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 2011- March 2012

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## Abuse is Everybody's Business

This annual report covers the third year of operations as two unitary councils for Bedford Borough and Central Bedfordshire. It outlines the progress made during the year from April 2011 to March 2012 and is provided to inform individuals, their families and carers, who use social care and health services, elected members, those who work in social and health care, all partner agencies, and residents of Bedford Borough and Central Bedfordshire.

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

During the past 12 months we focussed on 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. Strong foundations have been laid in the development of the safeguarding board, and we have been working together as partners to develop our strategic approach to safeguarding. We have been building on our focus on prevention to move towards a focus on improving outcomes for individuals. However, much work still remains to be done to take us to our safeguarding goals.

Over the coming 12 months we will be focussing on

- Improvements in safeguarding practice as a result of independent audit and Peer Review, and improvements in our approach to learning and development;
- Reviewing and addressing the reasons for the high volume of alerts received which do not require a formal investigation, the low number of alerts relating to hard to reach communities, and the low number of alerts from members of the public;
- Safeguarding and the role of informal carers; the vulnerability of people with disabilities to abuse and harassment, and quality of services for people with learning disabilities

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.

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

**Frank Toner**
Executive Director of Adult and Community Services
Bedford Borough Council

## Safeguarding is our Responsibility

## 1. The Developing Context for Safeguarding

1.1 Statement of Government Policy on Adult Safeguarding

The Department of Health released a statement in May 2011 which set out the Government's policy on safeguarding vulnerable adults. It included a statement of principles for use by Local Authority Social Services, housing, health, the police and other agencies for developing and assessing the effectiveness of their local safeguarding arrangements. The policy statement define 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** - 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
- **Partnership** - Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

1.2 Carers and Safeguarding Adults – Working Together To Improve Outcomes

The Association for Directors of Adult Social Services (ADASS) released a document in July 2011 which considered issues around carers and safeguarding adults. It linked to government polices including the Vision for Adult Social Care, the priorities of the national strategy for carers: Recognised Valued and Supported and the 2011 statement of policy on adult safeguarding (see1.1). It used the principles identified in 1.1 to explore issues around improving practice and securing desired outcomes for:

- Carers speaking up about abuse or neglect within the community or within different care settings.
- Carers who may experience intentional or unintentional harm from the person they are trying to support or from professionals and organisations
- Carers who may unintentionally or intentionally harm or neglect the person they support.

1.3 Hidden in Plain Sight, Inquiry into Disability Related Harassment

The Equality and Human Rights Commission produced a report in September 2011 following several serious cases of abuse of disabled people. The inquiry showed that harassment of disabled people is a serious problem which needs to be better understood. The evidence indicates that, for many disabled people, harassment is a commonplace experience. Disabled people often do not report harassment, for a number of reasons:

- it may be unclear who to report it to
- they may fear the consequences of reporting
- or they may fear that the police or other authorities will not believe them.

The inquiry found that there is a systemic failure by public authorities to recognise the extent and impact of harassment and abuse of disabled people, take action to prevent it happening in the first place and intervene effectively when it does.

1.4 SCIE Guidance

During the year the Social Care Institute for Excellence released a number of guidance documents including:

- SCIE Report 41: *Prevention in adult safeguarding* - this report shares findings from research, policy and practice on prevention in adult safeguarding and presents a wide range of approaches that can help prevent abuse.

- SCIE Report 45: *The governance of adult safeguarding: findings from research into Safeguarding Adults Boards* - the research for this report explored the governance arrangements for safeguarding adults. The findings focus on five key features of Safeguarding Adults Boards: strategic goals and purpose, structures, board membership, board functions, and accountability.

- SCIE Report 46: *Self-neglect and adult safeguarding: findings from research* - this report was commissioned by the Department of Health (DH) and examines the concept of self-neglect. The relationship between self-neglect and safeguarding in the UK is a difficult one, partly because the current definition of abuse specifies harmful actions by someone other than the individual at risk.

- SCIE Report 50*: Safeguarding adults at risk of harm: A legal guide for practitioners* - this guide is aimed at practitioners working in various settings for organisations involved in safeguarding and it may also be useful for volunteers and family. It aims to equip practitioners with information about how to assist and safeguard people by using case scenarios.

