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 2009- March 2010

Abuse is Everybody's Business
Safeguarding is our Responsibility

Abuse is Everybody's Business

This is the third annual report of the Adult Safeguarding Board which covers the first year of operational as two unitary councils for Bedford Borough and Central Bedfordshire. It outlines the progress made during the year from April 2009 to March 2010 and is provided to inform individuals, their families and carers, who use social care and health services, elected members, those who work in social and health care, all partner agencies, and residents of Bedford Borough and Central Bedfordshire.

During the past 12 months, a comprehensive improvement plan was introduced to address the findings of the 2008 inspection and other audits undertaken throughout the year and the need to bring about substantial and rapid improvement. We believe we have laid firm foundations and raised the profile and awareness of safeguarding across the partnership. We believe that the services we inherited required a fundamental review and have audited our policies, procedures and practices for compliance and quality and put in place large scale improvement plans. Robust strategic leadership and operational arrangements have been established and our initial work has laid the necessary foundations for robust safeguarding but we recognise that achieving excellence in this area requires sustained improvement on the part of all partner agencies

Following the audits we have implemented remedial action plans to address shortcomings, introduced new performance reporting systems to enable reporting against the national minimum data set for safeguarding and carried out extensive staff training. However, much work still remains to be done to take us to our safeguarding goals.

During the next 12 months it is our intention to embed the revised policy and procedures and ensure that all partner agencies prioritise safeguarding work to closely monitor and audit practice and learn the lessons from safeguarding investigations.

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

Frank Toner
Executive Director of Adult Services
Bedford Borough Council and
Chair of the Bedford Borough and
Central Bedfordshire Safeguarding Board

Julie Ogley
Director of Social Care, Health & Housing
Central Bedfordshire Council

Safeguarding is our Responsibility

1. The Developing Context for Safeguarding

There have been a number of influential national developments during the past 12 months which the Safeguarding Board have taken into consideration as it developed its work programme.

1.1 Review of No Secrets Guidance

Following a review of the No Secrets guidance, on 17 July 2009 the Department of Health published *Safeguarding Adults – report on the Consultation on the review of "No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse".*

The key messages arising from the consultation were that:

- safeguarding requires empowerment and the 'victim's' voice needs to be heard
- empowerment is everybody's business, but safeguarding decisions are not
- Safeguarding Adults is not like Child Protection.
- the participation and representation of people who lack capacity is also important

In January 2010 the government announced that it was to establish an Inter-Departmental Ministerial Group (IDMG) on Safeguarding Vulnerable Adults to determine policy and work priorities for the forthcoming year; provide a strategic and co-ordination role; and provide public and parliamentary advocacy for safeguarding adults policy. It announced the intention to introduce new legislation to strengthen the local governance of safeguarding by putting Safeguarding Adults Boards on a statutory footing, and to launch a programme of work with representative agencies and stakeholders to support effective policy and practice in safeguarding vulnerable adults. It is not clear how far the new government will continue with these developments, however the report and ministerial statement served to raise the profile of adult safeguarding and our local arrangements and improvement plans incorporate the elements we expect to be included in future directions.

1.2 Vetting and Barring Scheme

The Vetting and Barring Scheme (which was due to start on 26 July 2010) has been halted to allow the new government to carry out a review and to remodel the scheme to what it calls 'common-sense levels'. However, the regulations introduced in October 2009 still apply. They state that:

- a person who is barred from working with children or vulnerable adults will be breaking the law if they work or volunteer, or try to work or volunteer with those groups
- an organisation which knowingly employs someone who is barred from working with those groups will also be breaking the law
- any organisation who works with children or vulnerable adults and dismisses a member of staff or a volunteer because they have harmed a child or vulnerable adult, or would have done so if they had not left, must tell the Independent Safeguarding Authority

1.3 Safeguarding in the NHS

In February 2010 the Department of Health published *Clinical Governance and Adult Safeguarding: An Integrated Process*, which aims to encourage organisations to develop local robust arrangements to ensure that safeguarding becomes fully integrated into NHS systems. Four key areas were identified;

- greater openness and transparency about clinical incidents

- learning from safeguarding concerns that occur within the NHS
- clarity on reporting, and
- more positive partnership working

The Board's new Policy and Procedures incorporate all requirements of this guidance.

1.4 High profile incidents

A serious case review conducted by Leicestershire County Council into the death of Fiona Pilkington, as well as research conducted by the Equality and Human rights Commission have highlighted that:

- Disabled people are at greater risk of experiencing violence than non-disabled people. Disabled children and young people and disabled women, particularly those with learning disabilities, are particularly at risk.
- Ongoing 'low-level' incidents are widespread and may go undetected but may escalate at some point. These incidents are often ignored by public agencies even though they have a significant impact on disabled people.
- Disabled people restructure their lives to minimise real and perceived risk to themselves even if they have not experienced targeted violence personally.
- The No Secrets guidance may be flawed in that people who were not eligible for social care services are "at risk of falling through the safeguarding net"
- Police and local authorities should do more to take into account the impact of anti social behaviour
- Partnership working and communication between agencies is crucial to protecting vulnerable adults

In Bedfordshire we have been successfully implementing the "People in Partnership" (PIP) programme to combat bullying, discrimination and harassment of people with a learning disability. Our new procedures set out a policy of zero tolerance of abuse, maltreatment and neglect whether or not the alleged victim is eligible for community care services.

1.5 Deprivation Of Liberty Safeguards

The Deprivation of Liberty Safeguards were introduced as an addition to the Mental Capacity Act 2005 as a response to the decision of the European court of human rights in the case known as the 'Bournewood' Judgement. The safeguards are intended to support vulnerable people who lack capacity to consent to care and treatment, which are essential for their safety and best interests, but which may deprive them of their liberty.

On 1st April 2009 Bedford Borough and Central Bedfordshire Councils implemented procedures that put safeguards in place to ensure that any deprivation is fully assessed as being in a person's best interests and measures that are taken are the least restrictive and subject to timely review. We have benchmarked our use of the Deprivation of Liberty Safeguards with the Eastern Region authorities and ensured that our standards of practice and consistent with comparable areas.

2. The Safeguarding Board's Work in Bedford Borough and Central Bedfordshire in 2009/10

2.1 An Overview Of Safeguarding Improvement Work In 2009/10

2.1.1 The year 2009-20010 has both been very challenging and very exciting for the development of safeguarding in Bedford Borough and Central Bedfordshire. Two new unitary authorities replaced the former County Council and three District Councils and an Adult Safeguarding Board was established to steer the development of a new strategic partnership and address the safeguarding priorities of the area.

2.1.2 From the outset, the new Board recognised that radical improvements were required to protect people from harm and the critical importance of partner agencies working together. In May of 2008 the Commission for Social Care Inspection had judged safeguarding services in Bedfordshire to be adequate with uncertain prospects and the situation the two new councils inherited suggested that this had been a generous judgement.

2.1.3 The new Safeguarding Board established an Operational Group and three sub-groups to deliver a comprehensive improvement plan and tackle

- Policies and procedures
- Practice and Performance and
- Training and Development

2.1.4 The Safeguarding Board commissioned an independent audit of the existing policies and procedures which concluded that a complete re-write was required in order to bring them up-to-date and to make them easier to use for those tasked with safeguarding vulnerable adults. An external advisor was commissioned to draft new policies and procedures and our new documents are based on those in use in Bolton, the first council to be judged excellent in safeguarding at inspection.

2.1.5 A further audit of case files identified the need to improve case recording across the board, training of investigation staff and managerial oversight of safeguarding activity. As a result of these audits both councils undertook a comprehensive programme of case file audits and staff training and initiated follow up audit activity to ensure that the required improvements were achieved.

2.1.6 New procedures were introduced at the start of the year for serious case reviews and investigating serious concerns about an establishment or provider.

2.1.7 The Joint Improvement Partnership for the Eastern Region conducted an audit of Safeguarding Adults performance, policies and procedures across all councils with the aim of establishing a baseline position identifying areas of good practice and those where development and improvement are required both across the region and within each local authority. The final reports following this work were published in March 2010 and provided evidence that the improvement work in Bedford Borough and Central Bedfordshire was having a positive impact.

2.2 Strategic Leadership

2.2.1 The new Adults Safeguarding Board for Bedford Borough and Central Bedfordshire was established in April 2009 and has achieved collective support at a senior level from all key partners. The board has formal links to each council's Local Strategic Partnership whilst also reporting into each council's respective Elected Members committees for Adult Social Care. The Board is chaired by the Borough's Executive Director of Adult Services and the Vice Chair is the Director Social Care, Health and Housing in Central Bedfordshire.

2.2.2 Greater awareness of the importance of safeguarding has been achieved in partner organisations by involving senior managers and raising the importance of safeguarding in the priorities of their own organisations. As a result:

- All partners present a progress report to the board detailing developments, quality and outcomes related to their specific service/organisation improvement plans
- The Mental Health Trust made safeguarding the main element of a managerial post and safeguarding was made the subject for a Board / senior manager seminar
- All statutory partner agencies have appointed a safeguarding lead to take an active role in the work of the safeguarding board at operational group level.
- Service user groups have nominated representatives to join the Safeguarding Board's working groups. These representation groups have devised role descriptions and specifications for employing support workers to ensure that representation is effective and fully inclusive. They have prepared a training programme for service user reps and support workers.

