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 2010- March 2011

Abuse is Everybody's Business
Safeguarding is our Responsibility

Abuse is Everybody's Business

This is the fourth annual report of the Adult Safeguarding Board which covers the second year of operations as two unitary councils for Bedford Borough and Central Bedfordshire. It outlines the progress made during the year from April 2010 to March 2011 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 pursued to continue the improvement programme initiated in 2009/10 and other learning from practice and audits undertaken throughout the year. Robust strategic leadership and operational arrangements have been implemented providing a basis for more effective safeguarding but we recognise that achieving excellence in this area requires sustained improvement on the part of all partner agencies

During the past 12 months we embedded the revised policy and procedures and ensured that all partner agencies prioritised safeguarding and worked to closely monitor and audit practice and learn the lessons from safeguarding investigations. All agencies implemented remedial action plans to address shortcomings, maintained their 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.

Having focused closely on the safeguarding procedures, during the next 12 months it is our intention to focus on the areas of prevention of abuse and significant harm, empowerment and proportionality to ensure improved outcomes for all vulnerable adults involved in a safeguarding incident.

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

1. The Developing Context for Safeguarding

With the election of a new coalition government, the year 2010/11 saw the emergence of some new priorities for safeguarding which have resulted in the publication of a series of key documents shortly after the year end. The Safeguarding Board has monitored these developments closely and is well placed to hit the ground running in responding to this developing context.

ADASS Advice Notice April 2011

The Association of Directors of Adult Services (ADASS) published standards for safeguarding in 2005 which formed the basis of much of our procedures including the structure and the timetable for investigations. In April 2011, they produced an update to those standards including revisions to the use of terminology. In response to this, the Adult Safeguarding Board is gradually replacing the term 'vulnerable Adult' with a broader term 'adult at risk' - anyone with social care needs who is or maybe at risk of significant harm. This is to recognise that the term "vulnerable adult" can inappropriately suggest that the cause of abuse lies with the victim.

The guidance note also proposes replacement of the term "abuse" with "harm". However, the Adult Safeguarding Board has resolved to continue using the familiar term "abuse" because people know what this means. Where appropriate, we will use the terms harm, significant harm and avoidable harm using the context to ensure that it is the impact of harm that is important, not who did it or what the intent was.

ADASS recommends a clear link between safeguarding boards and the health and well being boards described in the NHS White Paper, 'liberating the NHS' July 2010. This proposes the options of operating boards across council boundaries and greater linkage with children's boards The advice stresses the importance of the commitment of active partners who are able to influence and direct their organisation and have in place policies and procedures for delivery.

1.1 The Law Commission's review of Adult Social Care

Following an extensive review and consultation, the government has announced that it will introduce legislation in 2012. This legislation will establish that the overarching purpose of Adult Social Care is to promote or contribute to the well-being of the individual.

The statute will reinforce outcome focused interventions and will set out duties and powers of local authorities to safeguard adults from abuse and neglect and emphasise the importance of local partnership working to achieve these principle outcomes. Local authorities will retain duties to investigate adult protection cases or cause an investigation to be made by other agencies. Lead responsibility will be retained by the local authority in maintaining safeguarding boards. Key functions of boards will be;

- To keep under review the procedures and practices of public bodies which relate to safeguarding
- To give information or advice or make proposals, to any public body on the exercise of functions which relate to safeguarding
- To improve the skills and knowledge of professionals who have responsibilities for safeguarding adults and to produce a report every two years on the exercise of the board's functions

The statute will establish a duty to promote co-operation with other relevant organisations in particular circumstances such as assessment, community care and adult protection investigations.

The statute will remove the existing power to remove a person from their home under section 47 of the National Assistance Act on the basis that it is incompatible with the human rights law.

1.3 Statement of Government Policy on Adult Safeguarding

This statement released in May 2011 sets out the Government's policy on safeguarding vulnerable adults. It includes a statement of principles for use by Local Authority Social Services and housing, health, the police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. It also describes, in broad terms, the outcomes for adult safeguarding, for both individuals and agencies and outlines the next steps. The policy statement defines a set of principles to benchmark existing adult safeguarding arrangements to see how far they support the government's aim and to measure future improvements:

- **Empowerment** - Presumption of person led decisions and informed consent.
- **Protection** - Support and representation for those in greatest need.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

1.4 Vetting and Barring Scheme (VBS)

The Vetting and Barring Scheme has been subject to a full review to remodel the scheme to what it calls 'common-sense levels'. Following consultation, the Government will introduce primary legislation in early 2012; the key changes will be;

- To maintain a barring function
- To abolish registration and monitoring requirements
- To redefine the requirements of 'regulated activities'
- To abolish 'controlled activities'

This means;

- The merging of the criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA)
- Those who work closest with children and vulnerable adults will be required to register
- Volunteers will not have to register with VBS and then be continuously monitored by the ISA
- Portability of criminal records checks between jobs to cut down on needless bureaucracy
- New penalties for those who knowingly request criminal records checks on individuals who are not entitled to them.

However, the regulations introduced in October 2009 still apply.

- 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

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

2.1 An Overview of Safeguarding Improvement Work in 2010/11

2.1.1 The year 2010/11 has again been very challenging and very exciting for the further development of safeguarding in Bedford Borough and Central Bedfordshire.

2.1.2 The safeguarding board have worked together to strengthen the partnership arrangements for safeguarding by undertaking organisational audits and overseeing organisational improvement plans.

2.1.3 The Safeguarding Board's Operational Group and three sub-groups have continued to embed the necessary improvements to address the findings of the audits, case reviews and lessons learnt from investigations undertaken.

2.1.4 The safeguarding board approved and launched the revised safeguarding policies and procedures at the safeguarding conference in October 2010.

2.1.5 Further audits of case files identified the need to improve the quality of safeguarding investigations through more robust managerial oversight of safeguarding activity.

2.1.6 Both Councils have completed their first serious case reviews.

2.2 Strategic Leadership

2.2.1 We have strengthened leadership in the partnership by overseeing, challenging and holding to account for the progress of individual improvement plans. As a result:

- All partners have launched the revised procedures within their organisations and created internal governance arrangements to ensure compliance.
- Each statutory partner has revised their commissioning and contractual arrangements to include safeguarding as a key deliverable.
- We have organised and delivered safeguarding and Mental Capacity Act awareness among clinical staff
- We have delivered promotional awareness to GP representatives, increasing the numbers of alerts from GP practices.
- Each partner has improved the quality of their progress report to the board detailing developments, quality and outcomes related to their specific service/organisation improvement plans
- Service user groups have nominated representatives to join the Safeguarding Board's working groups and are supported through independent advocacy. The review of representation has determined that 'their input is more meaningful at the operational and sub group level' as these groups are where operational decisions are made.

Good Practice Examples

A GP reported that an elderly patient with early onset dementia was refusing to go into hospital to receive treatment for a severe chest infection. The GP and social workers visited and determined that the patient lived alone and was worried that there was no one to care for his dog. Staff supported him to find an animal shelter that would care for the dog whilst he received treatment. The patient then agreed to go into hospital to receive his treatment. On discharge from hospital, the dog was returned home and home care was commenced and staff visited him four times a day to ensure that he received a meal, personal care and his medication. His health is improving and his independence returning.

2.3.1 Partners are engaged in the following ways;

- The Operational Group continues to oversee and govern the Board's improvement plan through reports from partners and the sub groups.
- All statutory partner agencies have retained their safeguarding leads to champion and develop awareness and practice in their organisation and contribute to the board's improvement plan through the task and finish sub groups.
- More partner agencies have engaged in the safeguarding agenda, such as the Fire and Rescue service, probation service, prison service, LINks, East of England Ambulance Service and are supporting each other to develop practice that focuses on prevention and quality and outcomes in services.
- All partners contributed to the Safeguarding and Dignity in Care conference last October and to the Dignity in Care Action day on the 24th February 2011.This has helped improve the knowledge and understanding of standards of care expected across the areas and demonstrates our unified commitment that safeguarding is everyone's responsibility and dignity in care is a basic right.

2.3.2 Dignity and Safeguarding conference

The Dignity and Safeguarding conference was arranged over two sessions. The morning was aimed at awareness raising of the Dignity in Care campaign and launching of the revised Multi Agency safeguarding adults policy and procedures. The afternoon session focused in more detail on current key issues in safeguarding for professionals who are involved in safeguarding in the day to day practice. Key talks were given by the Government's Dignity in Care ambassador, personalisation organisations, Police, NHS partners and advocacy organisations.

The day was well attended with 107 delegates for the morning and 188 in the afternoon. There was strong representation from local authorities, the private and voluntary sector and the NHS.

Delegates were invited to write down their pledge to encourage people to take away the key messages from the conference. 46 people pledged to sign up to the National campaign to become dignity champions. An example comment included; 'I will be a dignity champion because compassion, kindness and respect are the essence of dignified care' 'Caring is a big element in maintaining dignity'. 'I will be honest and communicate'.

44 people pledged that they would be a safeguarding champion. An example comment included; 'I will support and safeguard vulnerable adults by being a good and responsible citizen and remaining aware, being observant and reporting abuse appropriately'. 'I will support people with the same respect that I would want for myself and my family'.

Evaluations of the sessions

234 feedback forms were completed from 295 delegates. The scores given for all speakers, the quality of the venue, and information provided indicated a generally high level of satisfaction with the day.

The people who attended both of the sessions told us that the conference enabled them to;

- Increase their awareness of the vulnerable adults policy and procedure
- Understand how Bedfordshire services are taking a serious approach
- Understand how different agencies and the police are involved
- Develop knowledge and skills to use in their work
- See how all the strands all link together to make safeguarding such a wide issue

Good Practice Examples

Patient on ward was found to be anxious. On further exploration, it was determined that they had bumped into another person in the lift with whom they had been a witness in a criminal case. The patient had experienced intimidation as a result of this case and was frightened. The patient was moved to another ward, Hospital security and porters were ordered to do regular security checks, security escorted the patient on leaving the ward. The patient felt happy that they were believed and listened to and that their dignity had been upheld and they felt safe whilst receiving their treatment.

2.3 Operational Leadership

2.4.1 All agencies represented on the Safeguarding Board undertook an audit of their safeguarding arrangements building on the principles of the audit tool used for safeguarding children under Section 11 of the Children Act. This was used for agencies to develop their individual action plans and report against to the safeguarding Board on a quarterly basis. This audit was reported to the November 2010 Safeguarding Board and will continue to be undertaken annually.

The audit focused on the following to ensure a robust response to safeguarding concerns and improved outcomes:

- Senior management commitment to the importance of safeguarding and promoting vulnerable adults' welfare
- A clear statement of the agency's responsibility towards adults is available to all staff
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of adults
- Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of service users and their families.
- Staff training on safeguarding and promoting the welfare of adults for all staff working with or depending on the agency's primary functions, in contact with service users and their families
- Recruitment, vetting procedures and allegations against staff
- Inter-agency working
- Information Sharing

2.4.2 The audit demonstrated that:

- While information sharing is embedded into practice locally, the council and partners would benefit from a clear information sharing protocol which provides further detail to the current multi agency policies and procedures. This has since been developed with the children's safeguarding boards and will be incorporated into an amendment to the policies and procedures.
- While multi agency working is effective, all agencies reporting to the Safeguarding Board could work to improve barriers such as attendance at meetings, and clarity for staff over the role and responsibility of different agencies. This is being addressed by ongoing work through the Safeguarding Board, and improvements to the arrangements of the sub groups of the Board.
- There is a need to improve the involvement of individuals and families in planning the development of services.

2.5 Policies And Procedures

2.5.1 The new procedures were formally launched at the safeguarding conference in October 2010.

2.5.2 All partners have reviewed their safeguarding procedures based upon the multi agency policy and launched them within their own organisations.

2.5.3 Based upon lessons learnt and national good practice the safeguarding board have published further practice guidance on;

- Forced marriage
- Safer skin
- Falls management
- Discrimination and harassment
- End of life care
- Safeguarding competencies

2.6 Promotion Of Safety and Dignity

2.6.1 The partnership have worked together to produce a preventing harm to self and others booklet. This booklet is aimed at vulnerable adults and their carers in raising their awareness and knowledge about how to protect themselves and how they can prevent being harmed.

2.6.2 The past year's awareness campaign has focussed on the Dignity in Care challenges. National research clearly identifies that services providing excellent standards of care are putting service users views and wishes at the centre of all decisions about how and when their care is delivered and are less likely to infringe their dignity and rights to be free from harm and abuse.

2.6.3 The partnership have worked together to embed these principles into all aspects of the service being delivered and enhancing the prevention of infringement of human rights and abuse. The practice and performance sub group included the National dignity in care principles into an agreed charter for our area. Bedford Borough and Central Bedfordshire launched its 15 point Dignity charter;

2.6.4 February 25th was National Dignity in Care day. Each agency in the partnership facilitated a number of activities to further raise awareness of dignity. Some examples of the activities undertaken by partners on the day include service users' forums, coffee mornings, luncheon clubs, old time music hall singalong, staff meetings, poster and billboards in foyer.

Some of the comments made by partners about their activities:

We produced a card describing what dignity 'looks' like. This was given to staff, residents and relatives.

We held an event for residents/relatives etc to nominate a member of staff (doesn't have to be a carer) that they feel promotes the dignity of residents by the way they work and interact with the residents.

We launched a 'Dignity Tree' which we will leave in place for the remainder of the year. The idea of the tree is to enable our service users to express what dignity means to them and to encourage them to comment on any aspects of the service where they feel that they have / have not been treated fairly or with dignity and respect.