- SCIE Guide: *Safeguarding and quality in commissioning care homes* - this guide aims to support the NHS and local authorities who commission services from care homes to ensure that safeguarding is central and a primary concern for residential and nursing care home providers.

- SCIE Guide: *Commissioning care homes: Common safeguarding challenges* - this guide aims to identify the issues that commonly lead to safeguarding referrals from care homes. Prevention checklists are provided to help both commissioners and providers to work towards a reduction in occurrence of these issues. There are additional links to resources.

1.5 NHS Guidance

During the year health organisations released a number of guidance documents including:

- Department of Health – “Safeguarding Adults - the role of the health service”.
- British Medical Association – “Safeguarding vulnerable adults – a tool kit for general practitioners”.
- Department of Health – “Building Partnerships, Staying Safe: The health sector contribution to HM Government’s PREVENT strategy” which seeks to stop vulnerable people becoming terrorists or supporting terrorism.

1.6 Vetting and Barring Scheme (VBS)

The outcome of the review of the Vetting and Barring Scheme will be enshrined in legislation during 2012 with the introduction of the Protection of Freedoms Act (2012)

The key future changes include:

- abolishing the registration and monitoring requirements of the Vetting and Barring Scheme
- redefining the scope of 'regulated activities' – involving contact with children or vulnerable adults and is frequently, intensively and / or overnight
- abolishing 'controlled activities' - Frequent or intensive support work in general health settings, the NHS, further education and adult social care settings.

The provisions also mean that the services of the Criminal Records Bureau and Independent Safeguarding Authority will be merged and a single public body created. The new organisation will be called the Disclosure and Barring Service (DBS).

1.7 Personalisation and Outcomes in Safeguarding Adults

The Local Government Association and Association for Directors of Adult Social Services (ADASS) have worked together throughout the year to assist local authorities in reporting on and developing a more personalised outcomes focus in adult safeguarding. This includes guidance, toolkits and advice notes.

1.8 Learning Disability Services following the abuses at Winterbourne View hospital

In June 2011, the Care Quality Commission (CQC) stated that they would carry out a programme of unannounced inspections of services providing care for people with learning disabilities and challenging behaviours. This was in direct response to the BBC Panorama programme (May 2011) which exposed the abuses that had taken place at Winterbourne View hospital.

The inspections found that:

- Good quality commissioning and provision of care are central to ensuring people's wishes, needs and aspirations can be met so they can live fulfilling lives
- Care planning and care delivery need to be highly individualised with clear objectives that help people manage their complex needs over time
- There is poor staff understanding of restraint, a lack of monitoring of the usage of restraint leading to increased risk of restraint being used inappropriately.
- Public policy planning is being inconsistently implemented. Commissioners need to collaborate at a local level. They need to involve family carers in defining need. They must commission innovative and locally based services that are developed with clear measures of success and represent the needs and aspirations of people with learning disabilities.

1.9 All of the above findings will be incorporated into the review of the multi agency policy and guidance to reflect best practice.

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

### 2.1 An Overview of Safeguarding Improvement Work in 2011/12

2.1.1 Partners continued to provide robust quarterly reports which were monitored through the operational sub group and safeguarding board, building on the lessons learnt from the previous year.

2.1.2 The training and development, quality and audit and policy and procedure sub groups were amalgamated with those of the Luton Safeguarding Board, into a quarterly forum which has allowed partners to report on their own activity across the county of Bedfordshire. This has included:

- the implementation by health partners of the Department of Health's standards in safeguarding;
- the reporting of individual agency audit and quality assurance programmes;
- a multi agency quality audit undertaken each quarter which reviews the responses of all agencies involved in a particular safeguarding case
- reporting on the implementation of the Mental Capacity Act including best interests
- consideration of risk, unwise decision making and self neglect
- continuation of the health sector focus on the Harm Free Care programme, with a focus on pressure care via the County Wide Pressure Ulcer Steering Group as well as on falls and catheter care and sharing good practice
- joint learning across all three local authorities and partners

2.1.3 In June 2011 The Local Government Association undertook a peer challenge of safeguarding arrangements within the Central Bedfordshire Council locality. The review team found that the functioning of the Bedford Borough and Central Bedfordshire Adult Safeguarding Board demonstrated that:

- All the key partners at a senior level show a high level of commitment
- The Board has driven and delivered good policies and processes
- The Board has raised the profile of safeguarding within the services and the wider community
- The Board has dealt with individual and organisational service failures

2.1.4 At the end of 2010/11 partnership agencies identified six key strategic aims under which they would focus their safeguarding improvement work and report to the Safeguarding Board. These six aims are broadly aligned to the ADASS six principles outlined in 1.1 above. The work undertaken during 2011/12 in relation to these areas is summarised below.

