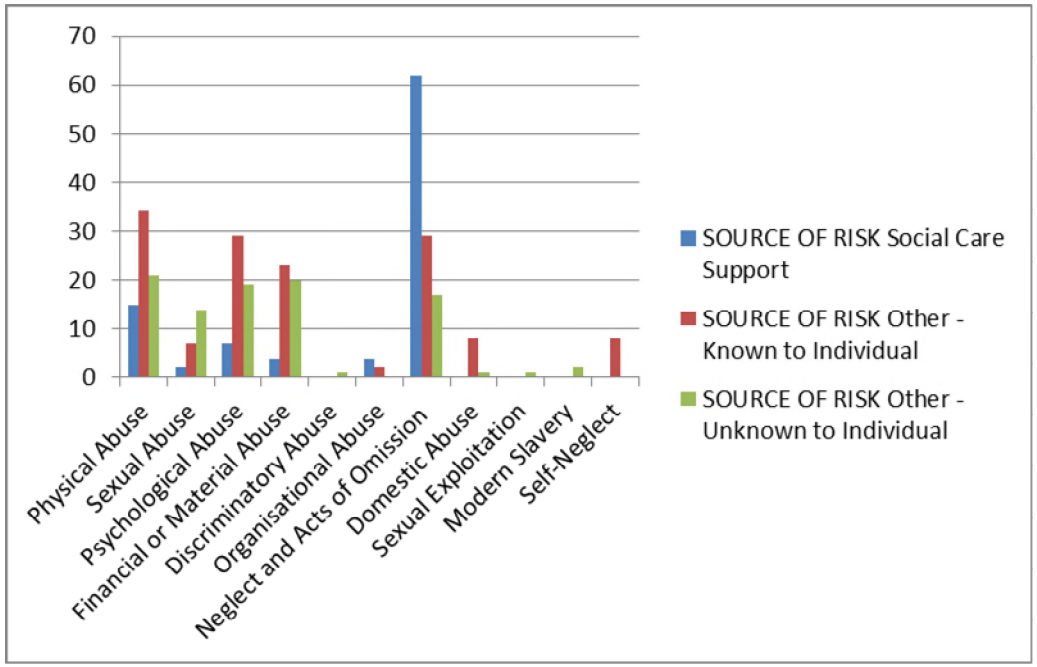


Bedford Borough

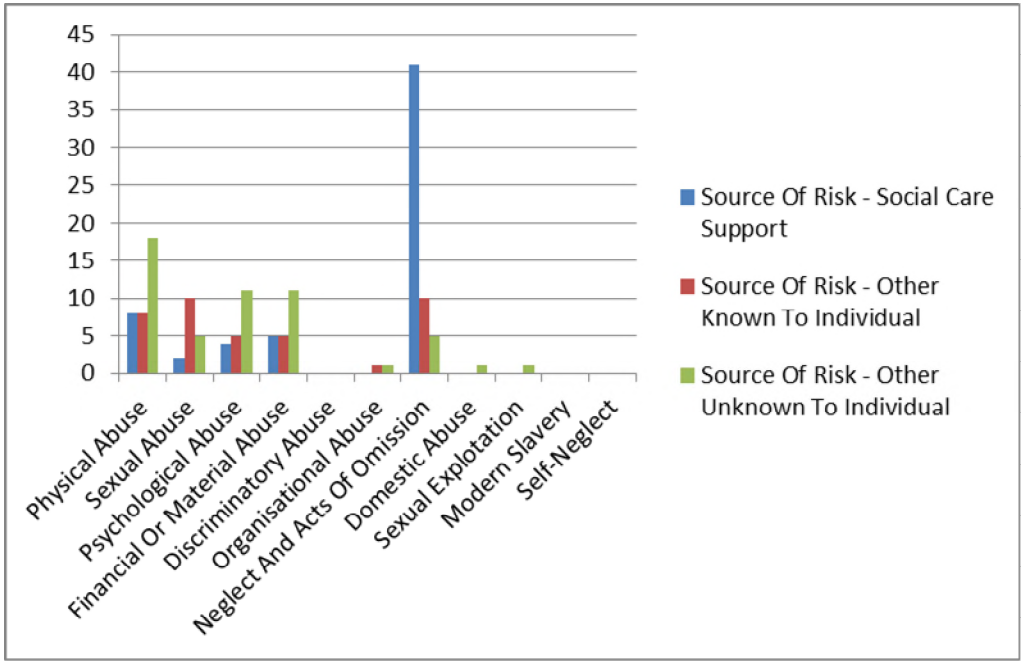


Safeguarding Enquiries by Type of Abuse

Central Bedfordshire

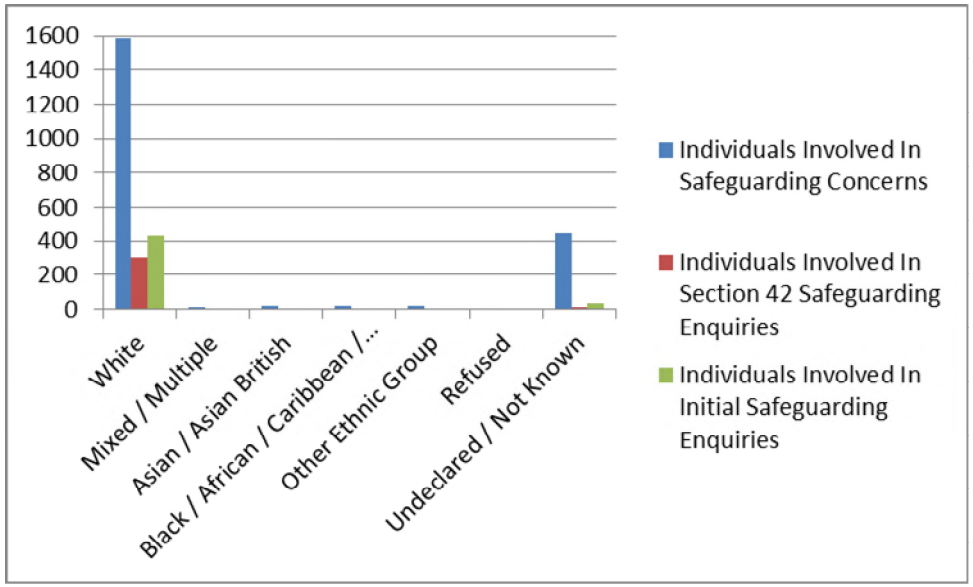