2.2.3 Elected Members have been engaged through:

- Receiving the Adult Safeguarding Annual Report at each council's Executive Group
- Training/awareness sessions on adult safeguarding covering the full range of safeguarding activity which was attended by a majority of elected members.
- As a result of this work, elected members have become more engaged in adult social care work including safeguarding and this has led to improved outcomes for residents.

Good Practice Examples

An elected member was approached by residents concerned that the sounds emanating from a registered care home in their road indicated that a resident was in distress. The elected member was supported to consult with the care provider and immediate neighbours and in partnership with the placing authority we were able to establish that the resident was not being abused and to initiate steps to improve the dignity of this resident and the quality of life for those sharing the house.
Bedford Borough

Following a complaint from a resident about the treatment of his wife in a registered care home, and the subsequent safeguarding investigation, an elected member spent time with the safeguarding manager to enable him to understand the safeguarding process. This provided clarity for him to pass on residents
Central Bedfordshire

2.3 Partnerships And Multi Agency Working

2.3.1 Partners are engaged in the following ways;

- Development of senior level links with the new Children's safeguarding arrangements. An Assistant Director from Children's Services in both councils has joined the Adult Safeguarding Board and an Assistant Director for Adult Social Care has joined each Children's Safeguarding Board
- A "Co-operation Between Teams" protocol has been introduced to ensure more effective joint working and that safeguarding issues are picked up and dealt with promptly

- All key partner agencies have joined the Board's Operational Group which has become a forum for sharing good practice and trouble shooting safeguarding issues. The Operational Group has overseen the development of the new policies and procedures.
- Each partner agency has been supported to develop an improvement plan for raising awareness and understanding of adult safeguarding issues in their own organisations.
- All agencies involved in the Adult Safeguarding Board have signed a concordat committing their organisation to a set of safeguarding standards and practices and each member of the Adult Safeguarding Board has signed an individual member agreement setting out their personal and collective responsibilities.
- Safeguarding and dignity in care is a standing agenda item at each of the provider forums. This has helped improve the knowledge and expertise of providers through shared lessons learnt.

Good Practice Examples

Joint training on safeguarding with the Police Vulnerable Adult Investigation Unit has been undertaken for a number of care homes in the area which were identified as requiring clarification of the safeguarding process.
Central Bedfordshire

There is a 'hot desk' facility for the Vulnerable Adult Investigation Unit of Bedfordshire Police in Bedford Borough Council offices. This has enabled them to act more quickly and write up reports promptly after strategy meetings as well as improving liaison between our organisations.
Bedford Borough

2.4 Operational Leadership

2.4.1 Each council has strengthened their safeguarding arrangements through establishing new safeguarding teams and providing additional resources.

2.4.2 NHS Bedfordshire, SEPT, Bedford Hospital Trust, Luton and Dunstable Hospital Trust and Bedfordshire Community Health Services have all appointed safeguarding managers to operationally lead the development of safeguarding in their organisation.

2.4.3 Audit work has been carried out extensively through the year:

- Each council reviewed all the adult safeguarding alerts and investigations which were incomplete on vesting day to ensure that safeguarding actions had been completed in all cases.
- The safeguarding board then commissioned an audit of files and review of the multi-agency policy and procedures through an external expert.
- Information obtained from the outcomes of the audits and all other safeguarding alerts and investigations from 2008/09 was used to inform the 2009/10 improvement plan.
- Follow up work from the audit included addressing a culture of poor recording and reporting the outcomes of safeguarding investigations.
- Further audits were undertaken including a validation check of the original audit, followed by monthly audits of completed safeguarding case files. These identified improvements in case recording, speed of response to an alert, gaining of consent and timeliness of completion of investigations.

2.4.4 Areas for improvement have been identified through these recent audits including signing and dating of documents, the format of protection plans, setting timescales for actions and the format of recording forms. These are all being addressed in each council's 2010/11 improvement plans.

> **Good Practice Examples**
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> In response to the audit outcomes, the Assistant Director for Adult Social Care led a series of "recording with care" workshops for front line practitioners. This reinforced a clear message for all staff. Monthly case file audits undertaken in the final quarter of the year showed significant improvements in the quality and detail of case recording.
> *Central Bedfordshire*
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> In addition to "Recording with Care" workshops led by the Executive Director for all Managers in Bedford Borough's Adult Services Department, a comprehensive audit tool for all safeguarding files was developed drawing evidence directly from SWIFT and enabling managers to examine each case file against best practice standards.
> *Bedford Borough*

2.5 Review Of Policies And Procedures

2.5.1 The safeguarding board commissioned an audit of the multi-agency policy and procedures by an external expert and file audits to see whether the policy and procedures were being delivered.

2.5.2 Procedures for serious case reviews and serious concerns about establishments were developed and introduced. These procedures, the first to be completed and adopted by the new Safeguarding Board, were found at audit to be qualitatively superior to the other existing policies and procedures.

2.5.3 Following the audit the Safeguarding Board commissioned a re-write of the multi agency policy and procedures so as to make them easier to navigate, adjust for organisational review (within the councils and CQC), adjust for changes in legislation and regulation and include arrangements for a differentiated response (action proportionate to response). The revised policy is based on the Bolton policy, draws on national best practice and material from Essex which recently became the second excellent authority for Safeguarding. Partners have been fully involved in drafting these procedures through the Operational Group and through drawing on their specific expertise

2.5.4 A tiered response to alerts has been introduced. This enables responses to risks to be proportionate for all cases including those not requiring a full safeguarding investigation. This ensures that positive actions are taken to safeguard people even when a safeguarding investigation is not required.

2.5.5 The new procedures are to be formally launched at a safeguarding conference in the autumn and roll out our will be supported by training and an awareness programme.

2.6 Promotion Of Safety

2.6.1 Safeguarding Leaflets have been updated by both councils as part of the safeguarding information.

2.6.2 The Three Counties radio 'Who Cares' campaign (elder abuse) enabled the Chair of the Adults Safeguarding Board to appear live on their breakfast programme to provide advice to listeners on safeguarding and choosing a care home safely

2.6.3 The Safeguarding Board has reviewed the ‘People In Partnership’ (PIP) programme currently being piloted with people who have learning disabilities. The PIP programme supports vulnerable service users to consider their own risks, how they might minimise those risks and determine who might help them to do this. It enables people to devise and have control over their own protection arrangements. It has been agreed that this programme will be rolled out to all adult services over the next year

2.6.4 Links have been strengthened in both councils with their respective Community Safety Partnerships and with Domestic Violence (MARAC) and Serious offenders groups (MAPPA). These relationships enable wider understanding of risks surrounding vulnerable adults and support more informed decisions about how to minimise potential risks.

Good Practice Example

An elderly lady had been physically and financially abused by a son who had an addiction problem. She was provided with medical, psychological and social care support and temporary accommodation. This support continued during the son’s prison term and on release monitoring and restrictions were put in place to provide ongoing protection.
Bedford Borough

2.7 Freedom From Discrimination And Harassment

2.7.1 In order to empower people through the provision of comprehensive reliable and up to date advice, we have:

- Reviewed our public information to ensure that it is available in culturally sensitive formats and in the main languages spoken by BME communities across the locality
- Started developing way in which potential service users and carers have good access to electronic information as well as written information
- Reviewed arrangements for interpreters services

2.7.2 The People in Partnership programme operated between the two councils, Bedfordshire Police and Advocacy Alliance has lead our work to eliminate bullying and combat fear of harm among people with a learning disability.

2.7.3 Worked with safer neighbourhood team within Bedfordshire Police was undertaken to launch; ‘Stop Hate UK’ in our area and to publicise it through posters and publications. Stop Hate is a charity which covers all strands of diversity and has a presence across an eighth of the UK. The call handler at Stop Hate UK (a 24 hour service) can assure the caller as to the seriousness of the complaint and that it will be handled seriously.

Good Practice Example

42 people with a learning disability across Bedfordshire have been trained through the People in Partnership programme from 5 courses across the year. It is intended that this programme should be rolled out to all adult services in the coming year.

Direct feedback from service users and carers who took part in the course include:

- I now feel safer in my community
- I know what a hate crime is and how to report it
- PIP saved my life and gave me purpose
- I like helping other people to understand how to keep safe
- I am not scared of police officers anymore
- PIP helps breakdown social barriers, I learned so much about people who have a learning disability and of course they have helped me to challenge my preconceived views about people with a learning disability, the course is brilliant.

Bedford Borough and Central Bedfordshire

2.8 Quality Assurance, Monitoring and Audit

2.8.1 The following outcomes and actions resulted from the audit of policies, procedures and practice:

- The councils and Mental Health Trust developed and implemented their own remedial improvement plan to address the findings
- The councils were able to secure additional resources to implement their improvement plan.
- The councils undertook an audit of all referrals received between April and December 2009
- Followed up the audit of all files by referring cases back to teams for further remedial work to ensure appropriate standards are achieved
- Provided additional training, supervisory support and on-site technical assistance to ensure that staff achieved the required understanding, competence and confidence in safeguarding practice
- Provided independent chairing for case conferences and strategy meetings to provide challenge and stronger governance

2.8.2 A particular focus was given to recording standards and associated auditing arrangements based on the Care Quality Commission records audit checklist

2.8.3 A culture of managerial oversight of safeguarding activity has been established. This has resulted in improvements to the standard of case tracking, recording and more robust safeguarding arrangements.

2.8.4 An improvement in the collection of performance information has enabled the focus of resources on areas of greatest risk.