### 2.2 Prevention / raising awareness

2.2.1 Both Councils have produced a community "keeping safe" handbook that covers safeguarding information as well as community safety, internet safety and other useful contacts. This is designed to raise awareness with those people who may only require adult social care support for a short time such as those who have been through re-ablement services

2.2.2 Both Councils in conjunction with Luton Borough Council held a Safeguarding Board Conference in February 2012 which was well attended by all partners across Bedfordshire. The conference identified some themes for the Board to address in the coming year, which includes training, thresholds, communication, and policy review.

2.2.3 Both councils have continued ongoing safeguarding publicity campaigns including:

- a biannual mail out and letter to service providers
- attendance at community outreach events, Council forums and partnership boards
- promoting the national dignity in care campaign and the ADASS guidance
- engagement with mobile Library services to distribute Safeguarding information leaflets to rural communities and to reach people who may not be mobile within the community

Safeguarding alerts continue to steadily increase and this is as a result of ongoing awareness raising.

2.2.4 Both Councils have continued to build effective links with the community safety teams, children's services and adult social care commissioning teams through a variety of strategic, monitoring and operational groups. Safeguarding information is shared with these teams and a number of cases have resulted in improved joint working arrangements.

2.2.5 The safeguarding teams have contributed to the refresh of Central Bedfordshire Council's and Bedford Borough Council's Joint Strategic Needs Assessment with comprehensive information on safeguarding adults. This ensures that safeguarding of adults is a key part of the area's assessment of current and future health and wellbeing needs and part of future service planning.

2.2.6 Both councils have identified that work needs to be done to raise awareness and the profile of safeguarding issues in hard to reach communities such as ethnic minorities and traveller communities.

2.2.7 Central Bedfordshire Council has redeveloped its website which includes a facility to make safeguarding alerts anonymously online. This facility has been used and has resulted in an increase in "hits" to the safeguarding pages of the website. This facility is already established within Bedford Borough Council.

### 2.3 Workforce development

2.3.1 Both Councils have undertaken a range of initiatives to develop the workforce in respect of safeguarding which have been targeted at areas of need for relevant staff. These include:

- Developing guidance documents for staff which includes the links between social work models and safeguarding practice, and quality and safety monitoring which form part of a staff resource pack on the Council's intranet.
- Holding workshops and focus groups with staff to test their level of understanding and confidence with safeguarding.
- Undertaking an assessment of the use and uptake of the competency framework and outcomes. The framework is widely used among care providers and form part of the contracts monitoring and quality assurance work with care providers. The assessment has led to an acknowledgement by the training and development sub group of the safeguarding board, that the competencies will be re-launched in 2012/13 within our social care teams.
- Developing weekly practice surgeries which involve a senior practitioner visiting each team for a day. Feedback from these sessions informs practice development. These have been welcomed by social workers and their team managers in assisting with the improvement of practice.
- Attending every training session on offer for safeguarding and the Mental Capacity Act to evaluate the training. This evaluation has been used to identify gaps in training and those service areas that need to be targeted for training.
- Developing two sets of E learning for safeguarding, for the SWIFT electronic recording system and for contact centre staff. This will assist in improving the recording of safeguarding cases and in raising awareness.
- Developing quarterly peer group reflection sessions for workers to share good practice across all teams.
- Commissioning and implementing a number of safeguarding training courses in a result of feedback from the independent auditor which includes Chairing Safeguarding Case Conferences, Safeguarding Minute Taking, Safeguarding Risk Assessment and Interviewing Alleged Perpetrators.
- Putting in place a programme of observation of chairing and minuting of Safeguarding Case Conferences to improve standards and consistency, by feedback, reflection and analysis.