Bedford Borough

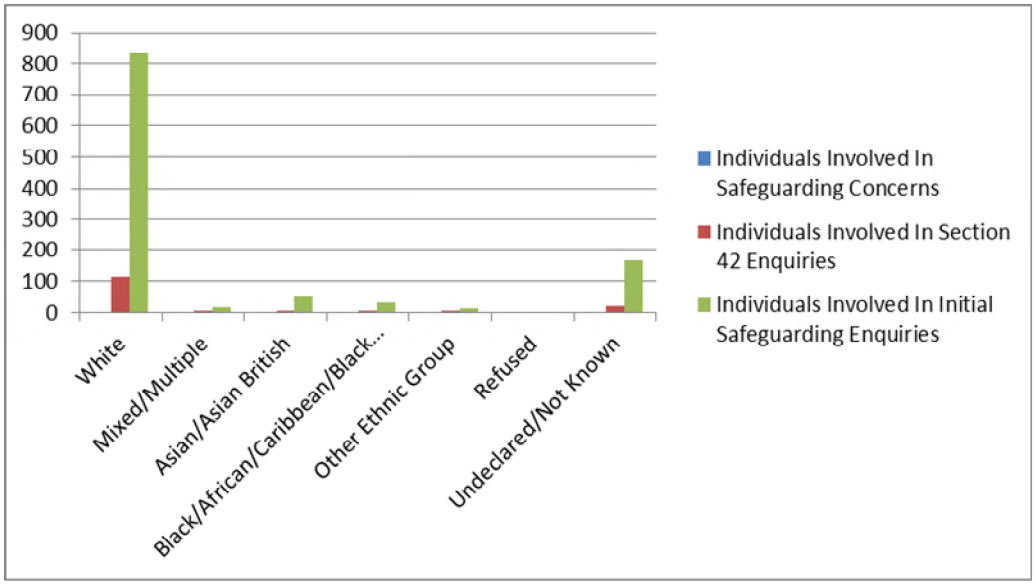


Safeguarding Enquiries by Ethnicity

Central Bedfordshire

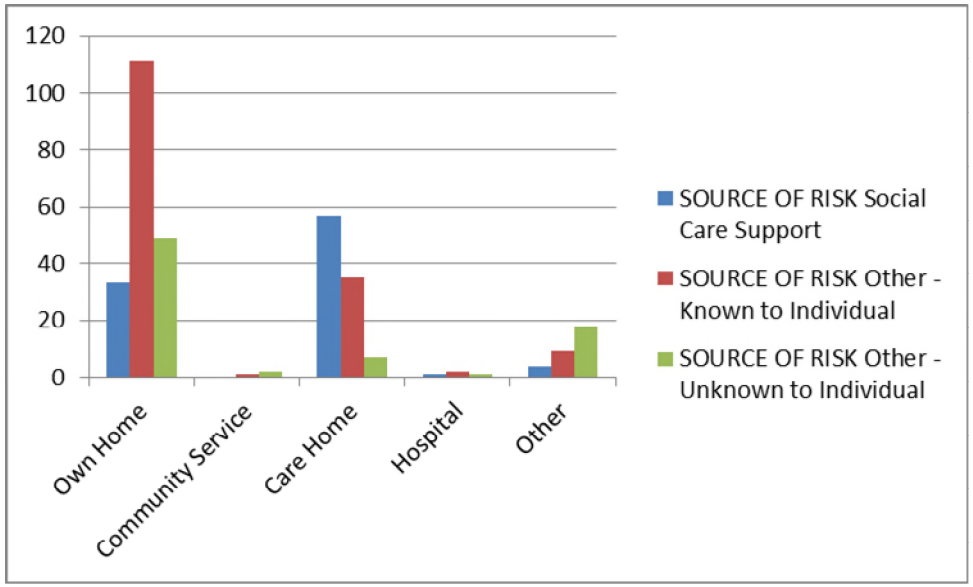


Bedford Borough