2.8.5 An increasing area of risk was identified in relation to financial abuse. As a result of this the police have undertaken additional training to increase their expertise in investigating concerns of financial abuse. Much more emphasis will be required over the coming year in enabling service users to become more aware of financial abuse and exploitation.

2.8.6 The Practice and Performance Sub-group has examined the cases judged as “Good” and have devised exemplar files to share with teams identifying what “excellent” looks like. This alongside the Councils’ remedial action plans, revised training and the audit programmes are gradually being able to evidence improvements in practice and performance.

> **Good Practice example**
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> A lady in a residential home was not receiving funds for her personal requirements. The police and the court of protection became involved and identified that a family member had become appointee but was not paying the lady’s care home fees or sending her funds to cover personal items. The court of protection and the benefits agency relinquished the appointee-ship and took over the management of her finances on her behalf. The lady now has regular trips to the hairdressers and chiropodist.
> *Bedford Borough*

2.8.7 Both councils have introduced a robust system for monitoring standards of care within provided for services, whether funded by the council or not. This system draws material from what people who use services and their families tell us about their experiences, contractual reviews, regulatory inspections and are benchmarked against other local authorities. These activities are overseen by the Quality Assurance which all operational services contribute to and have worked together sharing and responding to information, assessing risks and increasing standards of care and dignity for people who use services.

2.8.8 Contracts with registered care providers state the standards of service and outcomes service users should experience and these have clear focus on the prevention of abuse.

> **Good Practice Example**
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> A review of the support for a lady living in a nursing home highlighted a fall resulting in hospital admission with a fractured hip. No safeguarding referral form was completed and risks assessments were not up to date. The service user was considered to be at risk. The reviewing officer reported to the contracts compliance team. A contracts monitoring officer carried out a site visit to the home to advise them of required actions and remedies to ensure that the welfare and safety of service users is paramount at all times. A safeguarding alert was made and notification was also made to the neighbouring authorities safeguarding team who also placed within the home, informing them of the poor practices identified and actions being taken to raise the standards. Checks were made to ensure the actions were completed and all residents in the nursing home were safe and well cared for.
> *Central Bedfordshire Council*

2.8.9 An Adult Safeguarding Minimum Data Set and the associated tools for submitting the new Abuse of Vulnerable Adults return has been developed. Building this into SWIFT ensures compliance with the new reporting requirements

2.8.10 Timelines and responsibilities have been introduced for each stage of the safeguarding process linked to the Association of Directors of Social Services standards and supported with guidance for staff on roles and responsibilities in the new policies and procedures manual.

2.9 Training and Publicity

2.9.1 Extensive training programmes for providers and investigation staff have been delivered during the year with a particular emphasis on recording standards

- Training has been targeted at establishments with regular safeguarding issues
- A programme of additional training in the recording of safeguarding work was targeted at investigation staff
- Training has been provided for GPs through the GP forum
- Both councils have produced a new safeguarding information leaflet

2.9.2 The Chair of the Safeguarding Board appeared live on Three Counties Radio Breakfast programme to provide advice to listeners on safeguarding and choosing a care home wisely.

2.9.3 The training sub group have developed a competency framework and work books around safeguarding to ensure that staff who receive safeguarding training are competent and confident at identifying and responding to abuse.

2.9.4 The training sub group have also completed a workforce survey identifying numbers and levels of training and confidence in safeguarding. The survey evidences the impact of previous awareness raising campaigns and training. The work force knows what abuse is, know what to do if they suspect it and how they can prevent abuse happening. The survey identified the following priority areas for development within the coming year:

- Mental Capacity Act – Deprivation of Liberty
- Rights versus duty of care
- End of life planning
- Risk management

2.10 Eastern Region Joint Improvement Partnership Key Recommendations

2.10.1 In April 2009 the Eastern Region Adult Safeguarding Group identified a number of strategic and operational areas for development. These were drawn into a work programme and safeguarding adults formed one of fourteen work streams within the Joint Improvement Partnership (JIP) Programme designed to meet regional and local needs.

2.10.2 The information provided by ten councils and one NHS partnership in the region during December 2009 to February 2010 was used to produce individual feedback reports on safeguarding arrangements, identifying organisations' current position along with their strengths and areas for development. The report used the information gathered to provide a general account of Safeguarding Adults practice, procedure and activity across the region.

2.10.3 The reports received by Bedford Borough and Central Bedfordshire Council highlighted significant areas of good practice which demonstrated the improvements made during the previous months of the year. This included:

- Strong multi agency commitment, leadership and political support
- Good performance management, quality assurance and contracting processes
- Strong safeguarding teams with specialist staff

2.11 Serious Concerns and Serious Case Reviews

2.11.1 Procedures for serious case reviews and serious concerns about establishments were been developed and introduced. These new procedures, the first to be completed and adopted by Safeguarding Board, were found at audit to be qualitatively superior to the other existing policies and procedures.

2.11.2 The purpose of a Serious Case Review is to establish whether there are lessons to be learnt from a particular case about the way in which local professionals and organisations work together to safeguard and promote the welfare of vulnerable adults. Serious Case Reviews are not inquiries into how a vulnerable adult died or who is culpable.

2.11.3 The councils have both commissioned serious case reviews during the year, and are due to be reported on during 2010/11. Central Bedfordshire Council started this process early in the year which identified the need for improved formal reporting templates to aid the gathering of information. These have been developed and are being used by both councils.

2.11.4 The purpose of the Serious Concerns procedure is to adopt a consistent and proportionate response when serious, non compliance of minimum care standards are raised about a care provider that has or is likely to result in a potentially life-threatening injury through abuse or neglect; serious and permanent impairment of health or development through abuse or neglect; loss of choice, independence and well being; or when an investigation of specific concerns reveals wider issues about a provider and these cannot be resolved by local negotiation with the registered manager.

2.11.5 Serious concerns with registered providers have been identified through close working between the safeguarding teams, contract and care standards teams, and frontline social work teams within the local authorities. We also work closely with our partners in the NHS and police to identify concerns and work to improve services.

2.11.6 The serious concerns procedure has been implemented with 4 service providers in Bedford Borough Council and 3 service providers in Central Bedfordshire. This has enabled us to work intensively with providers to improve the health and well being of the 220 people receiving those services, improving standards of care and quality assurance mechanisms to minimise the risks of further concerns. Actions taken have included suspension of new admissions to the home concerned, reviews of care provision by social workers and reviews of tissue viability care by district nurses.

3. Partnership Contributions to the Adult Safeguarding Agenda 2009/10

3.1 NHS Bedfordshire

3.1.1 The Executive Nurse at NHS Bedfordshire has the designated Board lead role for safeguarding. A review of internal procedures was undertaken and as a result leadership roles and the ability to respond and identify areas of concern are managed as a priority within the quality and safety team. An internal panel has been established to review progress, share knowledge, ensure a robust response and learning from experience.

3.1.2 An essential piece of work has been commenced with the review of all grade 3 pressure sores. All grade 3 pressure sores are now considered as a serious incident and a root cause analysis will be undertaken with the aim of identifying areas of practice that can be improved to ensure a safer and better experience for all patients. This work will continue throughout 2010/11.

3.1.3 All provider contracts include compliance with safeguarding policy and a clearly defined performance management framework was developed as part of the contract schedule. This is monitored as part of all the contract review meetings.

3.2 Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

3.2.1 In April 2010 SEPT took over management of MH services from BLPT. This annual report seeks to inform the Board about the Trust's continued commitment to strengthening arrangements for Safeguarding Adults.

3.2.2 An external audit was undertaken in December 2009. The conclusion of the audit was that safeguarding arrangements were not yet secure and embedded within BLPT with concerns regarding quality of risk assessments and investigations and compliance with procedures.

3.2.3 Since January 2010 action to address these issues has been taken which has resulted in improved practice and performance. A Strategic framework outlining a vision for safeguarding in the Trust has been approved and agreed by our Board of Directors; reporting has been strengthened via trust internal performance framework, and increasing engagement of clinical staff in Safeguarding leading to improved reporting. The Executive agreed to appoint an adult psychiatrist as a named doctor for safeguarding adults to further strengthen clinical engagement with safeguarding in the Trust.

3.2.4 The safeguarding team undertook an intensive programme to improve staff understanding and engagement in safeguarding. This included:

- Briefings for staff and managers in relation to roles and responsibilities.
- Guidance to teams about the referral and investigation processes, pathways and timescales.
- Introducing audit arrangements to ensure the quality and completeness of safeguarding measures, including management oversight and supervision of casework.
- Group supervision sessions for staff to bring cases and questions for discussion and learning.

3.2.5 As a result, noticeable improvement in safeguarding practice has been achieved and under the leadership of SEPT, a detailed action plan for further improvement is under way.

3.3 Bedfordshire Police

3.3.1 The Vulnerable Adults Investigation Unit of Bedfordshire Police has achieved landmark prosecutions of the perpetrators of financial abuse and one of the first successful prosecutions under the Mental Capacity Act.

3.3.2 During the year, the police have developed a new IT system for safeguarding investigations, enabling the Police to improve auditing and trend analysis.

3.3.3 The police have also created a Hate Crime Forum in order to strengthen their capacity for dealing with discriminatory abuse.

3.3.4 Officers in the Vulnerable Adults Investigation Unit have undertaken specialist training in the investigation of financial abuse in response to a 25% increase in the number of referrals of this nature.

Many of the referrals received by Bedfordshire Police have increased in complexity, in particular around financial abuse. The constables working within the VAIU will now be embarking on a Trainee Investigator programme to enhance their investigation skills. In time, the unit will consist of substantive Detective Constables.