- Providing 1:1 training/mentoring sessions for individual workers and teams in relation to safeguarding practice. Clear feedback is given and learning outcomes are identified to improve performance.
- Regular meetings are held with the Learning and Development Team and the Safeguarding trainers to ensure the training is meeting the needs of workers and the required standard.

## 2.4 Partnership working

2.4.1 Both Councils, South Essex Partnership Trust (SEPT) and NHS Bedfordshire have worked together to review Serious Incident reporting. This has involved the drafting of a protocol and regular serious incident review meetings which are used to review the outcomes and to gather trends and patterns within health services and subsequently inform the work of the safeguarding board.

2.4.2 The Operational sub group has reviewed its terms of reference to ensure its ability to hold partners to account regarding their reporting and action plans. This is to ensure reporting remains robust and accurate information is supplied to the safeguarding board.

2.4.3 There have been three meetings of the pan-Bedfordshire safeguarding sub groups. This has established stronger links with the Luton Safeguarding Adults Board and has streamlined the work for the benefit of partners who work across Bedfordshire. This sub group continues to look at training and development, quality and activity, and policies and procedures.

2.4.4 The three local authorities and health partners have established a task and finish group to respond to concerns arising from a Care Quality Commission compliance inspection of the Luton and Dunstable Hospital. This has ensured progress is reported through to the safeguarding board and partners are aware of developments in response to the inspection.

2.4.5 Both Councils have worked with South Essex Partnership Trust to improve performance reporting on safeguarding. This includes regular safeguarding reports from SEPT and meeting with the Safeguarding Lead for SEPT to review all alerts received and the timeliness of responses. SEPT has invested in data inputting to enhance the quality of their data. This ensures that patterns, trends and any concerns can be identified early and ensures a coordinated response.

2.4.6 Both Councils have met with community safety teams, the East of England Ambulance Trust and the Public Protection Referral Unit to discuss thresholds of abuse and appropriateness of alerts. Discussions have aided closer links and a better understanding of roles between safeguarding and community safety, the use of data and intelligence to understand themes and trends and publicity and communication. Following these links being established there have been joint training days, regular sharing of data and communications regarding publicity events.

2.4.7 Both Councils facilitate a Providers Forum as a platform for information sharing and to raise topics. A recent forum included presentations on End of Life care and the national Dignity in Care campaign.

2.4.8 Both Councils have attend forums, partnership working groups and meetings including, The Hate Crime partnership, Her Majesty's Prison Bedford Safeguarding Group, County Wide Pressure Ulcer group, Harm Free Care Group, Safer Communities Thematic Partnership, Domestic Violence Sub Group and the Integrated Clinical Governance group to promote joint partnership working.

## 2.5 Quality Assurance

2.5.1 Both Councils have implemented a case tracking tool to assist team managers in monitoring the progress of their safeguarding cases

2.5.2 The Central Bedfordshire Safeguarding team undertake quarterly audits of case files from all teams including SEPT and has commissioned three independent external audits during the year. The results of these audits are fed back to managers and staff, and used to inform practice development work and action planning.

2.5.3 Common strengths arising from the audit work include:

- Multi agency working including working with the regulator where relevant
- Focusing on the views of the person concerned
- Proportionate response ensuring the person is safeguarded
- Concise reporting at the end of safeguarding work

2.5.4 Common areas for development arising from the audit work include:

- The use of risk assessment and protection planning as "live" documents that should be regularly updated
- Focusing on the strengths of the person concerned to safeguard themselves and involvement of family members/ advocates to assist
- The robustness of strategy meetings including follow up of actions
- The ability and confidence of staff to challenge and hold care providers to account
- The sharing the outcomes of safeguarding work with partner organisations

2.5.5 Bedford Borough Council has commissioned three independent audits from an ex regulatory inspector of Safeguarding cases over the last year with the next audit due at the end of July 2012. The audits have recognised the increase in the effectiveness and improvements in safeguarding within Bedford Borough due to:

- The introduction of a case tracking tool
- Good multi agency approach to safeguarding
- Appropriate application of Mental Capacity Assessments
- Robust managerial oversight
- Most of the safeguarding casework is in the range of good to excellent and there are some very good outcomes for service users