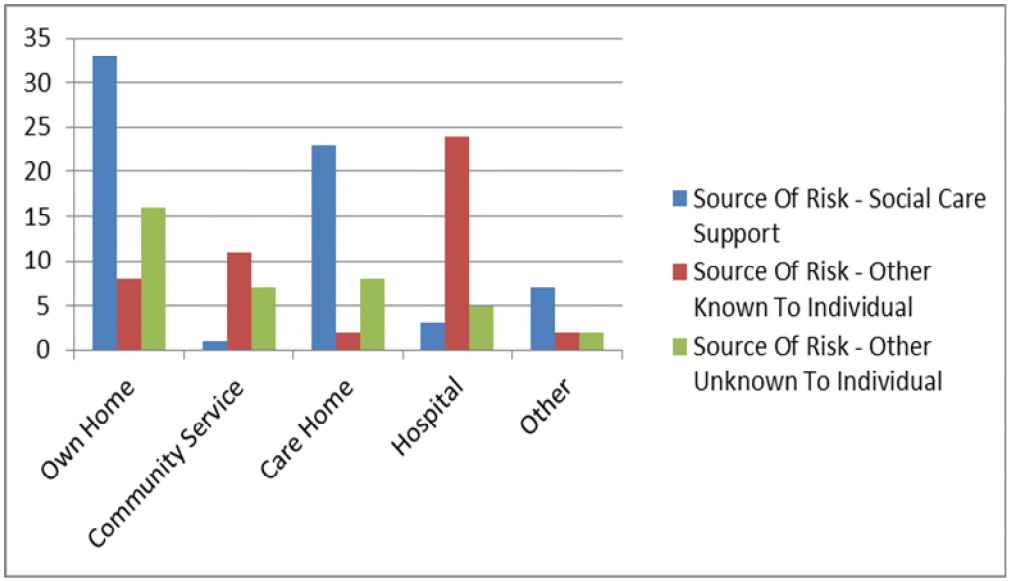


Safeguarding Enquiries by Location

Central Bedfordshire

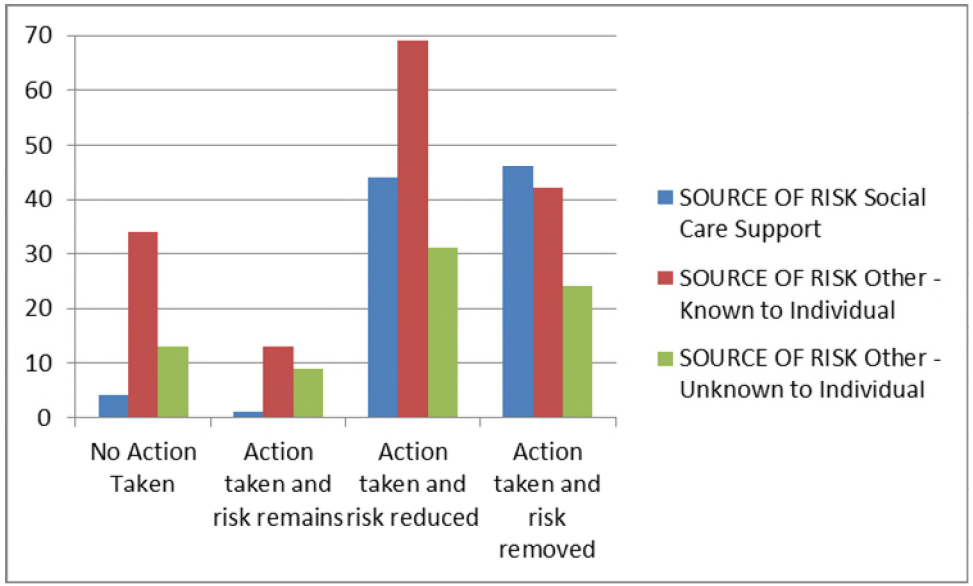


Bedford Borough

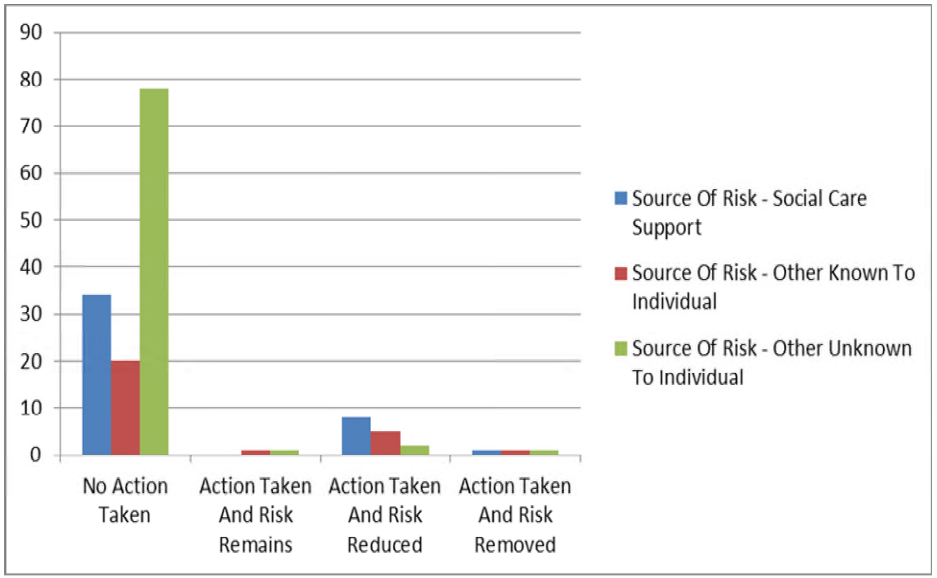