Bedford Borough and Central Bedfordshire

Dignity Charter

All organisations and staff working with vulnerable adults in Bedfordshire have a commitment to:

1. Having a zero tolerance of abuse
2. Raising public awareness and championing dignity and safeguarding
3. Challenging poor or substandard practice in health and care settings
4. Treating people as individuals and with the same respect we would expect for ourselves
5. Taking the time to explain what is happening and what we are doing
6. Involving people and their representatives in planning for all aspects of their care and support
7. Enabling the maximum possible level of independence, choice and control
8. Acting to alleviate loneliness and isolation by listening
9. Respecting privacy and confidentiality
10. Responding promptly to access and communication needs
11. Providing relevant and easy to understand information making sure we do not use jargon
12. Responding efficiently to all queries in a manner that is open, honest, and courteous
13. Supporting and encouraging complaints from people who use our services and other staff
14. Apologising if we have made a mistake and offering a resolution
15. Giving the opportunity to receive feedback on how we provide our services and the ways we communicate

2.7 Quality Assurance, Monitoring and Audit

2.7.1 Audit work continues to have been carried out extensively through the year:

2.7.2 Each council has established regular programmes of auditing of safeguarding activity.

2.7.3 The main areas for improvement that have been identified across both councils have been increased evidence of management oversight, better service user involvement, safeguarding actions required need be given clear timescales.

2.7.4 Each Council has established standards and timescales for safeguarding activity to assist staff in understanding what the standards expected are and have prepared case exemplars of what excellent investigations look like.

Good Practice Example
"This is a good comprehensive piece of work, which demonstrates how progress was made through the investigation and that both the Alleged Victim and Alleged vulnerable Perpetrator's welfare and views were considered throughout. This case had good management oversight and all actions had clear timescales and identified people responsible for delivering the actions."

Bedford Borough, Independent audit of a safeguarding investigation - January 2011.

"Service users who were interviewed were very positive about the process; workers had been readily accessible, approachable and supportive; they felt fully involved in the safeguarding process which had been clearly explained and their views respected."

Central Bedfordshire independent audit of safeguarding investigation conducted May 2011 from files October-March 2010-2011

2.7.5 Each Council has fully implemented quality assurance mechanisms with their contracted services. There are monthly multi agency forums to share information about services that are performing well and those that are not performing so well, based upon the feedback from the regulators (CQC), service users and families and other professionals. Each meeting has a set of clear recorded actions about how and by whom the necessary identified improvements are made and will be monitored.

2.7.6 In both councils the quality forums have implemented the serious concerns procedures with two organisations in the last year. Actions were swiftly taken with the owners and managers and were supported to implement the required actions and each met the requirements within a reasonable amount of time.

Good Practice Example
During a review of care, a lady living in a residential home was noted to have had continued weight loss.
The review identified;

- **Failure to seek clinical advice**
- **Failure to review records and pick up patterns of weight loss**
- **Failure to maintain and repair weighing machine**

The GP was called in to review and asked community nurses to monitor prescribed treatment and the lady returned to good health. The care standards team worker with the manager and CQC worked together to make necessary improvements to health monitoring systems to ensure this does not happen to anyone else within the service.

2.8 Training and Publicity

2.9.1 The Safeguarding Board launched the safeguarding core competency framework in August last year, to ensure that staff are competent at understanding what abuse is and how preventing abuse and how to raise a concern that abuse might be happening. 228 individuals from partnering agencies attended the four workshops to launch the competencies. Training in both councils has been reviewed to ensure courses are aligned with the competency framework.

2.9.2 The training sub group has 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
- Positive Risk management

2.9 Use of the Serious Concerns Procedure

2.9.1 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.

2.9.2 The serious concerns procedure has been implemented with 2 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 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 occupational therapists and reviews of medication regimes by the community pharmacist.

2.9.3 The serious concerns cases identified a number of key areas of concern. These were:

- Poor care risk management planning, particularly in relation to falls and aggressive behaviours
- Inadequate record keeping
- Delays in seeking appropriate medical assessment and treatment
- Poor nutrition and hydration
- Lack of stimulating/person centred activity
- Poor management of skin integrity
- Poor maintenance of equipment
- Poor understanding and implementation of the Mental Capacity Act.
- Inadequate financial and material safeguards for vulnerable people

2.9.4 As a result of many of these findings, the safeguarding conference focussed awareness on a number of these subjects and have been a key area for monitoring within individual care reviews and contracts and compliance visits. Other actions taken in response to this have been;

- Disseminating good practice exemplars and guidance in providers forums and care standards assessment visits
- Disseminated 'how to spot and stop malnutrition' guidance across all care settings.
- Re-enforced standards of care to all care settings on Dignity Action Day in February.

2.10 Serious Case Reviews

2.10.1 Bedford Borough Council commissioned a serious case review during the year:

Mrs A is a 65 year old lady living alone in her own home who had been receiving support services for 40 years. The serious case review was prompted by her admission into hospital in late 2009 with near fatal symptoms in spite of the involvement of 10 support agencies. Mrs A was consistently described as having the capacity to make her own choices and decisions. but was known to make 'unwise' choices that ultimately adversely impacted upon her health. A fire in 2007 resulted in her gas supply being cut off and the loss of heating and hot water facilities. This resulted in her overall decline in health and motivation.

The serious case review panel identified issues with:

- The absence of co-ordination of care activities between agencies and failure of services to identify who the lead agency responsible for care co-ordination was.
- Lack of communication and information sharing between services, Mrs A and family members.
- Lack of adherence to the Mental Capacity Act and lack of identified root causes for Mrs A's apparent 'unwise' decisions.
- Concerns about 'unwise' decisions not being escalated, so management arrangements and oversight failed to materialise.
- Inadequate follow up of referrals to other agencies.

Mrs A's physical health recovered and she returned to live at home with a multi agency protection and risk management plan co-ordinated by the Mental Health Trust. Her home was fully renovated and a new boiler, cooker, furniture and security system installed.

2.10.2 During 2009 Central Bedfordshire Council commissioned two serious case reviews arising from incidents that took place in 2008/9. These were reported on during this year:

Mr B died on 24 February 2009 following re-admission to hospital from a home where the Coroner described the nursing care as "woefully inadequate". The Coroner determined that MR B 'whilst incapacitated by rapidly deteriorating physical and mental health, died on this date for want of care by those charged with it." The cause of death was (a) sepsis (b) infected multiple pressure sores (c) dementia and (d) Parkinson's disease.

Mr C was an 87 year old man who suffered a CVA and was admitted to Luton and Dunstable Hospital on 29th June 2008. The cause of death recorded by the Coroner was sepsis, pressure sores, historical illness and stroke. Concerns were raised about the quality of care he had received at his care home before admission to hospital.

Learning from these reviews includes:

- The multi agency response to tissue viability concerns must be improved, ensuring concerns are addressed at all stages of an assessment of a person's needs, and that staff are appropriately trained and aware, including when to report as a safeguarding issue
- All health and social care assessments must be recorded promptly and communicated in a timely fashion with copies sent to all relevant parties, including carers where appropriate, and with the consent of the patient.
- The same standards for health care assessment, care management and support should be consistently applied to self funding service users as to those requiring an application to adult care services for funding approval. This includes the use of the Continuing Health Care (CHC) decision monitoring tool and timely application for CHC and Funded Nursing Care (FNC) where appropriate.
- All care home providers should be reminded of the importance of regular reviews and they should make information available to all residents and their carers about reviews and how to ask for one. This should be monitored through contract monitoring visits and regulatory activity.

3. Partnership Contributions to the Adult Safeguarding Agenda 2010/11

3.1 NHS Bedfordshire

NHS Bedfordshire has ensured safeguarding of vulnerable adults is a high priority within the organisation and has developed new and comprehensive processes to ensure strategic developments support multiagency work and good safeguarding practice.

3.1.1 Achievements for 2010/11

Integrated Clinical Governance and Safeguarding Committee:

- this group was established in June 2010 to ensure NHS Bedfordshire children and adult safeguarding requirements, including policy, processes and best practice are met
- ensures that all health investigations are kept within timescales; identify any emerging patterns or trends, lessons learnt and areas of concern that require addressing
- monitors recommendations/actions from Serious Case Review

Safeguarding Responsibilities:

- Executive nurse attends the local safeguarding board, operational leads attend sub groups
- two members of the Quality Team have been given safeguarding operational responsibilities
- HR working to ensure that all job descriptions have a standard safeguarding adult's statement.

Provider Contracts:

- all main health have a safeguarding adult service specification in their contracts
- this includes quality and performance indicators monitored via the Quality Monitoring process

Safeguarding Training:

- 69% of NHSB staff have completed the awareness sessions, those that have not attended have been contacted individually and line managers made aware

NHS Bedfordshire has facilitated training by:

- a number of MCA and DOL sessions for GPs which have all been well attended
- a GP Saturday Symposium
- Practice Based Commissioner (PBC) practice meetings
- safeguarding packs for all GP practices which includes relevant safeguarding information, contact details, policy information and a list of useful links/references.

Self Assessment:

- completed the Safeguarding Board's self assessment tool in October 2010
- NHS Bedfordshire scored well in the audit however acknowledged there were some gaps in arrangements which have been actioned via the improvement plan
- monitored via the Integrated Clinical Governance and Safeguarding Committee

Safeguarding Referrals:

- all health referrals and alerts are reviewed via the integrated clinical governance and safeguarding committee
- process is monitored weekly by the SOVA operational leads
- Serious Incident (SI) panel review all grade 3 and 4 reported pressure ulcers this panel also considers any safeguarding issues that may be present

3.1.2 2011/12 Work Plan Priorities:

- continue working proactively with all local partners
- develop integrated adult and child safeguarding action plan and deliver
- review any training needs and ensure these are effective and met
- to further develop early warning systems for care/residential homes (NHS Funded patients)
- continue to share intelligence with local partners
- continue to ensure learning from serious case reviews is implemented across the health economy
- begin proactive work to promote dignity and respect; prevent safeguarding incidents
- continue attendance and participation at local authority quality assurance groups

3.2 South Essex University Partnership NHS Trust (SEPT)

The Trust continues to prioritise and develop the safeguarding adult agenda within strategic plans, clinical practice and service user forums and is represented at the Board and its sub groups.

3.2.1 Trust Safeguarding Group

The Trust Safeguarding Group is chaired by the Executive Director of Clinical Governance and Quality. Membership has increased this year to include Associate Directors, Doctors and senior staff representing all Trust clinical services. The group have increased the frequency of meetings to monthly in order to address the growing requirements of the Safeguarding agenda;
All reports, policies and protocols, are tabled at meetings before being presented to the Trust Executive Team or Board. An action plan containing national, local and Trust directives is reviewed at each meeting to ensure compliance. The Safeguarding Board minutes are a standard agenda item at each meeting. Safeguarding Key Performance Indicators are presented at this meeting and reported to the Trust Executive Team monthly to ensure compliance is maintained and any emerging trends addressed.

3.2.2 Safeguarding Strategic Framework 2010-2013

A Strategic Framework for the Safeguarding service has been developed and aims to establish the vision for the Trust Safeguarding service for the period 2010-2013. The strategic framework builds on existing achievements and demonstrates the Trusts continued commitment toward ensuring clients are safeguarded, families are supported and staff are skilled in recognising and responding to Safeguarding issues. The Framework includes a number of key priorities including ♦ Structure & Reporting Arrangements ♦ Clinical Governance ♦ Partnership Working ♦ Serious Case Reviews ♦ Strengthening Learning ♦ Equality & Diversity ♦ Human Resources

3.2.3 Policy & Procedures

The Trust Safeguarding polices were ratified by the Trust Board in September 2010. Policies reflect the Safeguarding Board Policies in addition to national guidance. They contain a number of new requirements that comply with National Patient Safety (NPSA), National Institute for Clinical Excellence (NICE) and reporting pathways with the Care Quality Commission (CQC).

3.2.4 Partnership Working

Trust Directors and Associate Directors represent the Trust at the Bedford Borough and Bedfordshire Board. The Trust is able to offer expertise to Boards on Mental Health, Drug & Alcohol and Learning Disability issues. The Trust also works closely with NHS Trusts, Police and other agencies to ensure effective and consistent communication pathways.

3.2.5 Training

A training strategy has been completed outlining training levels for each group of staff and focuses on maintaining and promoting health, safety and security of all those who come into contact with Trust services. All Trust staff regardless of clinical contact must receive Safeguarding Adult training. The Trust has an E-learning and face to face training programme. The E-Learning Programme has been updated to comply with Bedfordshire Safeguarding processes.
Training Levels have increased consistently over the past year and were at 96% compliance in March 2011. Training reports are sent to all trust managers on a monthly basis and training compliance is a standard agenda item at the Safeguarding group.
In addition to basic awareness specialised sessions are delivered e.g. financial abuse, Mental Capacity, Deprivation of Liberty, Investigations training etc. Staff regularly attend Local Authority training programmes and benefit from the multi-agency approach this offers.

3.2.6 Safeguarding Leads

There are approximately 103 Safeguarding Leads within the Trust. The Leads are an active group who champion the safeguarding agenda within their respective teams by cascading information and advising colleagues. The Leads meetings contain a Lessons Learned element where staff bring case studies for discussion and sharing.

3.2.7 Trust Intranet – Safeguarding Site

The Safeguarding site on the Trust Intranet now contains all processes, policies and referral forms regarding Safeguarding across the Trust. A section on Lessons learnt is produced following the completion of a serious case review. Staff now routinely access the site for referral forms etc.

3.2.8 Audit

The Trust took part in a number of audits of case files involving safeguarding this year. The findings identified that there was a need to develop more robust monitoring system of cases. As a result the Trust has implemented a number of initiatives including, Timescales Framework, Managers Sign Off Assurance Form, Lessons Learnt and Quality measures system. Since implementation the adherence to timescales and quality of work undertaken has improved. The audit programme will continue for 2011.

3.2.9 Good practice examples

- Job Descriptions - A statement on staff responsibility to Safeguard people is contained within ALL job descriptions and emphasises the importance of adhering to policy and receive training
- Named Doctor - A Psychiatrist has been appointed as Named Doctor for Safeguarding Adults and will cover the Luton & Bedfordshire areas. The Named Doctor will work closely with the Safeguarding Team to embed the Safeguarding agenda within the Trust medical staff and be a resource for staff and partner agencies.
- Safeguarding & Personalisation Group - This group has been developed this year to ensure effective links and joint working with Social Care and Nursing staff regarding personalisation.
- Lessons Learnt - This newly formed group incorporates lessons learnt from Safeguarding, incidents and complaints and explores ways in which to embed these lessons into practice
- Safeguarding Forum - The Safeguarding Team hold regular forums for staff to discuss safeguarding issues, share experience and offer support and advice on safeguarding matters.