3.3.5 Awareness training has been delivered to front line officers. Additional training is planned for Autumn 2010.

3.3.6 The VAIU have moved their operating base to Eastern Avenue in Dunstable. The new premises are more appropriate and accessible than the previous location. The team work closely and are co-located with other areas of the Public Protection Unit, in particular the Child Abuse and Domestic Abuse units. The safeguarding risks of Vulnerable Adults are discussed at Daily Management Meetings which provides interoperability amongst PPU staff.

3.4 Bedford Hospital NHS Trust

3.4.1 Bedford Hospital Trust has begun a programme of awareness raising of safeguarding in all its forms among clinical and management staff. The Trust declared non compliance against outcome 7 – Maintaining Personal Dignity and Respect, in its application for Care Quality Commission registration but has developed a robust action plan which has met with CQC approval and full registration without conditions.

3.4.2 The Trust has established a Safeguarding Committee and a part time Safeguarding Lead post at Senior Nurse level for an initial 6 month period to set up systems to help embed Safeguarding processes internally.

3.4.3 The Trust has formed 3 task and finish groups – training, policies and procedures and clinical governance and audit which will report back to the Trust's overarching Safeguarding Committee.

3.4.4 Partnership working with NHS Bedfordshire and wider health economy has been developed to monitor and improve outcomes for both hospital and community acquired pressure sores.

3.4.5 Reporting of SOVAs increased month on month.

3.5 Luton and Dunstable Hospital NHS Foundation Trust

3.5.1 Luton and Dunstable Hospital is situated in the Luton Borough Council area but provides services to significant numbers of patients from Central Bedfordshire and some from Bedford Borough.

3.5.2 The Trust has clarified the use of processes and procedures as the hospital works with both Luton and Bedfordshire Councils and there have been some differences particularly in relation to processes.

3.5.3 Work has progressed in relation to Skin Matters / Safe Skin initiatives including the introduction and use of transfer records in relation to the status of pressure areas. Work has continued to reduce hospital acquired pressure ulcers through changes to essential care rounds and implementation of the practice of rounding (hourly checking in with patients which also involves encouraging mobility)

3.5.4 There has been an increase in training for staff exploring thresholds – this involved Ward Managers and other staff especially but not exclusively in elderly care and medical wards and also the complaints team. The emphasis has been on enabling staff to think proactively about prevention of harm and their work behaviours as well as what to do if harm occurs.

3.6 Bedfordshire Community Health Services

3.6.1 Bedfordshire Community Health Service (BCHS) has set up a Safeguarding Children & Vulnerable Adults Committee which meets on a bi monthly basis and has resulted in strengthened governance.

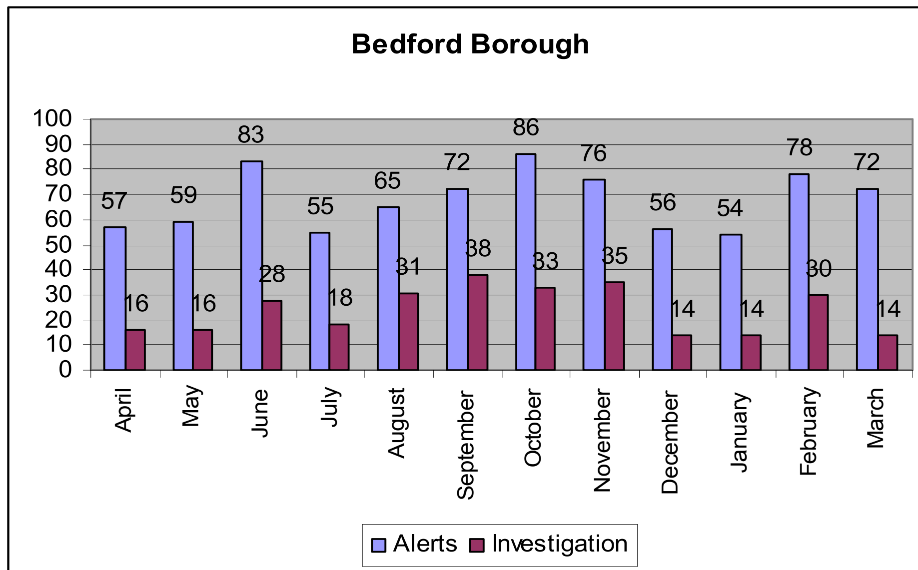
3.6.2 BCHS has employed a Clinical Service Manager to drive and support the vulnerable adult safeguarding agenda.

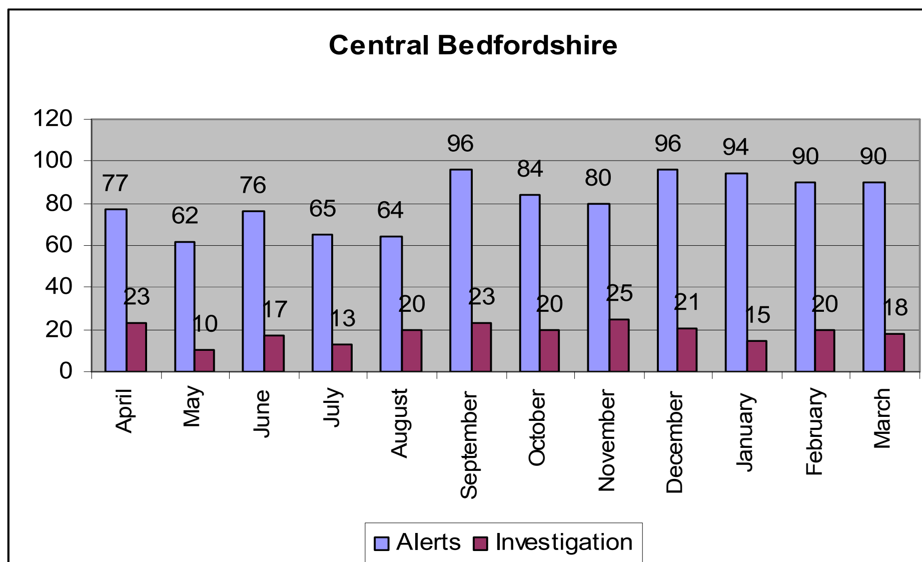
3.6.3 BCHS has a data collection system in place, which has facilitated identification of themes with respect to safeguarding of vulnerable adults.

3.6.4 BCHS continues to participate in the SOVA agenda, ensuring appropriate and active membership of the SOVA Board and sub groups alongside increasing activities in SOVA processes at operational level, including progress to improve communication between both Central Bedfordshire and Bedford Borough Councils.

4. Safeguarding Activity April 2009 – March 2010

4.1 Total Number Of Alerts



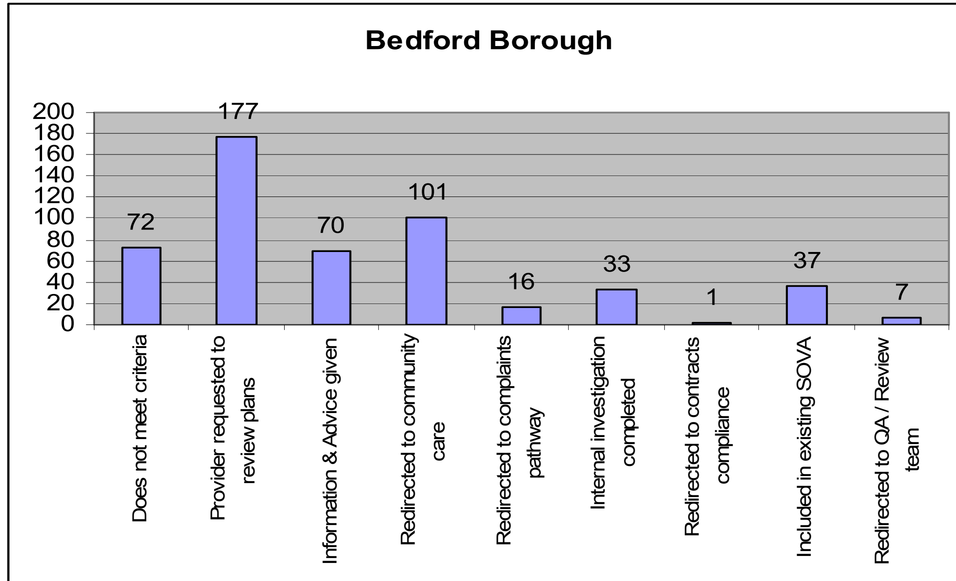


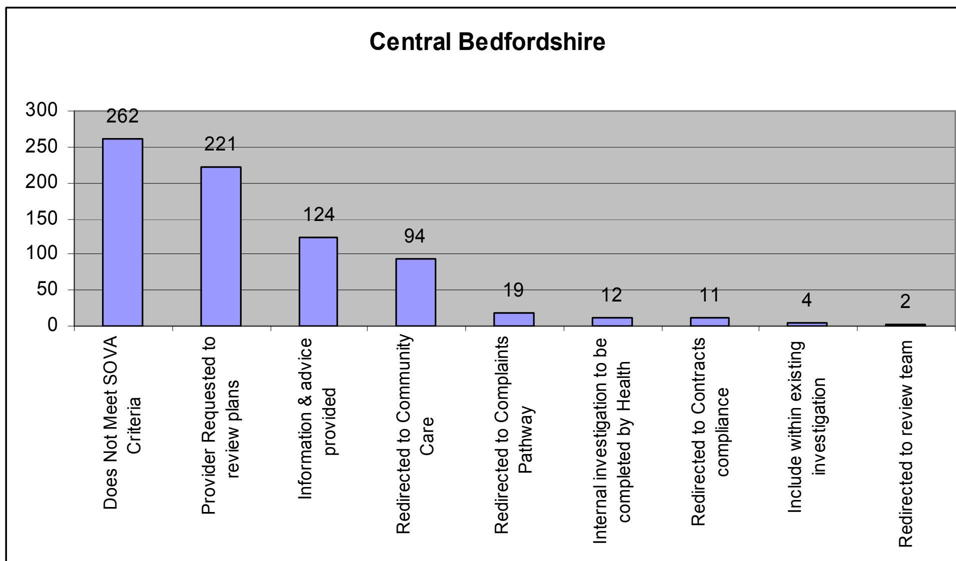
4.1.1 Bedford Borough Council received a total of 813 alerts. 287 (35%) progressed to safeguarding investigation. This is an increase in the number of alerts (277) upon the previous year's total figure (553). This is attributed to the increased awareness and reporting within partner agencies in the area.