Safeguarding Enquiries by Action Taken

Central Bedfordshire

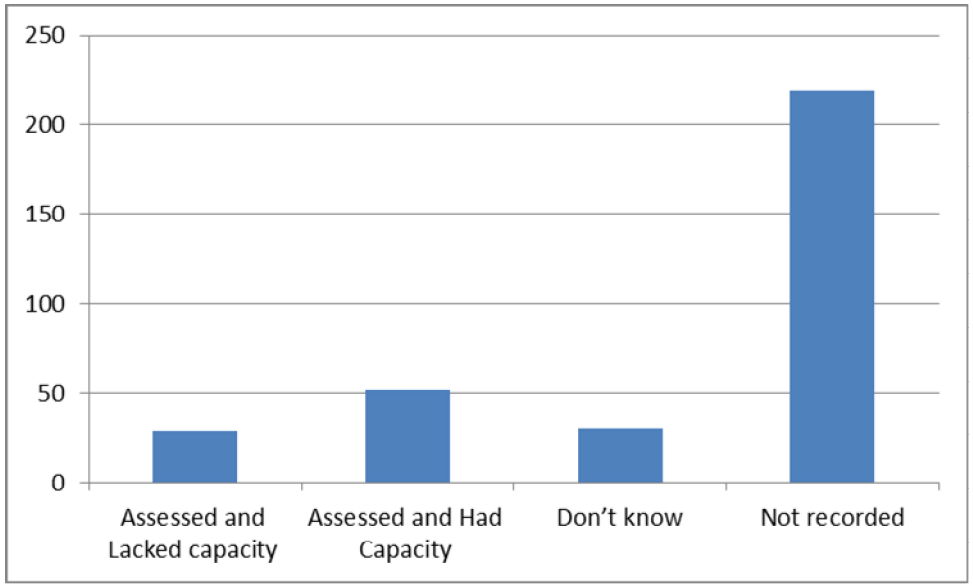


Bedford Borough

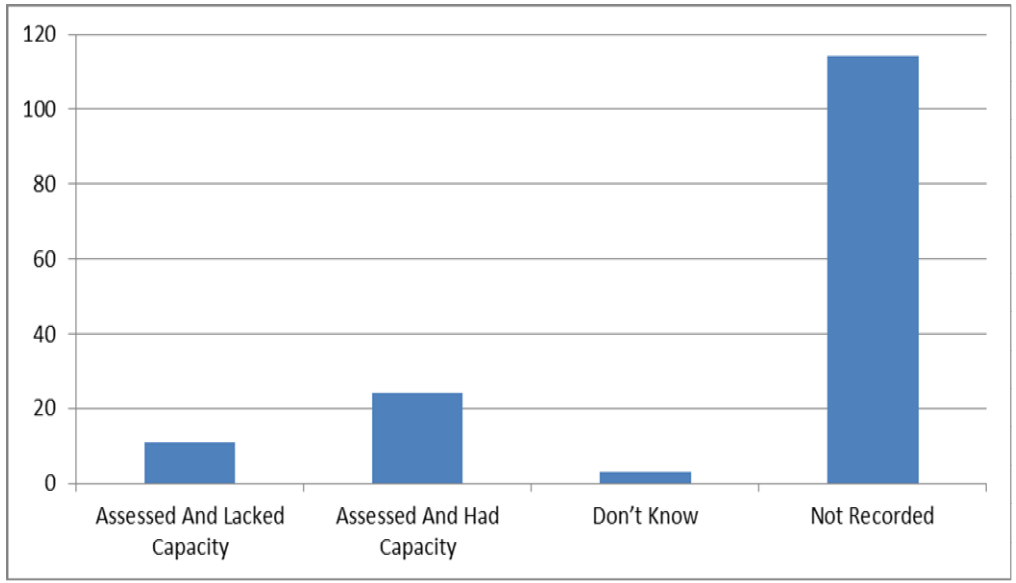