3.2.10 Service User Feedback Audit

A Service User feedback form is issued to all clients subject to a Safeguarding Investigation where appropriate. 12 feedback forms have been received to date and an audit has taken place. This shows positive results with the majority of clients stating that they felt included and informed regarding the investigation and treated with respect. One recent form stated ‘I feel much safer now’.

3.3 Bedfordshire Police

- A Safeguarding Adult action/improvement plan has been developed in line with the Public Protection Business plan reflecting our strategic intent. The headline areas of focus include Strategic Issues, Prevention, Audit Control and Performance, First Response, Victim Care, Investigation, CPS Liaison, Forensic Issues, NIM issues (National Intelligence Model), Multi Agency Engagement. This is a dynamic document which responds to emerging issues.
- Training and Development - Training provision across the force is being evaluated in line with the re-structure of Bedfordshire Police and the changes to be implemented. Public Protection and Safeguarding has been identified as a priority. There will be a requirement to work closely with partner agencies to ensure consistency of approach.

3.3.1 Improvements Made In Adult Safeguarding During 2010/2011

- Improvements with Information Technology - Referrals for vulnerable adults are now managed on a database called Case Allocation and Tracking System (CATS). This system provides a comprehensive chronology of any incidents/issues/crimes that are brought to the attention of Bedfordshire Police.
- Increased Investigative and Financial capacity - Constables working within the VAIU have now all embarked on the Initial Crime Investigators Development Programme (ICIDP) and other officers are also accredited in the National Financial Investigation Officers programme.
- Communication Strategy - the PPU is developing a communication strategy that encompasses both internal and external mediums. There is ongoing work to develop an internet/intranet ‘one

- Sexual Assault Referral Centre (SARC) - Bedfordshire Police and partner agencies including the NHS and Community Safety Partnerships have opened a SARC in the Enhanced Services Unit, North Wing, Bedford Hospital. This facility provides a 'one stop' shop for victims of serious and has been named 'The Emerald Centre'.
- Independent Sexual Violence Advocates (ISVA) - Bedfordshire Police have employed two ISVA's on behalf of the SARC Executive Group to support the opening of the Emerald Centre. They are co located within the SARC and Police premises at Saxon Centre, Bedford. Their role is to support victims of serious sexual assaults and provide them with the appropriate pathways to other services.

3.3.2 Improvements Planned In Adult Safeguarding During 2011/2012

- Project 2011 is an initiative Bedfordshire Police undertook to review all the structures, processes and policies within the force to identify cost savings whilst maintaining and improving service delivery. This project identified resilience and experience issues within the existing VAIU and recommended the team be subsumed into a Force Safeguarding Team. Staff in the central referral unit will be increased by 100 per cent and will provide a 'single point of contact' for partner agencies to provide timely, efficient and effective responses to referrals. Implementation is planned for October 2011
- Change of Location - The existing VAIU as part of the restructure will be moving their operating base as part of the Force restore. The Force safeguarding teams will have operational offices at Luton and Bedford.
- Standard Operating Procedures - The Policy and Procedures for Safeguarding Adults will be refreshed/reviewed in line with other areas of Public Protection and in conjunction with the Force restructure. Consultation with partners will be essential to ensure consistency and understanding of approach.

3.4 Bedford Hospital NHS Trust

The safeguarding of vulnerable adults is taken seriously by the Trust as the national emphasis is growing in line with that of safeguarding children and young people. The Trust has developed a comprehensive response to these strategic developments by developing a robust plan which includes:

- Identifying an Executive Director responsible for leading Safeguarding across the Trust
- Establishing a Trust wide Safeguarding Board (Adults and Children)
- Establishing a Safeguarding Vulnerable Adults Operational Group (to mirror the Safeguarding Children's Operational Group) which has been established to take forward the operational activity to achieve the strategic direction as set via the national agenda and local quality improvements.

Review of 2010/11.

- Training has been extended and implemented to include an E-learning module.
- Second on call rota implemented to include an Executive lead for safeguarding advice over 24 hours and 365 days.
- Working relationships with all multi-agency groups continues to improve.
- Reporting has increased since further training implemented.
- Won best poster / safety initiative at Patient Safety Congress in May 2011 for the Skin Bundle to reduce the risk of pressure ulcers.
- Development of Learning Disability and Dementia Fora.
- Enhanced senior management training has been delivered for out of hours procedures for all senior managers on call (SMOCs).
- Training has been commenced for volunteers and non clinical staff.
- Weekly pressure sore review group has been commenced working closely with the PCT and the wider health economy.

- The Trust has identified a CQUIN (Commissioning for Quality and Innovation initiative) in relation to ongoing work with patients with dementia – looking at improving care and treatment pathways.
- Adult Safeguarding Operational Group commenced – reporting to Trust wide overarching Safeguarding Board.
- 2 "champion" wards for Learning Disabilities / Dementia have been identified – building 24 hour expertise and availability of advice.
- Achievement of all MENCAP pledges for acute care.

Work Plan for 2011/12 will include the following priorities:

- Continue to work proactively with all local partners.
- Undertake a caseload audit with external assessor to identify system wide learning.
- Strengthen the team to recognise and address the Safeguarding Adult agenda.
- Implement the Organisational Development (OD) strategy in order to develop an organisational culture which supports high quality care.
- Review and update the Safeguarding Adult Policy and clinical guidelines.
- Agree an integrated training strategy for safeguarding.
- Update and implement the training packages in line with DH guidance (No Secrets 2010), "Clinical Governance and Adult Safeguarding – an Integrated Process", (2010) and other resources.
- Link in with Mental Capacity Act (MCA) and Deprivation of Liberty (DOLS) training.
- Develop a process to identify vulnerable adults on the alert sheet in the medical record and on the electronic patient information systems similar to that established in children.
- Explore the development of Adult Safeguarding supervision arrangements for lead professionals.
- Enhance working arrangements with the Safeguarding Children team to develop expertise.
- To keep accurate training records and maintain a rolling training plan.

3.5 Luton and Dunstable Hospital NHS Foundation Trust

- 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.
- The Trust has continued work to protect individuals from harm. For example monthly incidence of hospital acquired pressure ulcers has shown a reduction particularly in the last six months of 2010/11. 0.52% of in-patients acquired a pressure sore while in hospital 2010/11. This was 0.69% in 2009-10.
- The Trust has worked over the last year to raise staff awareness of safeguarding adults. During the year the number of safeguarding alerts raised by L&D staff has increased with 4 times more alerts being raised in March 2011 compared to April 2010. 55% of those alerts related to pressure ulcers in all settings but there is evidence of reporting across the range of types of abuse and alleged perpetrator.
- Patient Affairs and Risk Management staff are trained to recognise possible safeguarding concerns within formal complaints or incident reports
- Staff at the Trust have undertaken joint work with the safeguarding team in Central Bedfordshire in relation to the safeguarding pathway
- A number of methods, including daily rounds on wards and patient surveys are used to seek feedback from patients and families about their view of care delivery in hospital

  During a CQC inspection in February 2011 staff knowledge about the nature of vulnerable adults and the signs of abuse was found to be variable. Examples were also seen where discharge planning for patients needed to improve to ensure safe discharge and full patient and family involvement. Additionally the CQC were not aware of all safeguarding alerts raised to Luton Borough Council by Luton and Dunstable Hospital.

In response to CQC concerns the Trust has taken a number of actions. For example we have;

- improved notification of safeguarding alerts to the CQC as required (Through the National Reporting and Learning System at the National Patient Safety Agency)
- implemented an awareness raising campaign across the Trust
- reinforced to staff the reasoning behind our process of raising all alerts to Luton Borough Council in the first instance as the local authority in which the hospital is located
- set out and started to deliver (March 2011) a programme of additional training for all staff who work with patients
- reviewed policies and guidelines for safeguarding, mental capacity assessment and deprivation of liberty and for patient discharge from hospital and planned revisions where needed
- worked with partner organisations to clarify referral and discharge pathways for rehabilitation beds in the community
- worked with Local Adult Safeguarding Boards to clarify pathways and procedures and to participate in reviews of safeguarding arrangements

A Task and Finish Group has been set up to ensure that improvements are made. The Task and Finish Group made up of the Independent Chair of the Adult Safeguarding Board for Luton and the Director of Adult Services for Bedford Borough Council together with another senior health manager.

The Task and Finish group is accountable to the Adult Safeguarding Boards and to elected members of the three councils through the appropriate scrutiny committees.

3.6 Bedfordshire Community Health Services

3.6.1 Key Issues Arising During 2010/11

- Intra Agency policy / protocols reviewed to ensure compliance with best practice and Care Quality Commission standards for excellence. Formal acknowledgement that BCHS adopts Bedfordshire safeguarding over arching policy.
- BCHS has an integrated approach to safeguarding incorporating incident reporting and compliments and complaints. The main area of focus has been robust reporting of pressure sores through serious incident reporting mechanisms. This requires root cause analysis investigation which, can be used to influence current practice re skin care, identification of safeguarding concerns and support any safeguarding investigation. This is demonstrated by current work streams and activities with respect to pressure sore reporting. Countywide Pressure Area Care Group with a focus on prevention of avoidable pressure sores.
- Implemented a robust system to collect data with respect to safeguarding activity and identification of significant themes, to inform current and future practice to ensure a proactive / preventative approach to the protection and well being of vulnerable adults.
- Reviewed arrangements with respect to feedback from within agency and from Social Care (Central Bedfordshire Council & Bedford Borough Council) following a safeguarding alert being raised including any action requested as part of ongoing SOVA investigation or action require by individual agencies
- Staff awareness and competence of their roles and responsibilities with respect to the safeguarding of vulnerable adults: Safeguarding Adult Training:
    - 97% of staff completed awareness level
    - 76% of clinical staff completed practice level
    - 22% of staff completed mental capacity act training.
- Can demonstrate effective partnership working at both strategic and operational levels.
- Participation in Serious Case Reviews and implementation of action plans to ensure lessons have been learnt.

3.6.2 Improvements Made In Adult Safeguarding During 2010/11

- Bedfordshire Community Health Service (BCHS) has robust governance systems in place, with clear accountable leadership. This ensures that safeguarding remains high on the organisation's agenda, and is embedded into every day practice at all levels.

- Participation in safeguarding agenda, appropriate and active membership at safeguarding Board and sub groups alongside increasing activities in safeguarding processes at operational level, including progress to improve communication between both Central Bedfordshire and Bedford Borough Councils.
- Focus on the needs of adults with disabilities (implementation of the “Six Lives” action plan). Front line staff manager consultations to allow extra time for communication and currently developing carers policy.

3.6.3 Improvements Planned In Adult Safeguarding during 2011/12

- Ability to respond to participation in Serious Case Reviews and Individual Management Reviews, including competence of professionals, challenge to own agency and partnership agency, to ensure that standards of these reviews and implementation of the lessons learnt influence future practice with evidence of improved outcomes for vulnerable adults. In partnership with other agencies ensure that these reviews are monitored on content and completed within the required time frame.
- Increase competence of workforce with respect to safeguarding competencies and mental capacity assessments, via training, supervision and annual appraisal.
- Continue to monitor staff competence and compliance with agreements via audit, to include training attendance / evaluation and participation in multi agency safeguarding processes.
- Firm up arrangements re secure electronic information sharing with outside agencies.

3.7 East of England Ambulance Trust

EEAST have had a significant focus on strengthening arrangements for safeguarding adults, especially in relation to Mental Capacity Assessment which has emerged as a theme from recent Serious Case Reviews. With the development of a Safeguarding Hub office at the Trust Head Quarters in Cambourne Cambridgeshire, the Trust looks to further increase Trust awareness to safeguarding issues and maintain all legal and statutory requirements.
Review of 2010/11

- Establishment of monthly Safeguarding meeting and review of region wide action plans and Serious Case Review learning
- Board Safeguarding Champion appointed
- Board Training undertaken
- Review of safeguarding policies undertaken and approved by the Trust Board
- Development of Capacity to Consent Policy and clinical guidance for staff on the MCA and capacity assessments approved by the Trust board.
- Review of CPD training for staff including “return to basics” for safeguarding, safeguarding and vulnerability and MCA/capacity assessments to run from April 2011.
- Training strategy for safeguarding developed which includes specific audit of safeguarding training (focus on quality)
- Regional referral process reviewed and strengthened with support from the Safeguarding Board
- Development of Assistant General Managers, to equip them with necessary skills and expertise for local lead on safeguarding role including attendance at safeguarding boards (supported by named professionals)
- Dignity champions appointed
- Comprehensive safeguarding audit of Patient care Records completed

3.8 H M Prison Service

Significant progress has been made in 2010 to 2011 for HMP Bedford. The prison now has developed robust links with various organisations to develop Safeguarding in the prison and to ensure that Vulnerable people are protected. A member of the prison Senior Management Team attends the Safeguarding Board, has attended various training opportunities and trained as a facilitator to improve the knowledge of staff and prisoners knowledge of Safeguarding.

3.9 Bedfordshire and Luton Fire and Rescue Service

Following the Miss S case study and the support of Service Delivery Management Team amendments were made to the Fire and Rescue Service 'Safeguarding' Service Order as part of the consultation process. The new 'Safeguarding' Service order has now been produced, reviewed and input received by SOVA and LSCB before being released. This also took advantage of the 'Multi Agency Adult Safeguarding Policy, Practice and Procedures' document Version 1.0

An electronic 'SAFEGUARDING' page is set up on the Service intranet page. This is segregated into Child Protection, and Vulnerable Adults and is designed to provide all staff with a quick place to view current activities and progress. This page holds key documents (Service Orders, minutes from safeguarding meetings, links to relevant legislation and guidance documents) and will also hold a live version of the full audit once complete, identifying where and what tasks have been allocated to which individual.

The completion of the Section 11 Audit review has moved the Fire and Rescue Service into 'Effective' in all areas of working with children and young people. The evidence supplied as part of the process was substantial enough to be used as the supporting evidence for the safer recruitment audit. Much of this work including the evidence to support the data sharing protocols, data handling processes and secure data retention are all relevant to both SOVA and LSCB.