Comments from the independent auditor included

*'Cases evidenced a multi-agency approach, very sensitive social work, and appropriate application of the Mental Capacity Act',*

*'The combination of skilled staff, high expectations, a strong team work ethic and really robust managerial oversight, all helps to explain such good outcomes for the service users,*

2.5.6 Areas of improvement and development were identified, including

- A review of safeguarding paperwork to support practice
- The introduction of effective risk assessment
- The introduction of person centred protection plans clearly identifying the views and wishes of the individual
- Streamlining the decision making tool at the point of the initial alert
- A task group has revised all the current safeguarding paperwork in line with the recommendations from the independent auditor including detailed guidance for staff who will be using the revised paperwork. Draft paperwork to be trialled across the teams in July 2012

2.5.7 Central Bedfordshire Council have developed a safeguarding audit tool which has taken into consideration the LGA outcomes audit. This tool also focuses on clear documentation in protection planning and changes in the risk assessment, the balance between personal choice and discriminatory views, unwise decisions and the timeliness of investigation. The audit tool aims to improve practice in safeguarding adults' investigation work.

2.5.8 In Bedford Borough all Safeguarding cases are audited by team managers using the Bedford Borough audit tool which incorporates reflective learning and identifies areas for improvement.

2.5.9 Central Bedfordshire Council have incorporated all the findings and areas for development from the peer challenge in June 2011 into a comprehensive action plan. 85% of the action plan was achieved by March 2011 and the remainder will be transferred into the action plan for 2012/13.

2.5.10 Bedford Borough Council implemented an improvement plan for 2011/12 and the majority of the actions were achieved with 5 actions being carried over to the following year.

## 2.6 Involving people in development of safeguarding services

2.6.1 Both Councils have developed a method of seeking feedback from people who have undergone safeguarding interventions. This involves visits from safeguarding support workers and involves advocacy services. All feedback from these visits is incorporated in to service development work and action planning. Comments arising from these visits have included:

- "The social worker went to visit him a few times, said she was very helpful and easy to talk to. He felt that he was fully informed of what was going on with the investigation and that his views were listened to. At the end of our meeting he said that he would feel happy to contact social services anytime he felt he needed something"
- "When I asked him if he felt safer as a result of the investigation, he responded that he did - he was in a position to change the care agency if he wanted to i.e. felt more empowered."
- "She felt that she was very well supported by her social worker through the whole investigation and was very pleased with her social worker. She felt that she would be able to approach her worker with anything and also would feel comfortable in doing so, and that she would be listened to and taken seriously."
- Service user moved to supported living as a result of the safeguarding investigation. Service user stated that she "felt much safer and is happier now has more friends and is living with other people".
- Service user keeps a copy of action points from the case conference on her wall as a daily reminder of how to keep herself safe
- Service user felt listened to and considered, he was invited to attend the case conference but chose not to but was kept up to date with what was going on.

2.6.2 In Bedford Borough and Central Bedfordshire Council's decision making, the involvement of service users and advocacy services have been the focus of practice development work, best interest's audits and case file audit. While further work is required in this area, the Independent Mental Capacity Advocacy service (IMCA) and advocacy services providers have stated they have seen an increase in referrals to their services.

2.6.3 Central Bedfordshire Council has held three focus groups with people using services to discuss safeguarding and what it means to them. This was combined with the results from the first six months of feedback visits to identify areas for improvement in involving people in safeguarding service development.

2.6.4 Bedford Borough Council has commissioned a 'Keep Safe Course' course for service users with a learning disability to promote personal safety. This course is being facilitated by POhWER Advocacy services.

2.6.5 A workshop has been held with the Central Bedfordshire carers' delivery partnership to look at local arrangements in the context of the ADASS guidance on carers and safeguarding (see 1.2). A number of areas for development were identified and built into the action planning for the next year.

## 2.7 Outcomes and improving people's experience

2.7.1 Both Councils have developed a risk enablement forum, chaired by the safeguarding manager or assistant director, to examine issues where service users appear to be making unwise decisions with regard to their support plan. The forum examines ways in which decisions can be supported and provides a link between personalised support planning and preventing safeguarding incidents.