Safeguarding Enquiries by Mental Capacity

Central Bedfordshire

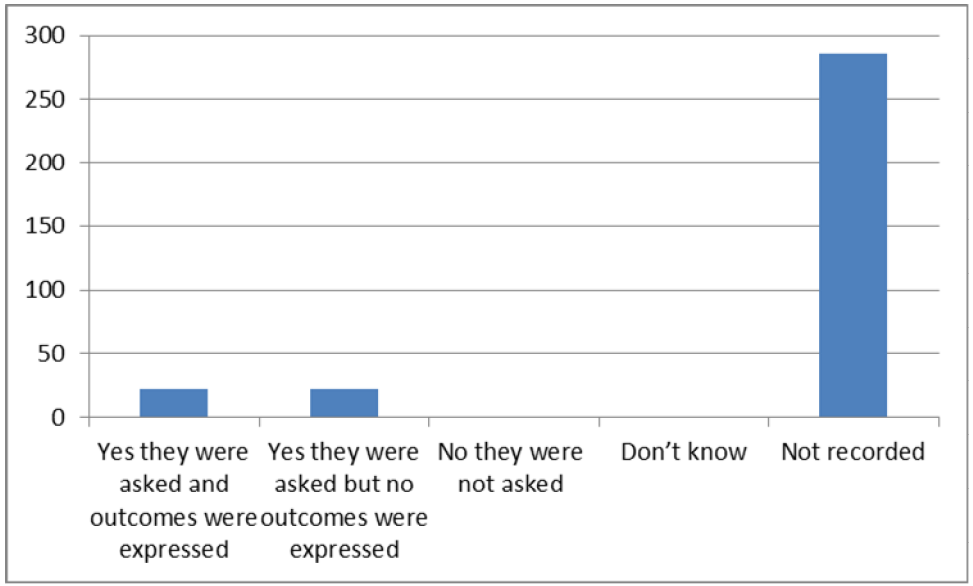


Bedford Borough



Safeguarding Enquiries by Outcomes

Central Bedfordshire



Bedford Borough