Although full safeguarding training is delivered face to face by Community Safety staff, which utilises e-learning programs to assess understanding of 5 modules, it is currently centred on Child Protection. It is envisaged that this training will be developed to cover ALL elements of safeguarding (incorporating children, young people and vulnerable adults). The ongoing support of the Safeguarding Vulnerable Adults teams will be required to achieve this. This will become a priority piece of work for the community safety managers in 2011-12 and has been written into relevant business plans

The completion of the safeguarding electronic audit has been written into the business plan for the community safety managers for the fiscal year 2011-12. Once completed the audit will be uploaded for review throughout the year and tasks for improvement work will be openly allocated via the intranet page.

To improve the understanding of BLFRS 'Safeguarding' policy and associated procedures the 'Working with children, young people and vulnerable groups' pocket book is to be reviewed and amended where necessary to better reflect advised best practices when dealing with potential abuse / maltreatment and / or neglect.

3.10 Bedfordshire Probation Trust

In 2010, Bedfordshire Probation Trust completed the Adult Safeguarding Audit tool. This has helped the organisation to identify strengths and areas for improvement

Improvement actions arising from the audit have been agreed and have been incorporated into Local Delivery Unit business plans for 2011-12

The Safeguarding Adult procedures have been put onto the Bedfordshire Probation Trust Intranet and key policies, for example, the Risk of Harm policy, are being updated to cross-reference with the procedures

Awareness and use of the procedures will be further embedded by briefing events in 2011/12

Bedfordshire Probation Trust is the lead agency for the Integrated Offender Management Scheme, developed during 2010/11 and scheduled for roll out in June 2011. The scheme involves a partnership approach to managing the risks and addressing the needs of offenders who cause the most harm to local communities. It will provide new opportunities to develop pathways for offenders who may also be vulnerable adults.

3.11 Voluntary and Community Action

Voluntary and Community Action is a Local Infrastructure Organisation supporting local voluntary organisations, community groups and social enterprises on a wide range of issues, including charity governance, policy development, funding advice and procurement, volunteering, volunteer management, community engagement and partnership working.

Our 'Getting Ready for Funding' Workshops and our funding, procurement and social enterprise advice work all advise organisations of the need to have Safeguarding Vulnerable Adults Policies in place for grant funding and tender Pre-Qualifying Questionnaires where service providers work with vulnerable adults.

Our development advice work involves working with organisations to assist them in developing and putting in place suitable Safeguarding Vulnerable Adults Policies (or a single Safeguarding Policy where an organisation works with both children and vulnerable adults). During the year, Voluntary and Community Action provided information, advice and guidance to three voluntary and community organisations developing safeguarding policies.

We also deliver a one-day training workshop on Safeguarding Vulnerable Adults, which is run as part of our 'open programme' or as a bespoke workshop for organisations needing their own 'in-house' training. We ran one workshop on the 18 November 2010, attended by 11 participants from six organisations. We also updated the training materials to take account of the Board's multi agency Safeguarding Policy. At the end of the year under review we were in discussion with the Safeguarding Manager for Central Bedfordshire to see if the workshop could be endorsed or accredited by the Safeguarding Board and to identify funding for future delivery.

We make available in hard copy and through our website Information Sheets on CRB checks and our publication Better Care – designed to help smaller voluntary organisations and community groups to put in place effective arrangements for safeguarding vulnerable adults. Now that the Board's multi agency Safeguarding Policy has been published we need to review and update this resource pack; unfortunately, insufficient funding and capacity is currently preventing this from being done.

Through our partnership work, we have raised safeguarding issues in relevant fora and partnerships. Staff from Voluntary and Community Action attended the Board's Safeguarding Conference on the 11 October 2010.

During the year we completed and submitted the Adult Safeguarding Audit Tool. This highlighted the need for us to review and update our own Safeguarding Policy against the Board's multi agency Safeguarding Policy and Procedures, and the Adult Safeguarding Audit Tool. Work on this has started and is ongoing.

We believe there is still much to be done to highlight the need for adequate Safeguarding Vulnerable Adults policies and training and to improve practice within voluntary organisations and community groups, in particular the smaller groups that are run by/use volunteers and/or a part-time members of staff; insufficient funding and capacity is currently preventing this from being done.

3.12 Community and Voluntary Service

Community and Voluntary Service (CVS) is a local support and development organisation that provides advice and guidance to local voluntary and community organisations on a wide range of issues, including fundraising, charity governance, procurement, quality standards, volunteer management, and safeguarding with regard to both children and adults.

Safeguarding is raised with the organisations that we work with on a number of levels:

- Our 'Fit For Funding' workshops, aimed at primarily new organisations – include identifying which groups are affected and provide initial guidance, model policies and signposting to routes to obtaining CRB checks where required. We particularly stress the requirements of funders for groups working with vulnerable adults and/or children. Our 'Tendering for Success' course also points out that safeguarding is a requirement of Pre-Qualifying Questionnaires.

- Our 1-to-1 advice work picks up safeguarding issues with relevant organisations, particularly around having the relevant policies.
- Our quality standards work includes safeguarding, as groups working towards a quality standard are required to review and improve their safeguarding practice as part of the programme. This often includes incorporating safeguarding for children and vulnerable adults into one policy.
- We also provide model policies for organisations to adapt to their own particular needs. These are freely available through our website.
- We also signpost those who make enquiries for adult safeguarding training to the Bedford Training Consortium courses and have alerted member organisations to these opportunities.

Over the past 12 months, in response to need, we developed training specifically for very small voluntary and community organisations (those with no staff, or sessional staff), where the safeguarding issues for both children and adults are covered. This training is aiming to improve practice within small community organisations working with children, vulnerable adults and those working with the general public. Three pilot sessions were received very well and we are working to roll out a programme of courses for 2011-12.

3.13 Advocacy for Older People (AOP)

During the past 12 months Advocacy for Older People (AOP) has made great strides in improving organisational measures to ensure that safeguarding remains a service priority.

AOP secured independent funding for a dedicated SOVA post. The latter specialist resource has enabled a multitude of key tasks to be progressed over and above existing safeguarding commitments.

Throughout the year AOP has continued to be an active partner and developed and strengthened in the following areas in respect of safeguarding:-

- SOVA action plan now in place.
- Specially trained advocates now dealing with three distinct disciplines: Safeguarding SOVA, Mental Health, general referrals.
- Safeguarding awareness training delivered both internally to advocates and externally to nursing homes and care homes.
- Training package on Accurate Record-Keeping delivered to nursing homes and care homes.
- SOVA policy and whistleblowing policy have been reviewed and revised.
- induction courses run for new advocates.
- Advocates (all volunteers) receive ongoing structured training and support programme throughout the year. 10 sessions delivered incorporating inputs on Dementia / SOVA Awareness / Mental Capacity Act / DoLS / Case Studies / Finance and Pensions / Criminal and Civil Law / Accurate Record-Keeping
- All SOVA referrals now audited monthly and there are robust procedures in place for dealing with safeguarding concerns.
- AOP Manager attends all SOVA Board meetings and relevant Operational Group meetings.
- AOP routinely disseminate SOVA information to all other Bedfordshire Advocacy Network (BAN) members.

The implementation of the SOVA action plan has led to a significant increase in the number of referrals being received. AOP continues to work with clients from all areas of Bedford Borough, Central Bedfordshire and Luton. The referrals relate to residents subject of abuse in the community, care homes and nursing homes as well as patients in hospitals. The nature of abuse reported to and dealt with by our advocates covered a wide-ranging spectrum of safeguarding issues ranging from bullying and assault through to burglary, sexual assault and financial abuse. In the latter part of the year there was a notable increase in the number of financial cases.

The future plans for AOP include securing additional funding for all elements of AOP work including safeguarding. We will be seeking to foster closer working relationships with local banking institutions in order to identify potential methods of stemming the increasing trend of financial abuse. The recruitment of volunteer advocates will continue so that the expertise within the organisation flourishes and impacts positively upon our ability to provide specialist support.

3.14 Advocacy Alliance

Advocacy Alliance continues to ensure that safeguarding is embraced by all staff and volunteers to enable effective advocacy support to be delivered.

Safeguarding training remains core within our advocate induction training and there are robust procedures in place for dealing with safeguarding concerns

Advocacy Alliance were also commissioned by the Adult Safeguarding Board to provide two pilots - Service User representation to the Board and Operations meetings and to run a Support group for any adult who has experienced a safeguarding issue. The support group provided peer support for individuals and offered signposting or further individual help as needed. The Service User Representative brought any relevant issues or concerns from the group to the Board meetings. The pilot commenced in October 2010 and was for a period of six months, however, through Advocacy Alliance the work continues at this time.

A total of eleven people were referred to the group. Attendance throughout the pilot period averaged at four attendees per session. The group were able to identify areas of practice which could be improved, including; service user feedback, the need for better information on how to seek help and the concern that the police and courts do not take safeguarding issues seriously. Positive feedback was also given, specifically towards the police for considerate and supportive initial contact. The group also looked at the Safeguarding Board quarterly report statistics and comments on these were passed on to the Operations group.

Service user representatives were selected by interview and were offered a range of training opportunities by Advocacy Alliance and relevant external agencies. The training offered was; Assertiveness, Roles and Responsibilities of board members, Guidelines for Attending Official Meetings and SOVA awareness.

Comments from group

- "I like being able to talk to people about what happened to me"
- "I think I can help other people because I have had some good and some bad experiences."
- "I think it's important for the council to listen to people, because how else would they know what it's like?"
- "When I didn't hear what happened to the person who attacked me,
- I didn't go on a bus for a year. I want to tell the council about that."

Advocacy Alliance have also developed a Keep Safe project which is a course utilising the skills and experiences of vulnerable adults who have been victims of either hate crimes or abuse. These adults help to deliver courses and add a personal perspective which is easy to relate to. The course highlights what can constitute abuse, including the more subtle, or institutionalised abuses which are often easily overlooked and the importance of reporting, as well as the pathways that are available, and who to talk to if you being abused.

The aim is to provide attendees with the knowledge to recognise any abuses that may be perpetrated against them, and enable them to use their skills and confidence to report it and stop it early, and prevent similar situations occurring in the future.

This project was delivered working in partnership with the emergency services and provided useful learning to those services.

Advocacy Alliance has also recently signed up to the Dignity in Care Challenge and now has a Dignity Champion. It is putting in place robust procedures and practice to ensure dignity in our practice.

Advocacy Alliance continues to work positively through advocacy to support individuals and will continue to be proactive in identifying opportunities to apply for funding to support people to keep themselves safe, for example preventative advocacy (Big Lottery Transforming Futures Bid).

3.15 Bedfordshire Care Group and Bedfordshire Home Care Providers

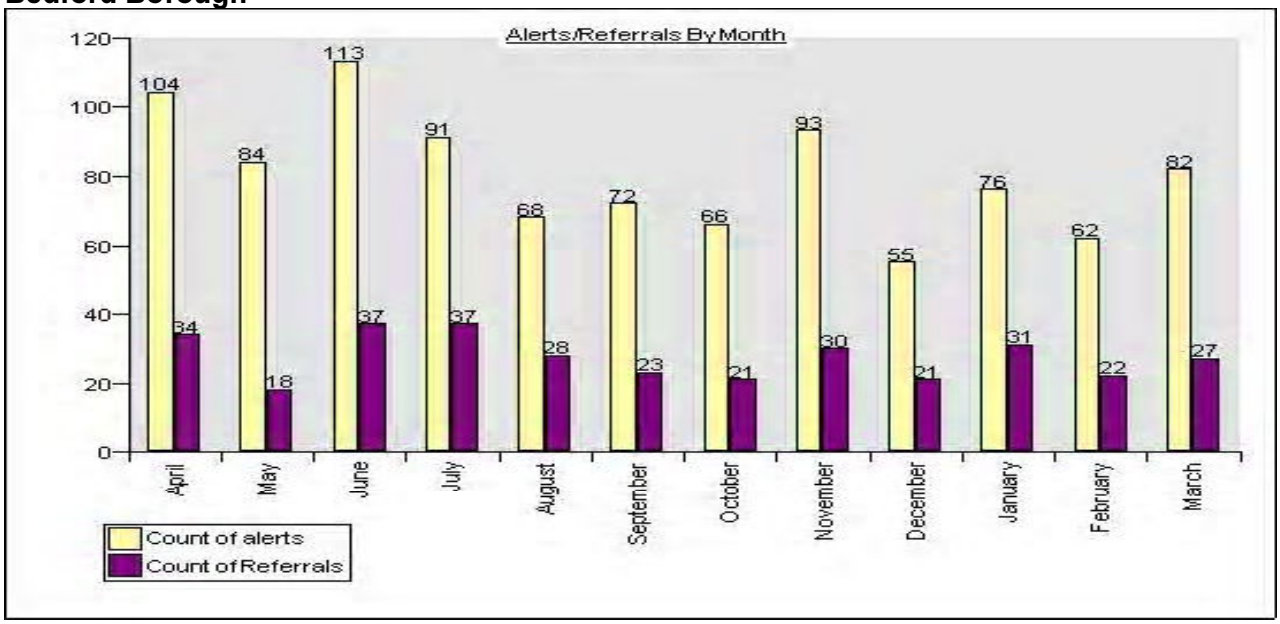
Bedfordshire Care Providers have been represented on the Board all year and Home Care Providers since November 2010. The representative of Home Care Providers has circulated relevant information to them and gained feedback from them both by e-mail and by convening a meeting. The home providers are now considering forming a group of their own similar to the Bedfordshire Care Group which represents Care Providers to ensure there is a clear forum to share information and lessons to learn.

Bedfordshire Care Providers have been consulted and had relevant information shared with them through the Borough and Central Provider forums and also through the Bedfordshire Care Group where lessons learnt from the serious care reviews have been shared along with information around the SOVA competencies, best practice with respect to record keeping and prevention and management of pressure sores along with updates with respect to the subgroups and policy and procedures.