4.1.2 Central Bedfordshire received a total of 974 alerts. 225 (23%) progressed to safeguarding investigation. This is slightly less (69) upon the total for the previous year (1043). This is attributed to increased understanding of what constitutes significant abuse and referral requirements for investigation. These 974 alerts involved 646 different alleged victims.

4.1.3 Overall, alerts have increased by 12% over the previous year to almost three times the 2007/08 level. This confirms that awareness and understanding of safeguarding continues to increase. However there is still work to do to increase standards of overall care and increase understanding of what constitutes significant abuse. The revised policy and procedures will make definitions much clearer.

4.2 Alerts Not Proceeding To An Investigation

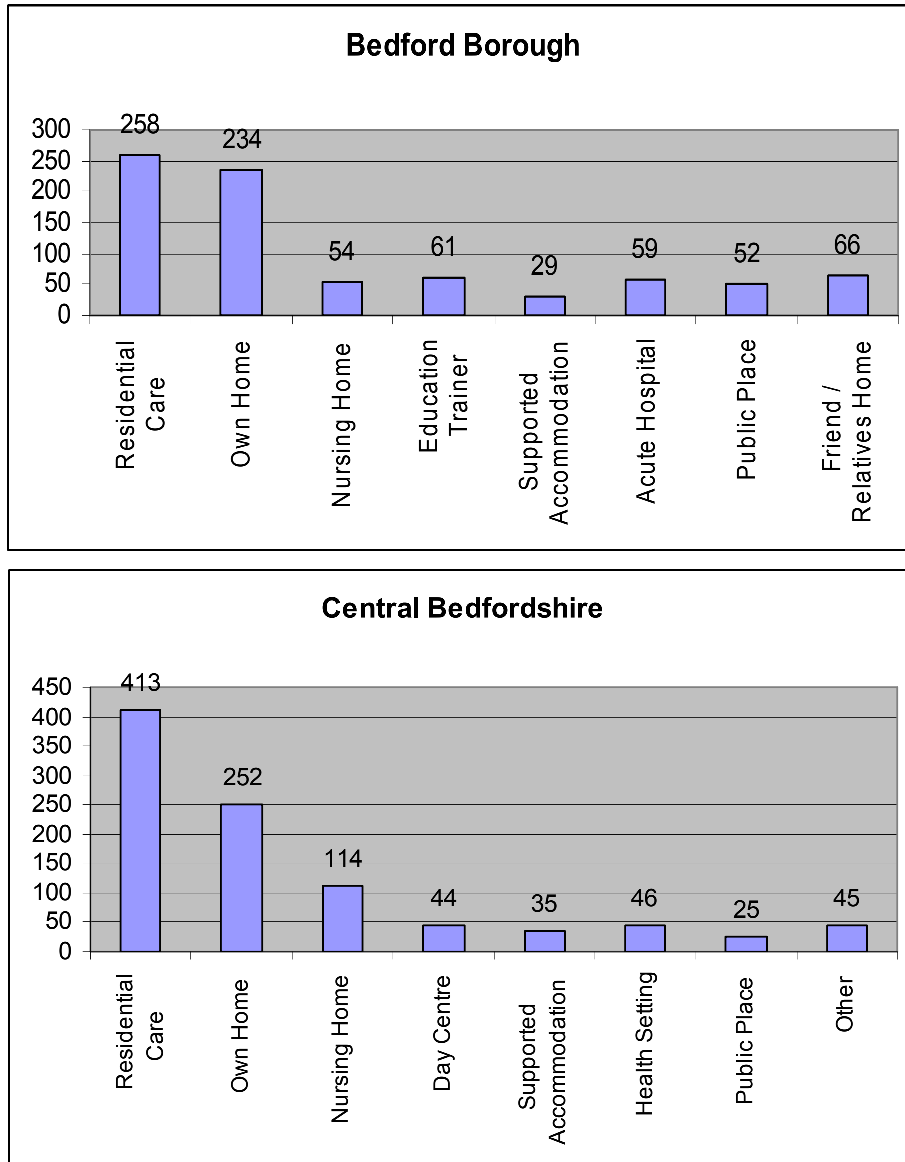




4.2.1 Up to 65% of alerts do not require a full safeguarding investigation. Many of the reported concerns relate to minor incidents, such as slips and trips within registered care provider establishments. These tables show where alerts were signposted to for further safeguarding work. Improved data collection and analysis has enabled the board to monitor and ensure that the people for whom there were concerns raised, but did not proceed to formal investigation, are appropriately safeguarded.

Good Practice Example
A lady was identified as having frequent falls, resulting in minor tears and bruises. Assessment and analysis of these falls by the care management team identified patterns and trends at particular times of the day. It was found that the falls coincided with times that the lady was taking her medication. The lady was supported to have her medication reviewed by her GP. The review resulted in changes in her medication that minimised the effects upon her balance. The lady continued to increase her balance and confidence to become more independent and mobile again.
Bedford Borough

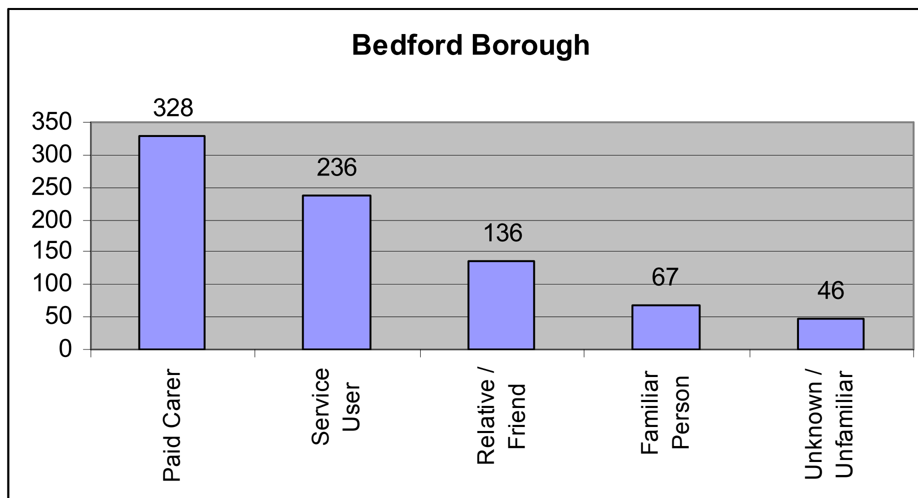
4.3 Location Where Abuse Happened

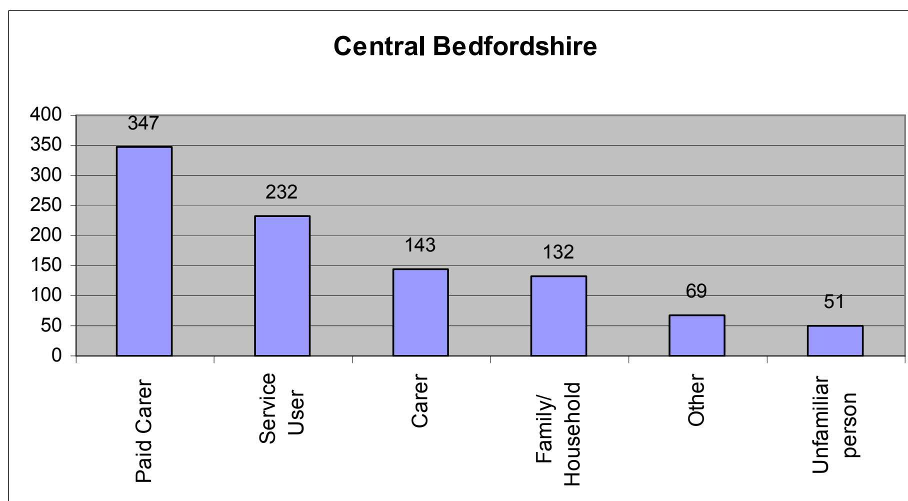


4.3.1 The numbers of alerts from people who are living in their own home identifies a continued increase on last year's figures (26%). This is attributed to the raised awareness during reviews and in domiciliary services and recent media articles and campaigns. There is significant need to increase awareness of abuse and reporting within community and acute health services. Partnerships with GP's have been strengthened as they are more likely to meet with people who are vulnerable, therefore able to identify potential abuse and potential risks of abuse that could be minimised with support. The board has begun to form closer links with the wider community safety agenda in raising awareness and practical supports that are available to all vulnerable people in the community.