2.7.2 The Central Bedfordshire safeguarding process now includes an information leaflet which can be personalised to the individual. This contains simple information about what to expect from the safeguarding process and definitions of terms such as “strategy meeting”. The purpose of this is to ensure people understand the safeguarding process.

2.7.3 Initial feedback from Bedford Borough Service user’s who have completed the Service User Feedback form has indicated a need to develop user friendly information leaflet explaining the Safeguarding process and what to expect. A draft leaflet is being compiled.

2.7.4 Central Bedfordshire Council has developed a one day mandatory training course for social workers entitled “Safeguarding – planning a personalised response”. This training course was developed with the assistance of an “expert by experience” and focuses on communication and involvement of service users and their families and advocates throughout the safeguarding process.

2.7.5 Central Bedfordshire Council has been successful in obtaining funding from the Social Care Institute for Excellence to run a year long pilot under the Social Work Practice Pioneer Project. This looks at the concept of family group conferences in adult safeguarding (called “Network Meetings”). This enables individuals and their network of family or friends to meet together in a supported environment to develop their own plan to address safeguarding concerns. At the time of writing three of these meetings have been held with positive outcomes for individuals concerned.

Comments from people who have used a network meeting included:

- *I would like to express my gratitude for the chance to talk, I wouldn’t change any of it*
- *I feel more happy and content now we have sorted things out*
- *I would recommend a network meeting to other people*
- *Longest time I can remember that we had sat face to face and had a conversation*

The learning and outcomes from this work is being shared with Bedford Borough to ensure learning across the partnership.

### 2.8 Use of the Serious Concerns Procedure

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

2.8.2 Central Bedfordshire Council has initiated the serious concerns procedure in relation to four services during 2011/12. These concerned three nursing homes for older people including dementia and one service for people with learning disabilities.

2.8.3 The concerns for all of these services arose from reported safeguarding alerts that in turn revealed wider issues with service provision. Common to all of the concerns was the service response to safeguarding investigations. This included the standard of care and support for people with very complex needs, people at the end of life, people showing challenging behaviour as a result of dementia and mental ill health and people with severe learning disability and complex physical health needs.

2.8.4 As a result of these serious concerns individual actions plans were set up with each service in order to address their specific development needs. In addition, NHS Bedfordshire and Central Bedfordshire Council learning and development team have worked together to look at nursing competencies in care homes in the area, and are working with local care homes to offer training and support for nursing homes.

2.8.5 Bedford Borough Council has temporarily suspended services from several providers due to concerns about the standard of service delivery. The Care Standards Monitoring Team has actively worked with these providers to improve standards by implementing an improvement plan to address the specific issues. None have gone to Serious Concerns and all resolved in partnership with the local organisation.

2.8.6 Bedford Borough Council has developed a new Suspension of Care Services Protocol. The quality of care provided or commissioned by Bedford Borough Council is monitored by Bedford Borough Council in partnership with the Care Quality Commission and takes the form of specific contractual conditions and routine monitoring. Where any care provider continues to fall short of their duty of care, despite increased intervention and support from the various inspections/monitoring bodies the protocol will be used to place a suspension on the provider which will remain in place until improvements have been addressed.

## 2.9 Serious Case Reviews

2.9.1 The purpose of a Serious Case Review is to establish the lessons learnt from a case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults at risk. It is used to identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result. As a consequence the outcomes are to improve inter-agency working and better safeguard and promote the welfare of adults at risk.

2.9.2 Central Bedfordshire Council initiated one serious case review during 2011/12. D was admitted to Hospital with a suspected stroke. Examinations revealed that she was suffering from advanced stage cancer and given a poor prognosis, it was decided that she would be provided with palliative care. It was arranged that this would be provided in a local nursing home, where her husband had been admitted when D was taken into hospital. She had been his carer, as he suffered from dementia. She was admitted to the same care home and died three days later.

2.9.3 The family and some professionals raised concerns about the care that D had received and a safeguarding investigation was commenced. The outcome of the safeguarding investigation was 'not determined/ inconclusive' and a recommendation was made to the Safeguarding Adults Board that they consider commissioning a Serious Case Review in order to give further consideration to the circumstances of D's care.