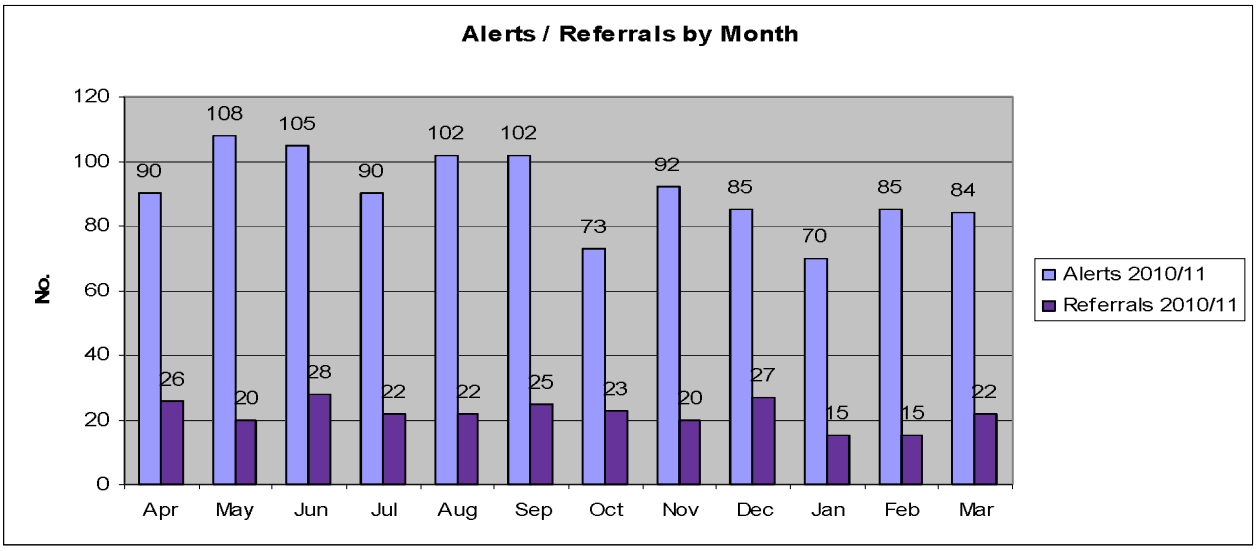
4. Safeguarding Activity April 2010 – March 2011

4.1 Number of alerts and referrals

Bedford Borough



Central Bedfordshire



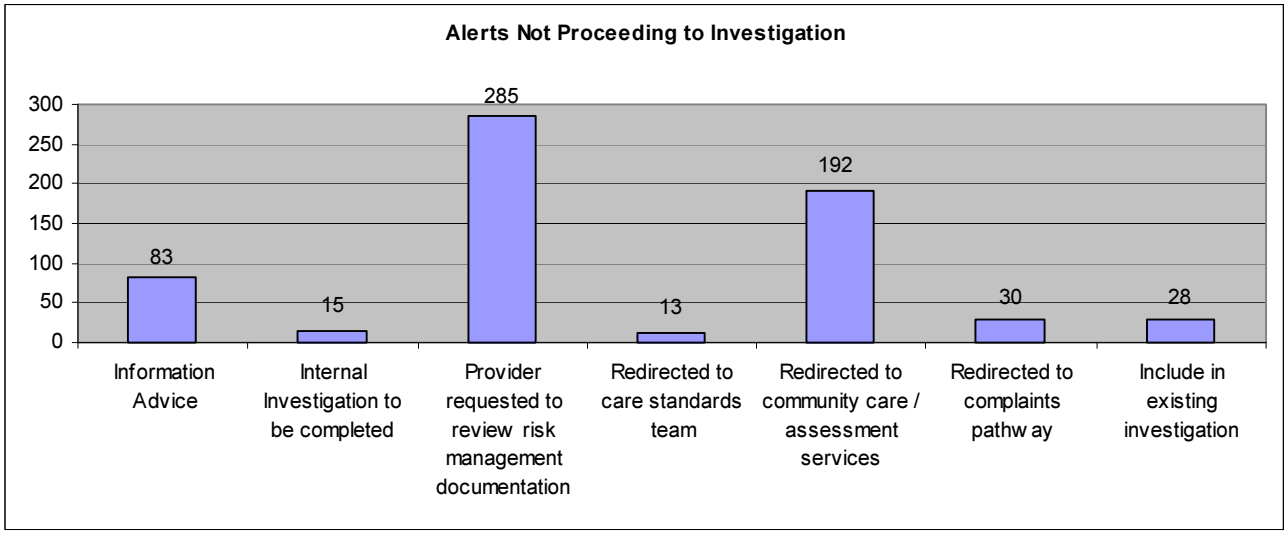
4.1.1 Bedford Borough Council received 949 alerts during the year. 329 (34%) progressed to a referral (safeguarding investigation). This is an increase of 136 alerts over the previous year (813) continuing the upward trend resulting from increased awareness, training and monitoring.

4.1.2 Central Bedfordshire Council received 1086 alerts during the year. 265 (24% progressed to a referral). This is an increase from the previous year by 112 alerts. The proportion of alerts progressing to referral is the same as last year.

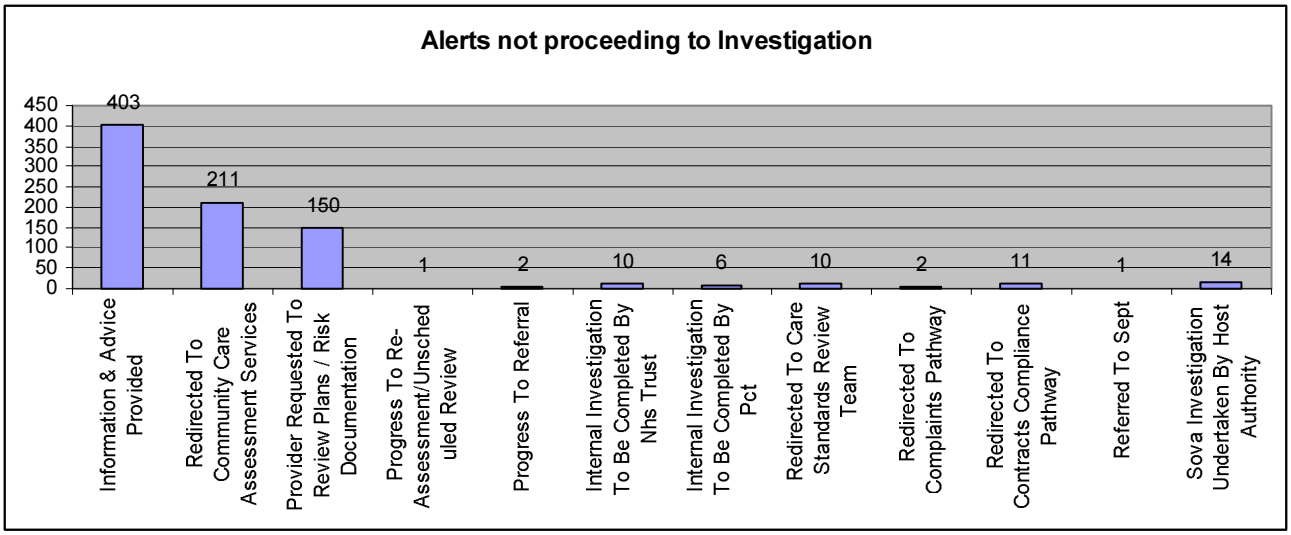
4.1.3 Both safeguarding teams are receiving fewer inappropriate alerts. The figure of one third and one quarter from each council represents proportionate responses to an alert. For example alerts may reflect unmet need, or increased risks, which require further intervention by the care provider or adult social services.

4.2 Alerts not proceeding to referral (investigation)

Bedford Borough



Central Bedfordshire



Note that more than 1 reason may apply.

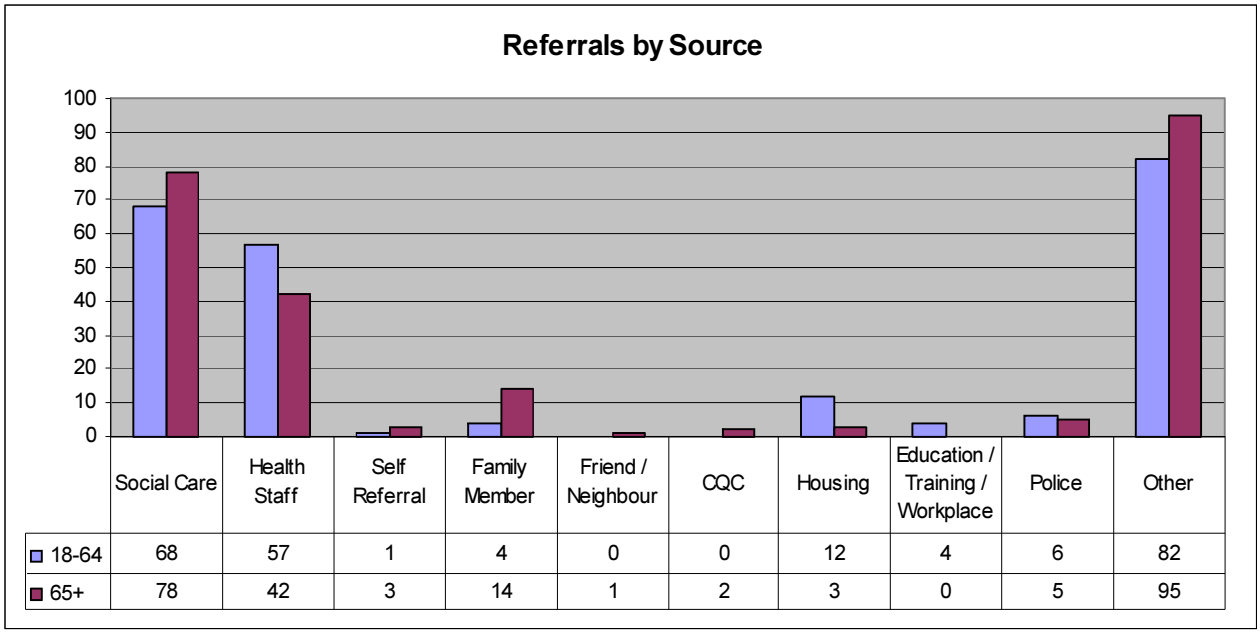
4.2.1 620 alerts received by Bedford Borough Council did not progress to referral and formal investigation. The majority of cases redirected were in relation to service user on service user incidents, particularly of an aggressive nature. Investigation into the trends of these alerts identify that many of these arise in inpatient and residential services. This discrepancy between the two councils is to be expected because of the larger number of specialist residential units in the Borough. All of these establishments have been targeted for specific dignity in care and anti bullying awareness raising.

4.2.2 821 alerts received by Central Bedfordshire Council did not progress to formal investigation. Half of these resulted in information and advice being provided. A further quarter were referred to care management teams for a response.

Practice example
A lady was having frequent falls, resulting in minor tears and bruises. Assessment and analysis of these falls by staff identified patterns and trends at particular times of the day. The falls coincided with times that the lady was taking her medication. Her GP reviewed her medication and the changes to her medication reduced the adverse effects upon her balance. The lady's balance stabilised, increasing the lady's confidence to become more independent and mobile again.

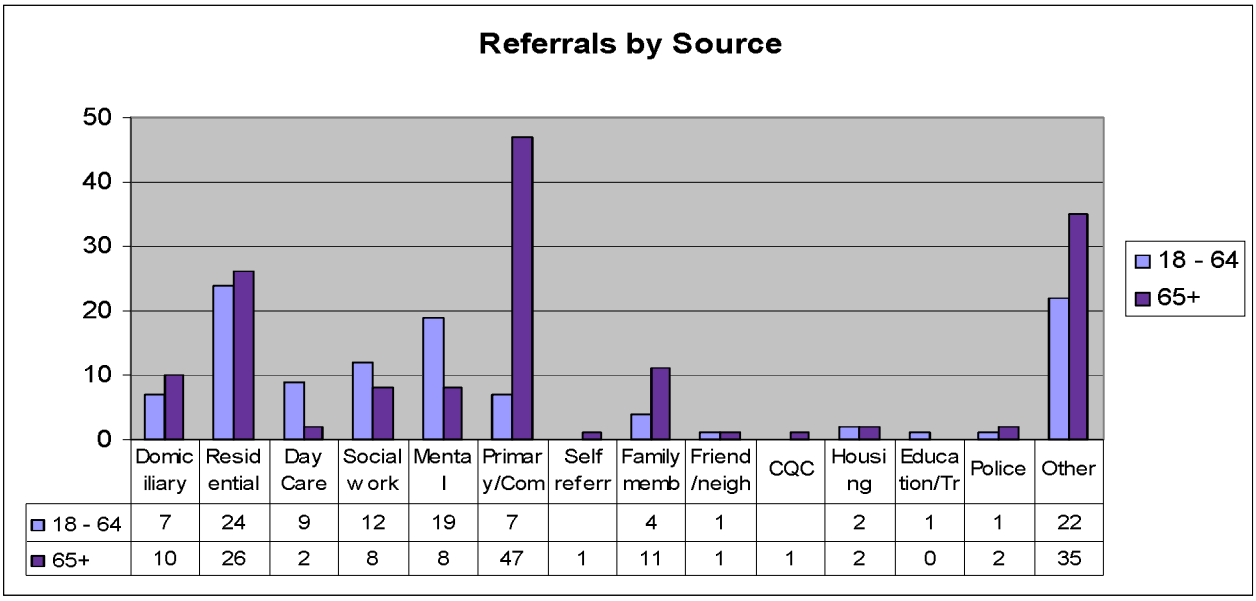
4.3 Source of referral

Bedford Borough



	Social Care	Health Staff	Self Referral	Family Member	Friend / Neighbour	CQC	Housing	Education / Training / Workplace	Police	Other
18-64	68	57	1	4	0	0	12	4	6	82
65+	78	42	3	14	1	2	3	0	5	95