4.3.2 The largest number of alerts continues to come from registered services. These incidents include manual handling errors, accidental falls, medication errors, skin integrity pressure care management issues. Providers are required to notify the regulator of these incidents. Feedback from service providers through surveys and individual work with providers whose alerts rates are significant tells us that although they understand safeguarding as a process, understanding risk remains a challenge. These concerns will be addressed through training and individual work with providers such as assistance with falls monitoring.

4.4 Relationship To Abused Person





4.4.1 These tables identify increasing trends in the numbers of concerns being raised about people living in their own home where the alleged abusers have been a relative or friend of the person. The tables identify a significant decrease in alerts relating to paid carers from 47% in 2008/09 to 37% in 2009/10 across the area covered by the Board.

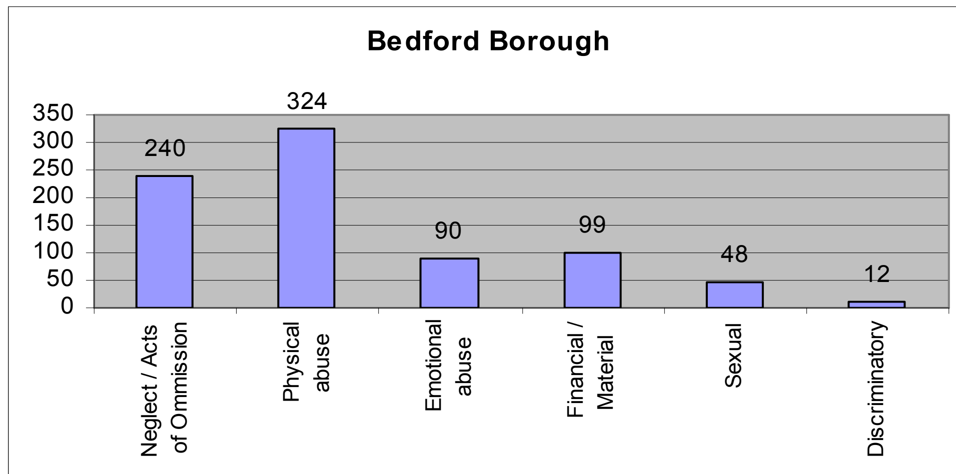
4.4.2 The key factors for the victims have been:

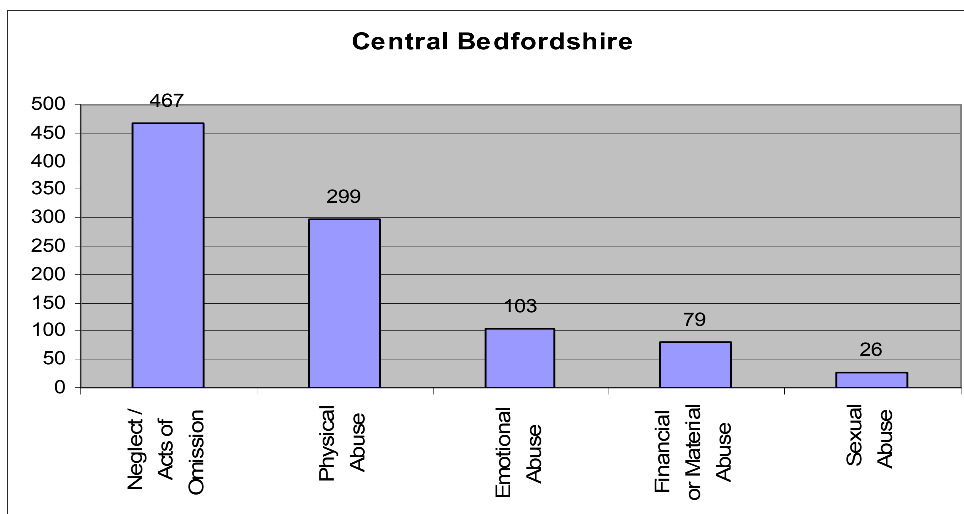
- Diminished capacity to make or be enabled to make their own choices
- Increased dependence upon others for daily support to complete essential tasks
- Increased isolation and lack of opportunity to have other supports and relationships
- Increased stress and tiredness of main carers

4.4.3 Other trends identified in these incidents appear to be as a result of:

- Increased community and domiciliary support awareness
- Increased awareness of safeguarding and duty to prevent abuse
- Lack of clarity between minimum standards and contractual requirements
- Lack of user involvement and person centred approaches
- Variable standards of risk management
- Variable quality assurance and outcome focus

4.5 Types Of Abuse





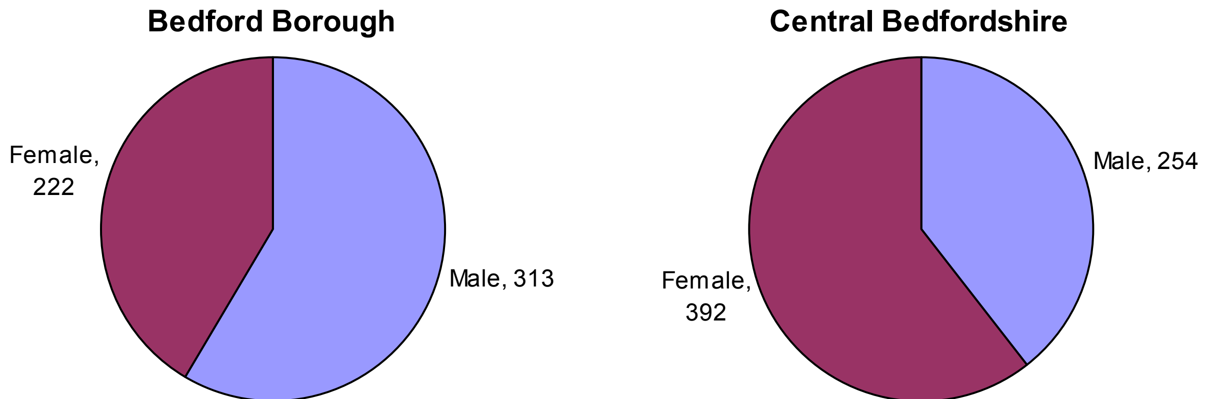
4.5.1 The most reported cases of abuse are of physical abuse or neglect and acts of omission. This encompasses a wide range of deliberate acts such as direct punches, slaps and kicks to acts causing physical distress through inappropriate or rough manual handling / hoisting or lack of physical care. To combat this partners in the Safeguarding Board are promoting the dignity in care agenda and using our quality assurance mechanisms to monitor and raise awareness. The NHS is leading an initiative to reduce the incidence of pressure sores and the police are prosecuting where appropriate and possible.

4.5.2 A recent provider survey identified that providers would like to develop further risk management practices and would contribute to devising a standard template for risk management plans that has been agreed as a good practice and accessible format. A review of the risk enablement policy and templates will be supported through the boards sub group's policy and procedures and in the provider's forum which will support a reduction in the number of alerts categorised as inappropriate manual handling and neglect.

4.5.3 The numbers of concerns regarding sexual assault is of particular concern. There is an emerging pattern of people with mental health needs who are subject to sexual assaults by people who are familiar to them. As well as directly responding to protect victims involved in each of these incidents, work is being undertaken jointly with community safety to tackle the underlying trends and with the police to prosecute where possible.

4.5.4 Preventative work which has started in 2009/10 includes research to address re-offending in domestic violence and multi-agency initiatives to combat bullying and hate crime.

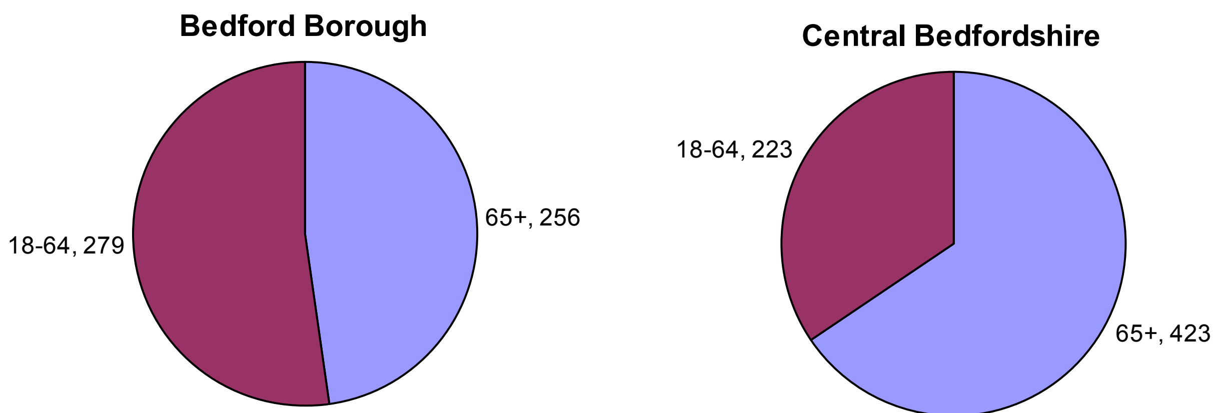
4.6 Referrals By Gender



4.6.1 The numbers of males and females being reported as victims are proportionate to the numbers of people accessing community care services. Overall the majority of alerts derive from residential care services. The majority of the residential care population are over 65 and female. Therefore it is statistically more likely that an incident will involve a female than a male from those services.