Central Bedfordshire

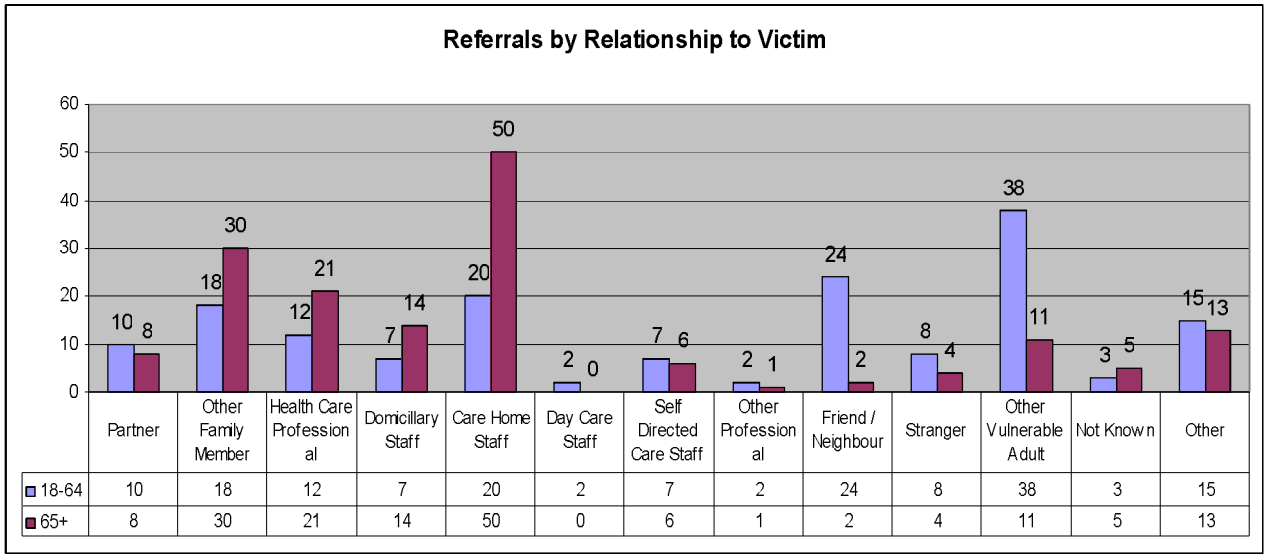


	Domiciliary	Residential	Day Care	Social work	Mental	Primary/Com	Self referr	Family memb	Friend /neigh	CQC	Housing	Education/Tr	Police	Other
18 - 64	7	24	9	12	19	7		4	1		2	1	1	22
65+	10	26	2	8	8	47	1	11	1	1	2	0	2	35

4.3.1 The main source of all referrals continues to be from social care staff from residential / nursing homes, but the number, as compared with other partnering agencies, is levelling out. The increase in referrals from health services (both acute and community) is the most notable difference within the last year. This is considered to be the intended impact of increased awareness and reporting. The increase in the number of referrals from across the partnership is beginning to demonstrate that continued safeguarding activity on the prevention of abuse, challenging poor standards of care, supporting high standards of care, raising safeguarding adults awareness and consistency in responses is evidence that the safeguarding board's key message that safeguarding is everyone's business and everyone's responsibility.

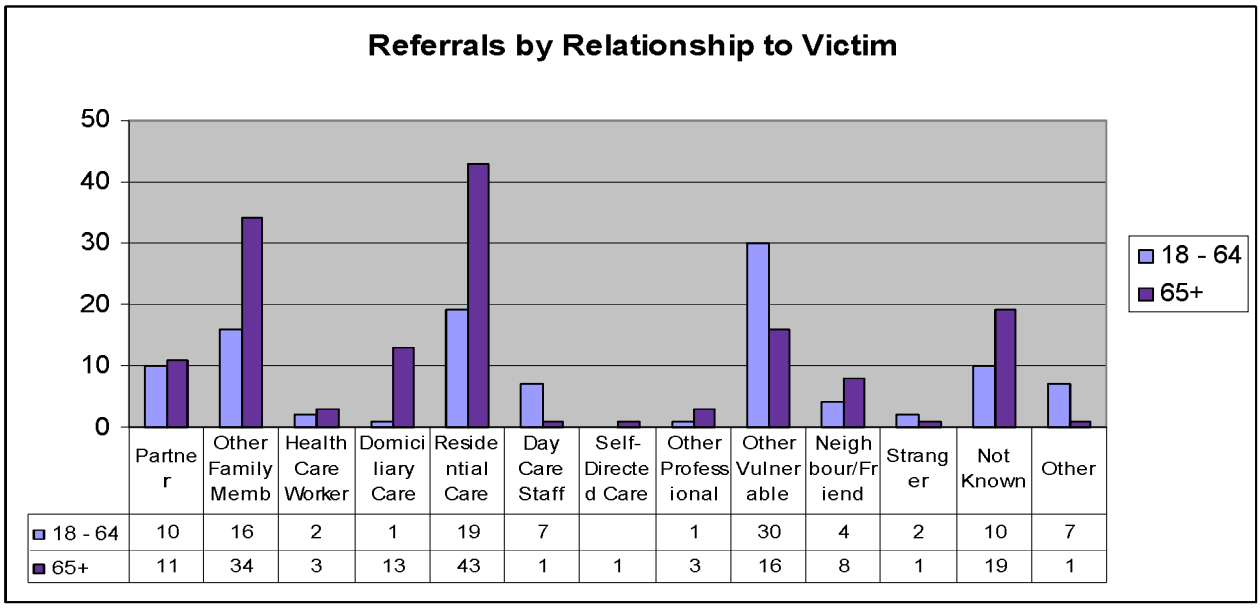
4.4 Relationship to Victim

Bedford Borough



	Partner	Other Family Member	Health Care Professional	Domicillary Staff	Care Home Staff	Day Care Staff	Self Directed Care Staff	Other Professional	Friend / Neighbour	Stranger	Other Vulnerable Adult	Not Known	Other
18-64	10	18	12	7	20	2	7	2	24	8	38	3	15
65+	8	30	21	14	50	0	6	1	2	4	11	5	13

Central Bedfordshire



	Partner	Other Family Memb	Health Care Worker	Domiciliary Care	Residential Care	Day Care Staff	Self-Directed Care	Other Professional	Other Vulnerable	Neighbour/Friend	Stranger	Not Known	Other
18 - 64	10	16	2	1	19	7		1	30	4	2	10	7
65+	11	34	3	13	43	1	1	3	16	8	1	19	1

4.4.1 The proportion of incidents in Bedford Borough relating to paid carers remains constant at about half of all alerts, but this position masks an increase in reporting within health settings and the impact of the dignity in care campaign in improving overall standards.

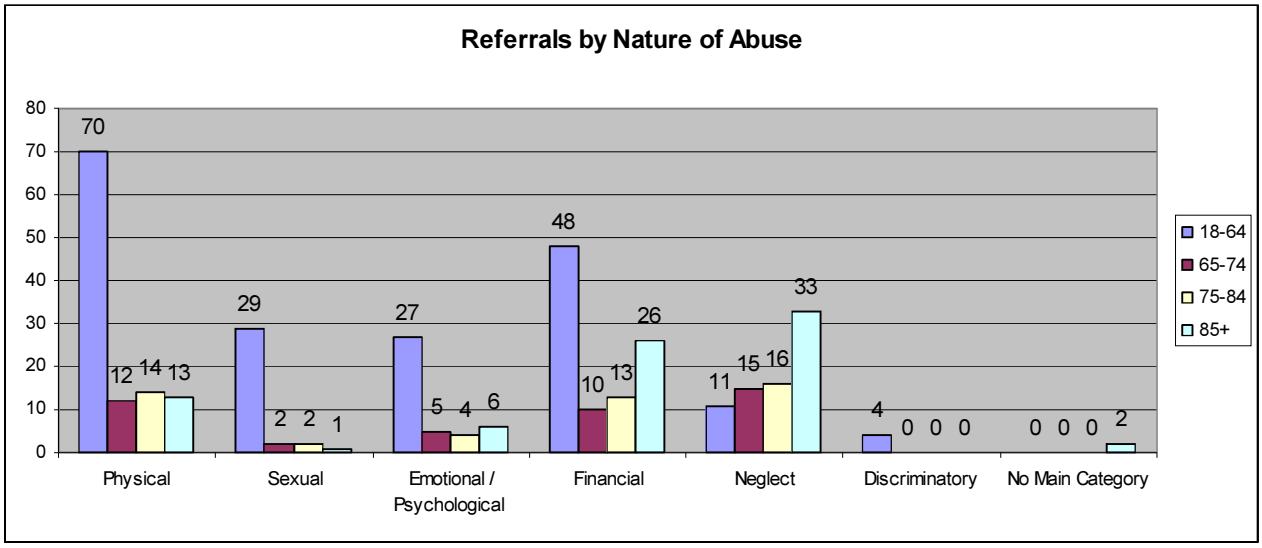
4.4.2 In Central Bedfordshire the most common perpetrator in relation to older people is a residential care worker or family member. In relation to people under 65 the perpetrator is more likely to be a residential care worker or another vulnerable person.

4.4.3 This year, for the first time, we are able to record the number of alerts raised for people in receipt of self directed support. Numbers are low indicating a need to monitor this area more closely and ensure full recording of circumstances.

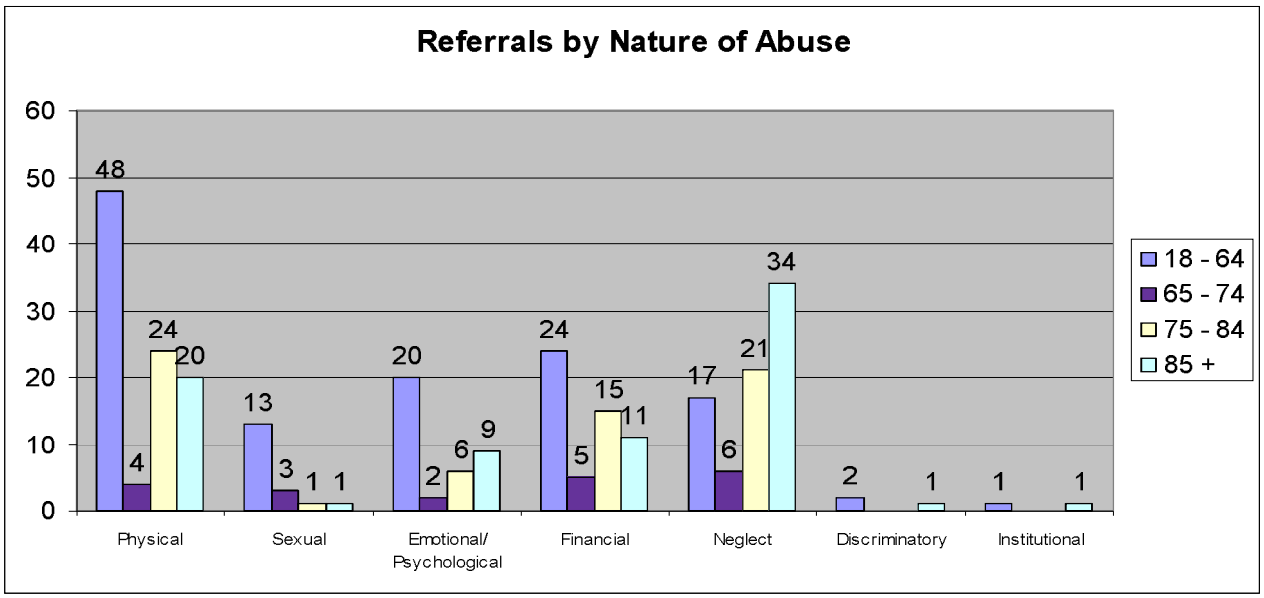
4.4.4 Whilst the number of referrals about family and friends remains consistent, further work is required to reiterate the zero tolerance of abuse messages. Both Councils have commissioned a “preventing harm to yourself and others” handbook to advise vulnerable people and their carers on identifying and reporting abuse and preventing avoidable harm.

4.5 Types of abuse

Bedford Borough



Central Bedfordshire



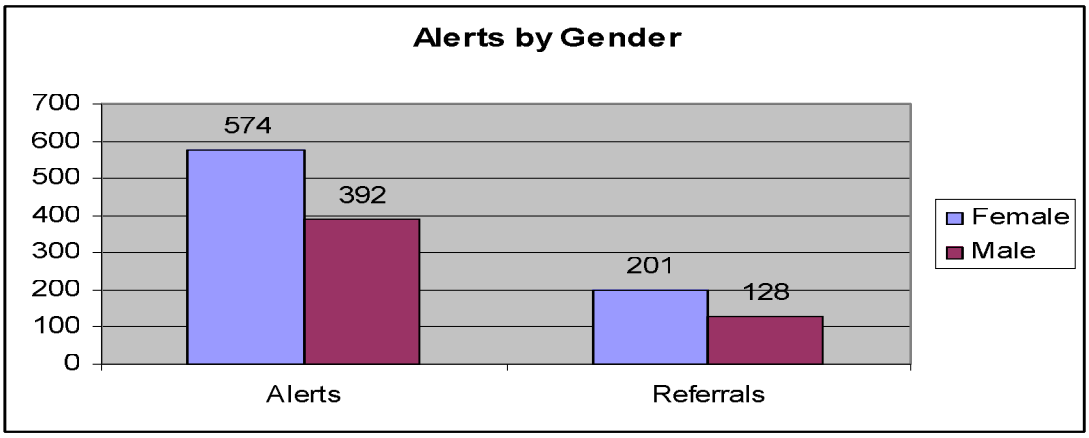
4.5.1 Incidents of physical abuse continue to be the most common in Bedford Borough, although the proportion of incidents has fallen from 39% in 2009/10 to 33% in 2010/11, which is attributed to the Dignity in Care campaign and work with provider services to manage risk and prevent aggression. This work will need to continue in learning disability and mental health services which have predominantly the highest proportion of aggression between service users. The proportion of reports regarding neglect has decreased over the last year from 29% of the overall referrals in 2009/10 to 17% of the overall referrals in 2010/11, however reports of emotional abuse are increasing which indicates that the work around Dignity in care should continue to be reinforced.