4.6.2 This higher number of referrals for males in Bedford Borough is predominantly attributed to learning disability services reporting service user to service user aggression. Within the last quarter of the year, there was in increase in alerts from a large provider whose service user group has a high percentage of males who are known to have behaviours that are aggressive. There were several repeat referrals regarding the same victims from this provider service.

4.7 Alerts By Age

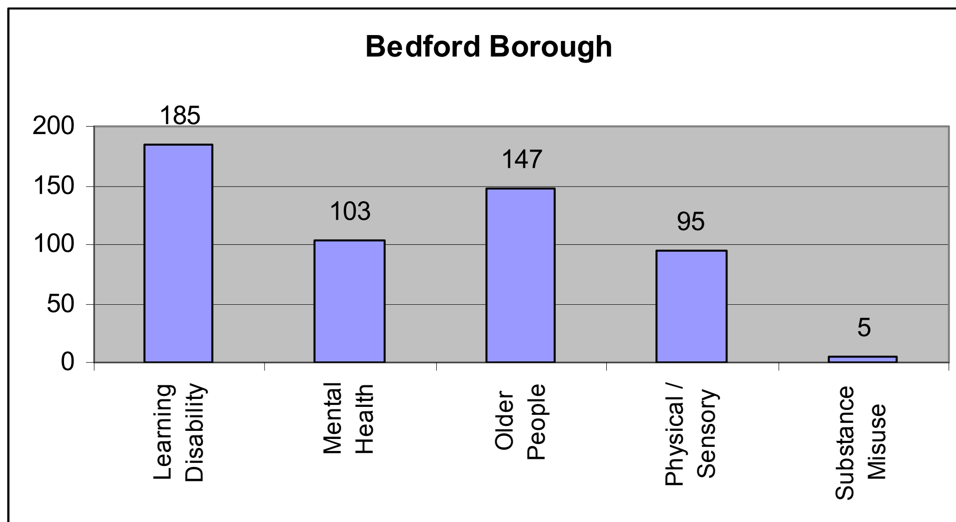


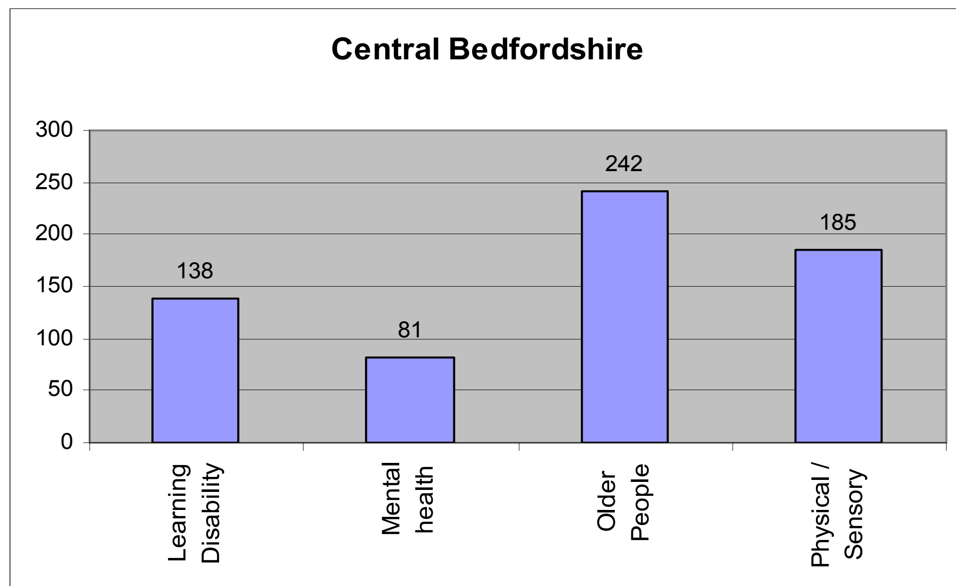
4.7.1 In Bedford Borough a slight majority of alerts related to people of ages 18-64. In Central Bedfordshire the majority of alerts related to older people. These trends reflect the statistics above, and may also reflect the age of the respective populations in the two councils.

4.7.2 The proportion of alerts regarding older people and people with learning disabilities remains fairly consistent, albeit a slight increase for learning disability services in the last quarter within Bedford Borough relating to a single establishment where extra safeguarding attention is being given to bring down the number of incidents.

4.7.3 The significant proportion of alerts relating to older people in Central Bedfordshire is because of the number of alerts in residential care homes and work is being undertaken with some homes to improve awareness and training and to assist with falls monitoring.

4.8 Alerts By Support Need



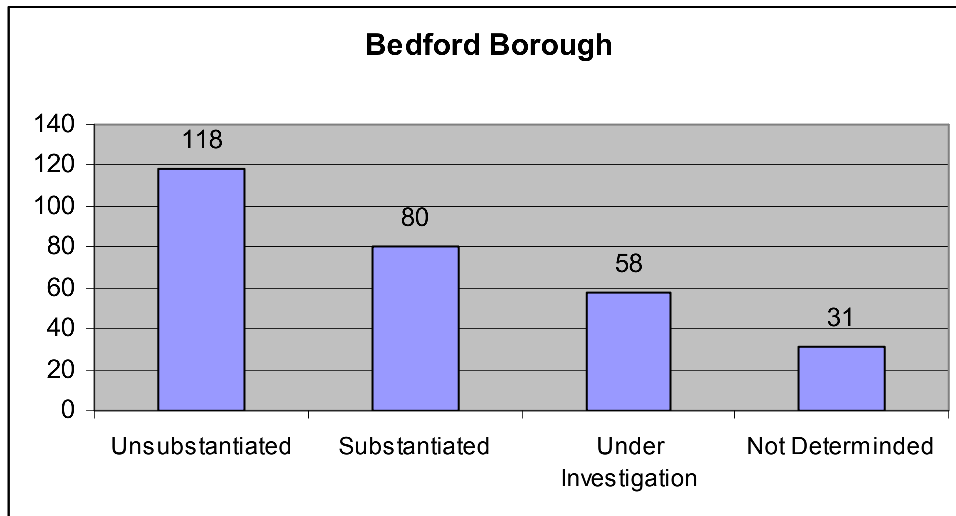


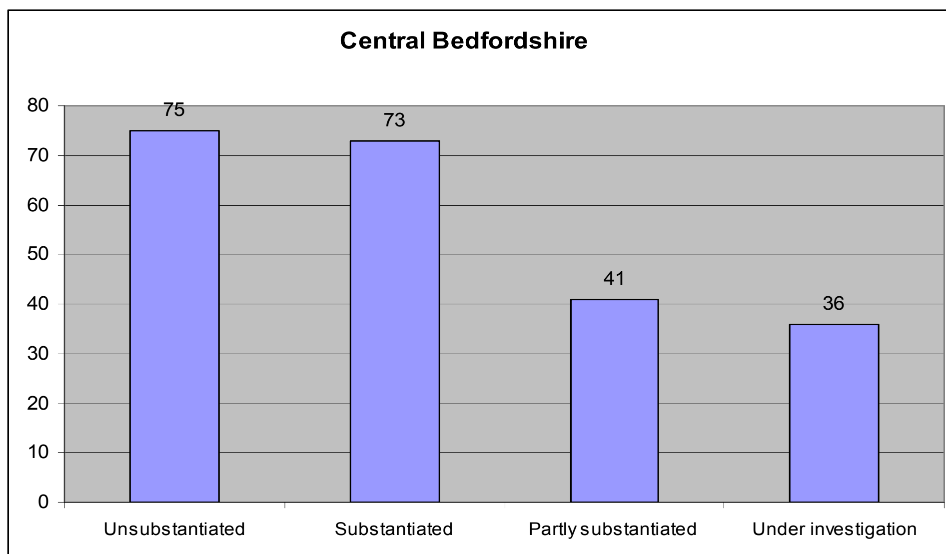
4.8.1 The proportion of alerts regarding older people and people with learning disabilities remains fairly consistent, albeit a slight increase for learning disability services in the last quarter within the Borough.

4.8.2 The number of alerts about people with physical disabilities or sensory impairment was considered very low at the end of last year. A programme of awareness raising through the partnership boards and targeting domiciliary services for awareness training has increased understanding of what abuse is and how to support people in preventing abuse happening.

4.8.3 There is a slight increase in the numbers of referrals from substance misuse services, although most of these referrals have related to people who have full mental capacity to choose to disengage with their support mechanisms and continue to misuse substances placing themselves in vulnerable positions. Further work is taking place to bring drug and alcohol services closer to other adult services to support people in making what might appear to be unwise decisions about their lifestyles.

4.9 Outcomes Of Safeguarding Investigations





4.9.1 Cases still under investigation include a high proportion where abuse has been established and further legal or disciplinary procedures are taking place. The external audit process has verified that the judgements and responses have been valid and proportionate and show that improvements have been achieved in the quality of investigations and practice..

4.9.2 The audit and remedial works have confirmed our expectations about the need to undertake further training, guidance and supervision of investigation activity to ensure that minimum standards are achieved.

4.9.3 The revised procedures clarify the timescales for investigation work to be undertaken. Whilst evidence shows us that people are being visited and protected promptly, there are still delays in completing the full investigation within the standard time scales. Cases are being kept open to ensure that monitoring continues when it would be more appropriate to close the investigation phase and continue to review.