4.5.2 For people under the age of 65 in Central Bedfordshire, physical abuse is the most common form of alert. This is consistent with the trend in incidents between other vulnerable people within the same age group. For people over the age of 65, neglect is the most common form of alert. This is consistent with the trend that most referrals are in relation to paid care staff within residential homes. There are higher incidents of physical, emotional and neglect for

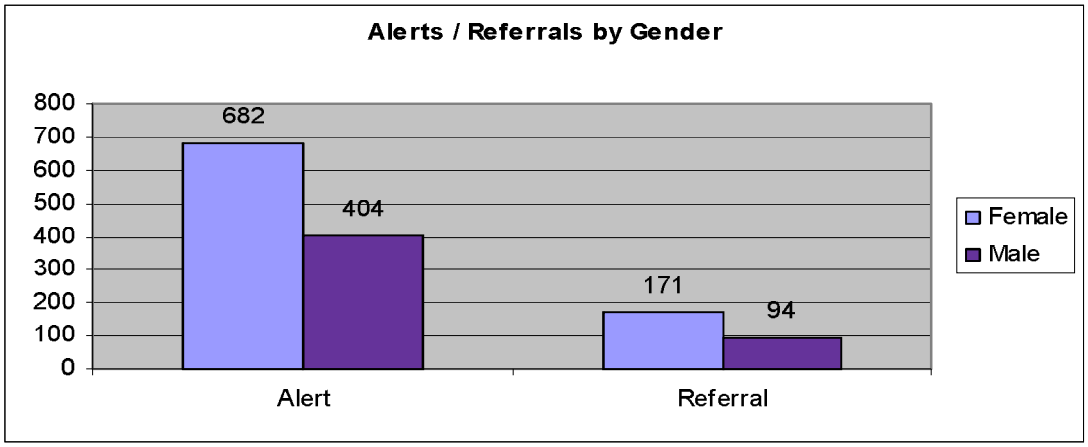
4.5.3 The incidence of financial abuse reported is consistent with the numbers reported last year. Individual investigations have identified trends where the service user lacks the capacity to fully manage their own financial affairs, and/or have been made dependent upon others. The majority of the referrals indicate that the alleged perpetrator is a close relation or friend. Further work is required to support service users to understand the need for and to make decisions about their financial affairs before they lose the capacity to make informed decisions. Further work is required to raise awareness with the public that using relative's money or material effects for their own personal gain is a crime and will not be tolerated.

4.6 Alerts and referrals by Gender

Bedford Borough



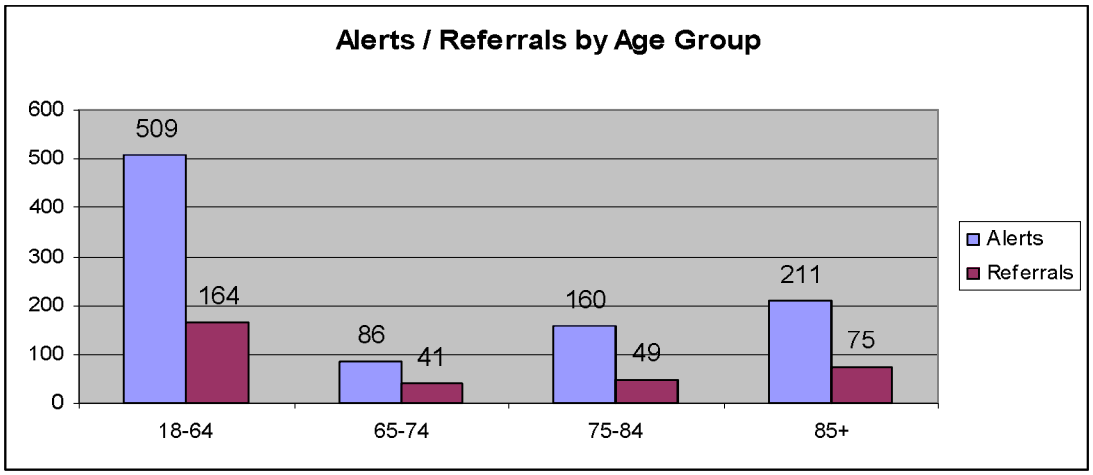
Central Bedfordshire



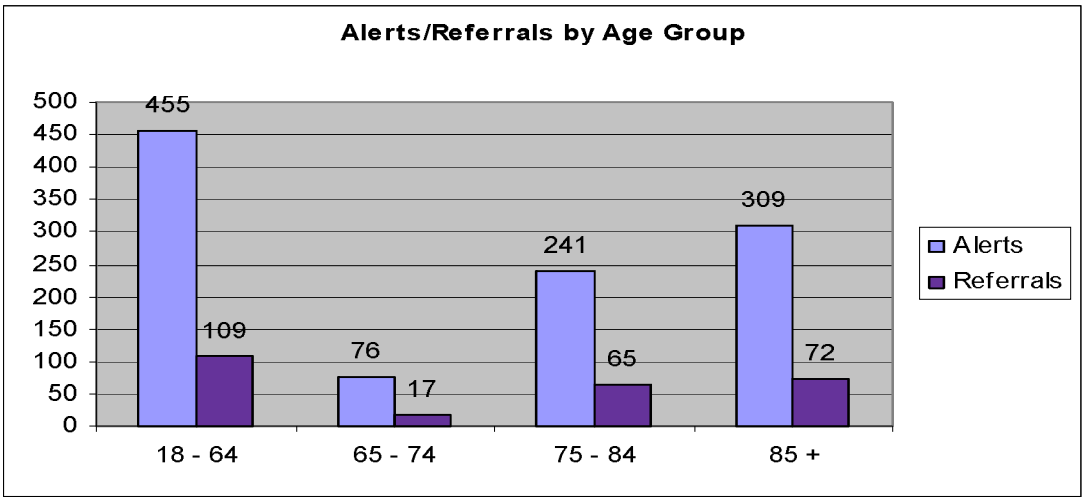
4.6.1 The larger proportion of alerts and referrals relate to women. This is a reflection of the population of people using care services, particularly within older people's services. The majority of alerts come from residential and inpatient units, as well as people using domiciliary care services at home. The majority of alerts are redirected through other, more proportionate routes. This is because the awareness of safeguarding within regulated services is greater than within the public domain and should be the subject of further awareness in the coming year.

4.7 Number of alerts and referrals by age group

Bedford Borough



Central Bedfordshire



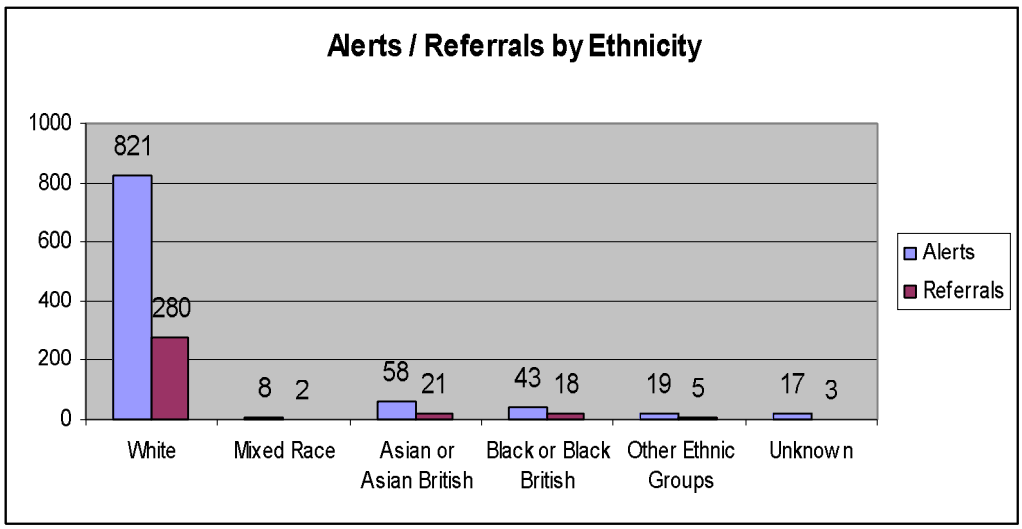
4.7.1 The majority of safeguarding alerts and referrals with Bedford Borough relate to people aged 18-64. Many of these alerts relate to incidents between people using services, a large proportion of the perpetrators lack the mental capacity to be accountable for their actions in criminal law. Bedford Borough has more care homes and inpatient facilities for adults with learning disability and mental health needs and these locations are by the nature of the service, known to accommodate people who have communication limitations and unpredictable behaviours that frequently result in aggression and violence towards other patients and staff. The dignity in care campaign has reinforced the zero tolerance of abuse and anti bullying messages given to staff and patients within these services.

4.7.2 A common response to these alerts may be to safeguard through an investigation where significant harm has occurred, or when there have been repeated incidents. Alternative responses would be through a care management approach or for the care provider to respond through their risk management procedures.

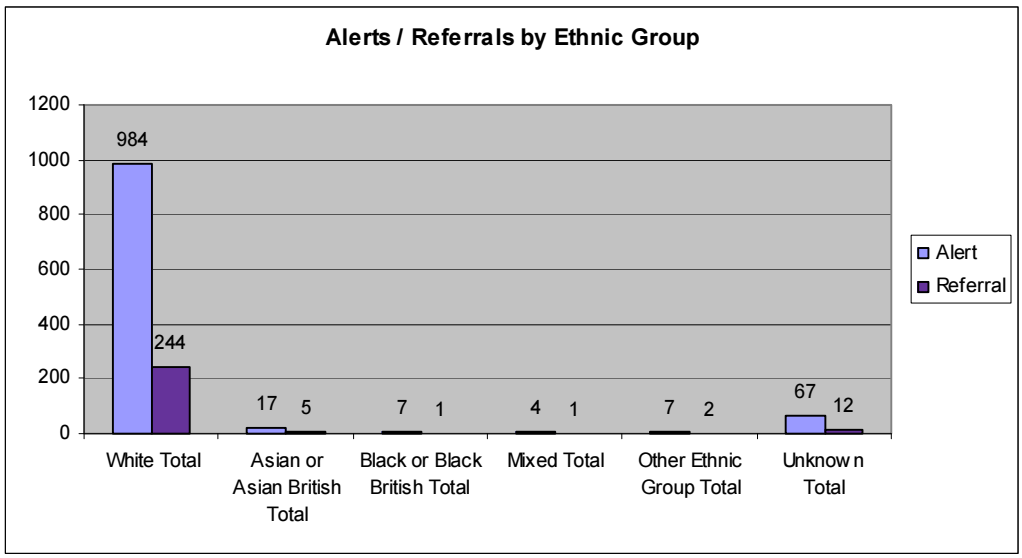
4.7.3 The majority of safeguarding alerts and referrals in Central Bedfordshire relate to people aged 65+. This is a reflection of the population using care services in the locality. 32% of these alerts progress to investigation. During the year Central Bedfordshire Council has worked to reduce the number of inappropriate alerts such as minor slips trips or falls resulting in more appropriate alerts and an increased number of investigations.

4.8 Alerts and Referrals by ethnic group

Bedford Borough



Central Bedfordshire

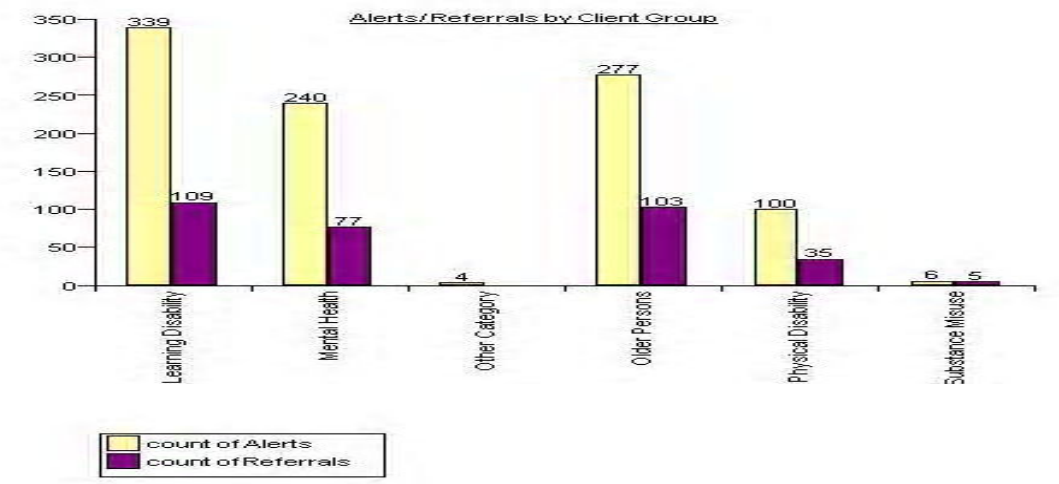


4.8.1 Bedford Borough receives a greater proportion of alerts relating to minority ethnic communities than those in Central Bedfordshire. This is reflective of the overall population There is an improvement on the numbers of alerts received from minority ethnic groups during the previous three years in the Borough. In 2008/09 the County Council received just 48 alerts from minority groups and by 2010/11, this had increased to 142 in the Borough alone. The increase has been as a result of targeted work undertaken within Bedford Borough to raise awareness within specific minority communities.

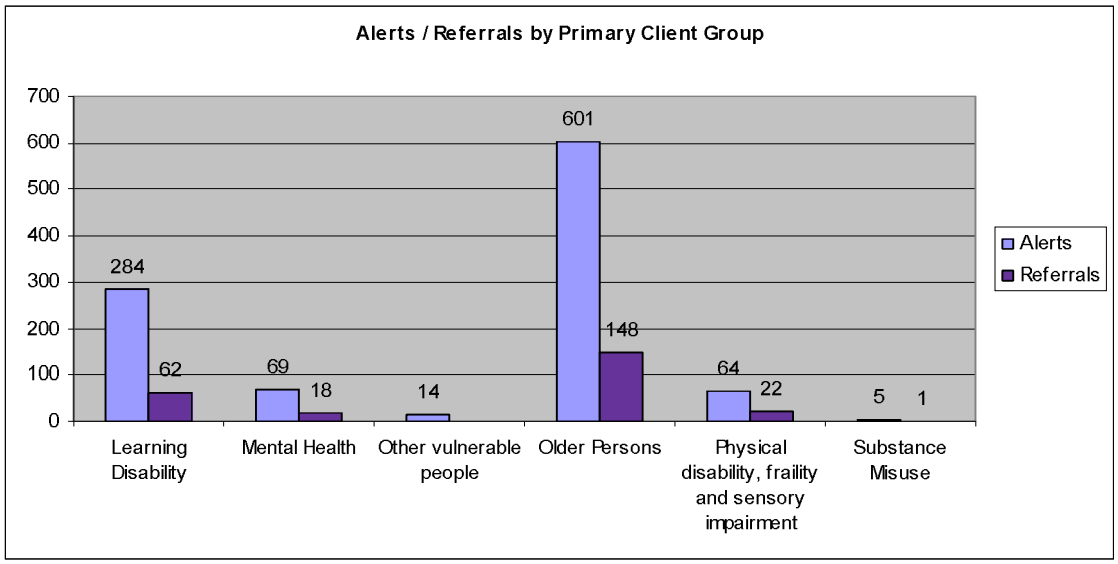
4.8.2 The low number of alerts within Central Bedfordshire is a reflection of the communities within the locality and the presenting population which is predominantly White/ British.