4.10 Mental Capacity Act - Deprivation Of Liberty Safeguards

4.10.1 The Numbers of Deprivation of Liberty assessments have been much lower than expected. This is in line with the national picture. The proportion of Numbers of Deprivation of Liberty assessments leading to an authorisation is higher than expected. This is also in line with the national picture. This demonstrates a wide understanding of people's dignity and the range of options available to keep people safe without infringing their rights.

4.10.2 Bedford Borough has had 51 requests for Deprivation of Liberty Safeguards Assessments since April 1st 2009. Of these 38 have been authorised and 13 declined. Bedford Borough has had a consistent flow of assessments throughout the year.

4.10.3 Central Bedfordshire received 38 requests, of these 18 were authorised and 20 declined.

4.10.4 Initially there were a high number of inappropriate applications being made relating to people who have mental capacity. Both authorities targeted this area through individual meetings and forums with providers, and in the last 2 quarters of the year no Deprivation of Liberty Safeguard Assessments failed on Capacity.

4.10.5 The Mental Capacity Act Co-ordinators work closely together to maintain consistency in practice and decision making and to develop good practice within the area. They cascade information from the Regional Group and communicate local learning and best practice guidance regularly with service providers and assessment and care management staff.

4.10.6 They also ensure that there are shadowing opportunities for new Best Interests Assessors or trainee Best Interests Assessors to go with more experienced Best Interests Assessors.

4.10.7 Awareness and Implementation of the Mental Capacity Act and Best Interests Decisions has increased significantly across both councils which demonstrates that more vulnerable people are being treated with dignity and respect in consulting and enabling them regarding important decisions.

4.10.8 Audits of assessments has identified that there has been an increase in the quality of Mental Capacity Assessments completed, although there is further development work planned to improve the quality of best interest decision making.

4.10.9 Assessments have identified that there is further work to do in raising confidence and understanding of how and when to assess an individual's mental capacity. Areas identified for additional training and awareness raising are consent to; serious medical treatment, control of personal finances and choice of accommodation.

Good Practice Examples

A gentleman with a learning disability resident in a care home has epilepsy which is more prevalent at night. The care home with the agreement of the family had installed CCTV in his room so that staff could respond quickly with life saving medication if needed. A Deprivation of Liberty Safeguards Authorisation was put in place which permitted the CCTV use with restrictions and enabled a less intrusive monitoring arrangement to be obtained.
Bedford Borough

An 81 year old lady with Alzheimer's disease enjoys walking and regularly attempts to leave the residential home where she lives but has no insight to environmental dangers such as traffic and would be unable to return home independently due to her short term memory loss and confusion. Authorisation to restrict her liberty by supplying her with a wrist band that activates an alarm enables her to wander in the safety of the extensive secure grounds to the home, whilst restricting movement out of the front door onto a busy road. Without this technology Mrs C would have to live in a locked door environment for her own safety.
Central Bedfordshire

Learning From Safeguarding Activity

Issue	Action To Ensure Learning
A high proportion of alerts do not require safeguarding investigation. This would suggest that there is good awareness of the safeguarding agenda but further work is required to distinguish between matters of abuse or the need to protect and issues to be picked up by other processes including contract management and health & safety procedures. Feedback from service providers through surveys and individual work with providers whose alerts rates are significant tells us that although they understand safeguarding as a process, understanding risk remains a challenge.	Launch new multi agency policy and procedures in October 2010.. Continue with training improvement plan, using examples and monitor outcomes from this through feedback/ evaluation. Further research of outcomes of cases not requiring full investigation but requiring intervention to improve circumstances and quality of life. Further work through the providers forum to raise understanding and confidence within the sector about the safeguarding procedures and quality assurance throughout 2010/11..
Over 500 alerts were assessed as requiring protection and further investigation.	The Board's key objectives 2010/11 and agency improvement plans aim to address deficits and reduce the incidence of abuse. The Adult Safeguarding and contracts/ care standards teams will continue to work with providers to increase overall standards of care and quality assurance and prevent abuse happening. An audit and practice improvement programme during 2010/11 to improve competence and practice for workers undertaking investigations.
The incidence of alerts involving repeat victims implies that risk management plans are not effectively preventing abuse. This indicates that some providers are not appropriately responding to individual need following an incident.	Further work through the providers forum, individual reviews and contracts / care standards teams to ensure that all services have clear risk management procedures and that individual plans identify support arrangements to minimise risks and maximise independence. Care managers to ensure that all new services have clear risk management plans in place prior to placement. Care reviews to focus on this area over the next year.
Whilst the proportion of alerts from people who live in their own homes has increased, the numbers of alleged victims living in residential care or nursing homes continue to be proportionately far more than people living in their own homes.	Targeted training and development. Development of a risk enablement procedure and keeping safe booklet to support vulnerable people and their carers to operate their own health and well being plans with a clear focus on independence and prevention. Extension of the People In Partnership programme from learning disability to cover other vulnerable care groups. Both to happen in 2010.

5. Key Objectives for 2010 – 2011

6.1 For each agency to ensure safeguarding underpins all aspects of their business

i) Each member to establish their own improvement strategies to be presented and agreed by the board.
ii) Each member to present an update and progress report at each board meeting
iii) To increase the proportion of staff in all agencies with mental capacity act and deprivation of liberty safeguards training, to monitor the take up of this training through audit and develop a competency framework
iv) To ensure that compliance against standards, including recording, is monitored through routine audits of adult protection records
v) Agree and organise an audit programme of all safeguarding work undertaken including independent scrutiny
vi) Implement programme of audits for deprivation of liberty and produce reports to show quarterly benchmarking against national data
vii) Ensure regular and planned review of the multi agency policy and procedures and devise mechanisms for changes and updates
viii) Make provision for impact assessment of new policy and procedures

6.2 To ensure that a strong safeguarding theme runs through the development programme for self directed support within each agency

i) Multi agency policy and procedures to be launched as part of the safeguarding and dignity campaign
ii) To develop awareness of safeguarding matters among service users and informal carers. Training sub group to present a programme of awareness raising among informal carers
iii) To analyse trends in safeguarding and use this analysis to inform the work of the Operational Group
iv) Activity reports to be considered at each Operational sub-group and Board meeting including lessons learnt and recommendations
v) Devise risk enablement policy and guidance
vi) Develop a policy and tool for the safeguarding of service user finances

6.3 To reinforce the values of dignity and respect to raise standards and reduce incidents of abuse within each agency

i) Safeguarding conferences for the public and professionals to take place in Bedford Borough and Central Bedfordshire
ii) Ensure People in partnership programme is rolled out to all and outcomes of this are monitored
iii) Measure quality and impact of training provided in all agencies and identify a mechanism and tools for completing this
iv) Development of a dignity in care charter which provides clear set of principles for the safeguarding and dignity in care campaign.
v) To carry out a further public awareness campaign with targeted input to Black and Minority Ethnic communities.

6.4 To achieve meaningful inclusion of service users and carers with appropriate support within each agency

i) Finalise proposals for service user and carer support to engage as full members of Board and sub groups.
ii) Devise a training programme for service users to include identifying and reporting abuse, dignity in care, anti bullying
iii) Devise a mechanism for victims of abuse and their representatives to provide feedback on the safeguarding process
iv) Analyse feedback from people using services and lessons learnt and make recommendations for improvements
v) Devise "keeping safe, staying safe" mechanisms for service users and carers, including anti bullying

Safeguarding is "all work which enables an adult who is or may be eligible for community care services to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect"

Safeguarding Adults, A national framework of standards for good practice and outcomes in adult protection work, ADSS 2005.

Abuse is mistreatment by any other person or persons that violates a person's human and civil rights. The abuse can vary from treating someone with disrespect in a way which significantly affects the person's quality of life, to causing actual physical suffering.

Abuse can happen anywhere – in a residential or nursing home, a hospital, in the workplace, at a day centre or educational establishment, in supported housing or in the street.

Abuse is a violation of an individual's human or civil rights by any other person or persons.

"No Secrets"
Department of Health, March 2000

Abuse may happen to people with a learning, sensory or physical disability, older people, people with mental health problems, people with dementia or people who cannot always look after or protect themselves.

Abuse comes in many forms – physical, sexual, psychological, financial, neglect or discriminatory abuse. Institutional Abuse can happen when people are mistreated because of poor or inadequate care, neglect and poor practice that affects a whole service. Any of these forms of abuse can be either deliberate or be the result of ignorance, or lack of training, knowledge or understanding.

The person who is responsible for the abuse is very often well known to the person abused and could be a paid carer or volunteer, a health worker, social care or other worker, a relative, friend or neighbour, another resident or service user or an occasional visitor or someone who is providing a service. It could be anyone.

We can all stop abuse.

We can make a difference by taking notice of what is going on in our workplace, in our home or neighbourhood.
If you are being abused or you suspect that someone you know, may be the victim of abuse you should call Adult Services as soon as possible between 9am and 5pm. Out of these hours and at weekends or bank holidays please call the Emergency Duty Team on 0300 300 8123.
Your concern will be taken seriously and you will receive prompt attention.
If the abuse is also a crime such as assault, racial harassment, rape or theft, you should involve the police to prevent someone else from being abused. If the police are involved, Adult Social Services will work with them and you to support you.

Contact details:

In Bedford Borough
Tel 01234 276222, **Fax** 01234 276076 **Email** adult.protection@bedford.gov.uk

In Central Bedfordshire
Tel 0300 300 8122, **Fax** 01582 818031 **Email** adult.protection@centralbedfordshire.gov.uk