4.9 Alerts/Referrals by support need

Bedford Borough



Central Bedfordshire



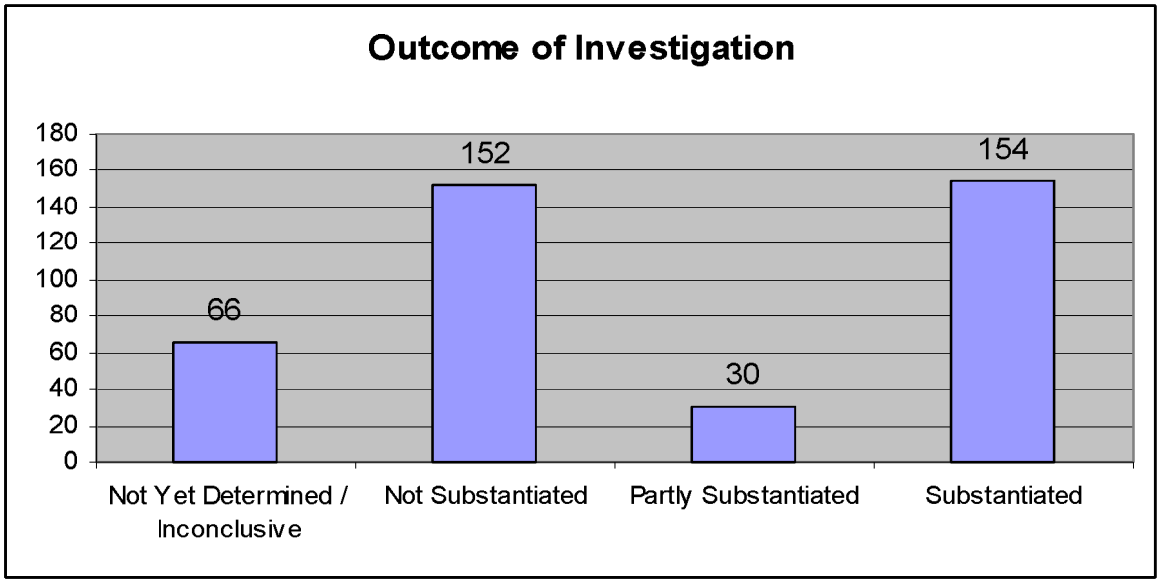
4.9.1 In Bedford Borough the proportion of referrals relating to each care group has remained consistent with previous years. Learning disability (33%) is the care group with the largest number of alerts reflecting the large number of residential and inpatient services in the Borough for this care group.

4.9.2 The number of referrals for investigation in Central Bedfordshire has increased slightly from 225 in 2009-10 to 265 in 2010-2011. 55% of all alerts in Central Bedfordshire relate to older people and 26% relate to people with a learning disability. The difference between the two local authorities reflect the different types of service and population within each area. The data in this report shows that people over the age of 80 have proportionately more alerts made.

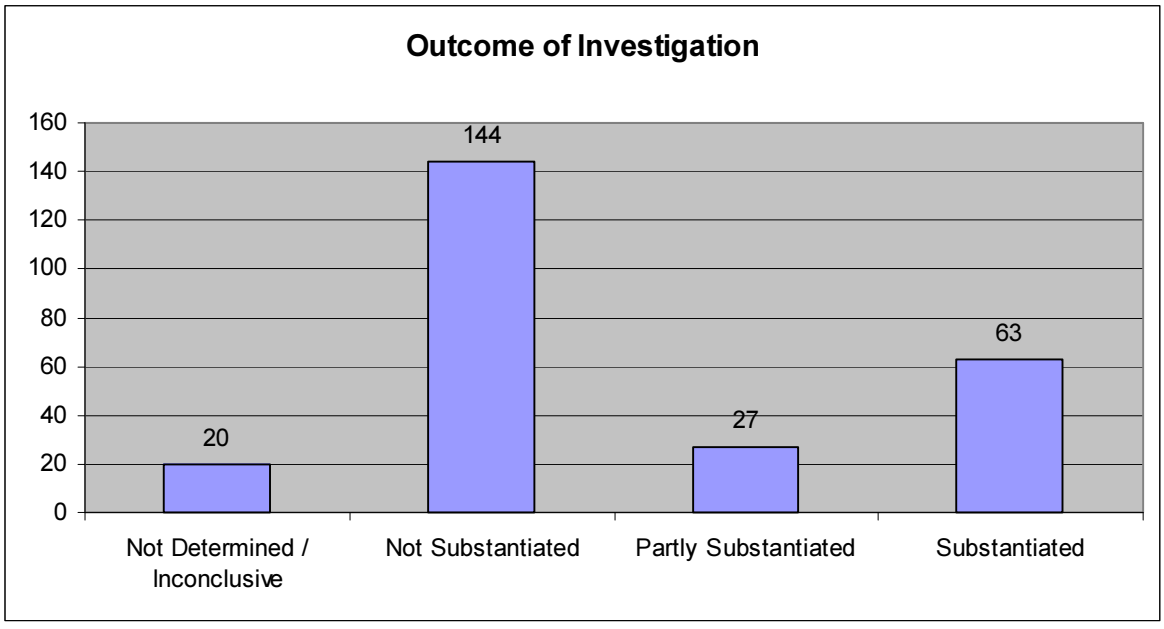
4.9.3 There is an increase in service users choosing to have their concerns addressed through other routes as opposed to the formal safeguarding procedures. This is more empowering and supports them to increase independence and have more control.

4.10 Outcomes of investigations

Bedford Borough



Central Bedfordshire



4.10.1 44% of completed investigations in Bedford Borough Council are substantiated. This has been attributed to the revised safeguarding training programmes, staff forums and audit programme increasing staff knowledge and confidence in being able to gather and analyse appropriate evidence.

4.10.2 The increase in substantiated cases also further demonstrates the appropriateness of approaches in terms of safeguarding proportionality and choices of vulnerable adults.

4.10.3 Improved safeguarding investigation has improved Outcomes for victims:

The majority of victims have agreed for further post abuse support mechanisms to assist them to increase their independence and minimising the risks of their vulnerability and further abuse.

Examples of outcomes for victims have been:

- 26 people referred to the domestic violence service,
- 25 referred for counselling support,
- 40 people have agreed to additional support to access the community
- 38 people have been supported to move to alternative accommodation.

4.10.4 The majority of outcomes for perpetrators have required further support and action to reduce the risks of further incidents of abuse to vulnerable people.

Examples of outcomes for perpetrators have been,

- 12 staff referred to the Independent safeguarding authority,
- 9 regulatory actions by CQC,
- 22 people removed as power of attorney, restricting access to finances,
- 27 people moved to alternative accommodation away from the victim.

4.10.5 The majority of outcomes of investigations in Central Bedfordshire are unsubstantiated. This corresponds with the low numbers of police prosecutions in adult protection which is often due to lack of evidence. Further work is required to analyse the relationship between the source of referral, the alleged victim and the outcome of the investigation.

5. Mental Capacity Act and Deprivation of Liberty

5.1 The trend continues to be less authorisations, which is in line with Government expectations (1 in 4 authorised) and the expectations that Deprivation of Liberty Safeguards are a last resort once other least restrictive options have been exhausted:

- Bedford Borough Council received 49 applications for Deprivation of Liberty in 2010-2011, compared with 50 in 2009-2010. Of the 49 applications, 13 were authorised and 36 were not. This compares with 30 authorised and 20 not authorised in 2009-10.
- Central Bedfordshire Council received 25 applications for Deprivation of Liberty in 2010-2011, compared with 42 in 2009-2010. Of the 25 applications, 3 were authorised and 22 were not. This compares with 21 authorised and 21 not authorised in 2009-10.
- NHS Bedfordshire received 14 applications for Deprivation of Liberty in 2010-2011, compared with 11 in 2009-2010. Of the 14 applications, 4 were authorised and 10 were not. This compares with 5 authorised and 6 not authorised in 2009-10.

5.2 Overall together these figures indicate a small decrease in the number of requests 88 in 2010-11 compared with 103 in 2009-10. This decrease is attributed to the targeted Deprivation of Liberty workshops and increased awareness and understanding of the requirements of the Act within care settings.

5.3 Audits of Mental capacity assessments undertaken in September 2010 identified the need for further support and training to ensure the quality of assessments and best interest decisions have considered the persons wishes, upheld their human rights and the decisions made are the least restrictive options. This work reduced the number of inappropriate authorisation requests in the last quarter of 2010/11.

5.4 The local and regional Mental Capacity Act Coordinators continue to work together to maintain consistency in practice and decision making and to develop good practice and learning within the area.

5.5 Increased awareness and implementation of the Mental Capacity Act has been done with Bedford Community Health Services. 8 workshops were facilitated with clinical staff and GP's and further support is being provided to develop a strategy for future training and audit of work. This work has resulted in more enquiries about mental capacity issues from clinical staff, predominantly around end of life care, Power of Attorney, and refusal of medical treatment.

5.6 Audits of assessments and decisions have become a regular part of the Mental Capacity work and through workshops and forums, increased standards of work can be evidenced and improved outcomes for those being supported. Audits of assessments have identified that there is further work required across all care sectors, in building confidence and understanding of how and when to assess an individual's mental capacity.

Good Practice Example
Having a greater emphasis on person centred approaches and multi agency working has reduced the timeframes for Deprivation of Liberty safeguards to be required.
A person in a care home was demonstrating self injurious behaviours. Professionals worked together to identify root causes and trends in the behaviours and were able to explore alternative and less restrictive methods with the person enabling them to have more control in their environment and reducing the self injurious behaviours.

5.7 The first successful prosecution under section 44 of the Mental Capacity Act in Bedfordshire was achieved during 2010/11. A carer was given a 12 month conditional discharge, after an elderly person in her care suffered a broken leg after a fall, which was not discovered for four days. The carer failed to record the fall and failed to seek medical assessment.

6. Learning from Safeguarding Activity

Issue	Action to Ensure Learning
Partners have become much more engaged this year in contributing towards the safeguarding agenda	The value of publicity and senior engagement is paying of, but this will need to be built upon in the coming year through more robust reporting and monitoring of partner's improvement plans.
Safeguarding activity should focus more on service user involvement and outcomes as opposed to the current focus upon the business process	All agencies to implement the Department of Health's principles to benchmark existing safeguarding arrangements
Record keeping is still a regular issue identified from serious case reviews and individual safeguarding cases	Audit and quality assurance programmes will be reported through the safeguarding board and sub groups.
There is a need for all agencies to understand roles and responsibilities of the other organisations that they work with. This will improve information sharing.	A multi agency quality audit will be undertaken each quarter which will enable the partners to understand their role and contributions towards multi agency approaches to safeguarding.
Audits of mental capacity assessments have identified variable quality in terms of the issues being assessed, being able to evidence the process employed and the quality of the best interest decisions.	All agencies will ensure that staff have the appropriate knowledge and skills and have in place audit programmes to ensure that the principles of the Mental Capacity Act are being fully implemented.
A serious case review identified that "unwise decision making" is an area that should be appropriately escalated and reported.	Agencies should review how they deal with unwise decisions, for example by adopting a process to escalate high risk issues and consideration of risk enablement panels
Two serious case reviews have identified that there were different responses between services that were funded by the council and those funded by service users themselves.	Agencies will ensure that responses to need will be seamless, irrespective of who is funding those services.
Regionally, the numbers of approved Deprivations of Liberty applications are low. It is not clear whether our assessments are enabling less restrictive actions or whether proportions are due to low applications from providers.	To undertake further research into the applications being made locally and regionally and further audits of mental capacity best interest decisions.
Pressure sores and tissue breakdown have been factors in significant numbers of alerts raised to the safeguarding teams	The NHS Bedfordshire safety Express programme will support the provision of training, advice and equipment and the Safeguarding Board's own guidance on tissue viability will assist prevention.

7. Strategic Objectives for 2011-12

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 activities are monitored and audited

Strategic aims:

1. Prevention / raising awareness
2. Workforce development
3. Partnership working
4. Quality Assurance
5. Involving people in development of safeguarding services
6. Outcomes and improving people's experience

Prevention / raising awareness

- Information on 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
- Information is 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

Workforce development

- 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

Partnership working

- Secure electronic information sharing arrangement - receive reports and monitor progress and management of this

- Tissue viability issues from task and finish group. Put arrangements in placements - 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 made to the new Health and Wellbeing Boards, Community Safety Partnerships, Local 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

Quality Assurance

- 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 multi agency case file audits and what they tell us about the 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

Involving people in development of safeguarding services

- 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

Outcomes and improving people's experience

- Ensure people are empowered to drive safeguarding processes and find effective personal resolutions to harmful or abusive circumstances
- Ensure advocacy services are available for people who are unable to challenge or change circumstances that they experience as abusive or harmful
- Involve people during the investigation process
- Provide more detailed information than the current public information leaflets about 'what is abuse'
- Build confidence in the process of investigating concerns by making people feel comfortable at the start of a safeguarding process

Abuse is Everybody's Business
Safeguarding is our Responsibility

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

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

Tell

If a person is in immediate danger, call the police or ambulance straightaway on 999

If you are unable to report your concern or you don't feel that your concerns have been acted upon **say something** to the Adult Safeguarding Team or report your concerns to the

BEDFORD BOROUGH COUNCIL

Central Bedfordshire

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

CareQuality Commission

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

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

SAFEGUARDING ADULTS

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