2.9.4 The Serious Case Review found that:

- There was not complete clarity about the overall leadership and accountability for the detailed elements of D's care and this led to some differences in expectations.
- Feedback and conversations were not always well documented, well coordinated or subject to the same understanding by all concerned.
- Recording was not always consistent within and across the agencies. Some important documents were not provided, not available at the time, or were incomplete.
- There was no multidisciplinary care planning meeting involving all the relevant agencies outside the hospital and linked disciplines.
- Placement options were limited, given the lack of available, suitable places and the wish to place D close to her husband.
- The nursing home's known lack of experience in palliative care meant that they did not understand the external support that could be made available.

2.9.5 All agencies involved have developed comprehensive action plans which are being monitored through quarterly reports to the safeguarding board. A local End of Life Strategy has been initiated since this review by NHS Bedfordshire which addresses many of the communication and coordination concerns across the locality.

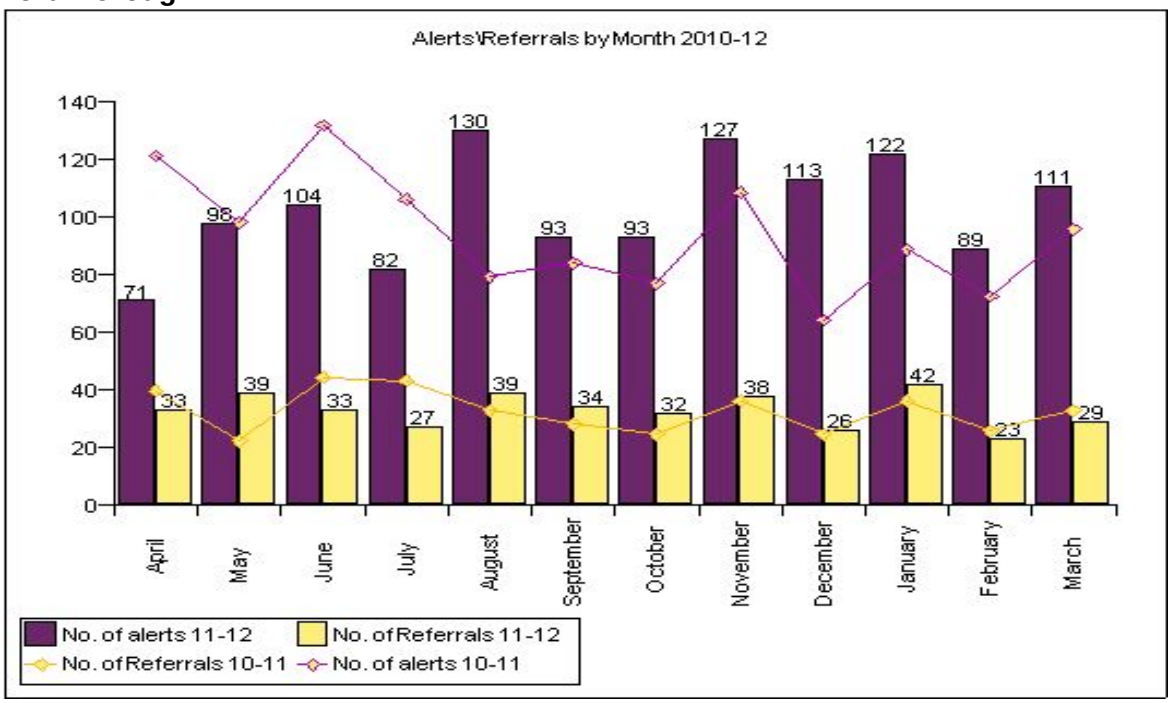
2.9.6 Bedford Borough Council has had no Serious Case Reviews.

2.9.7 The Luton and Dunstable Hospital in conjunction with Luton Borough Council safeguarding adults' board initiated a review following a number of allegations by patients during early 2011. Bedfordshire Police began an investigation into alleged serious sexual offences on former patients of Ward 17 at the hospital; a member of staff was arrested, questioned and released on police bail pending further enquiries. In September 2011 the suspect, who was due to appear at Luton Crown Court in respect of these offences, was found dead at his home. The review has been commissioned to examine the lessons to be learned from this case, and a report is due in the autumn of 2012.

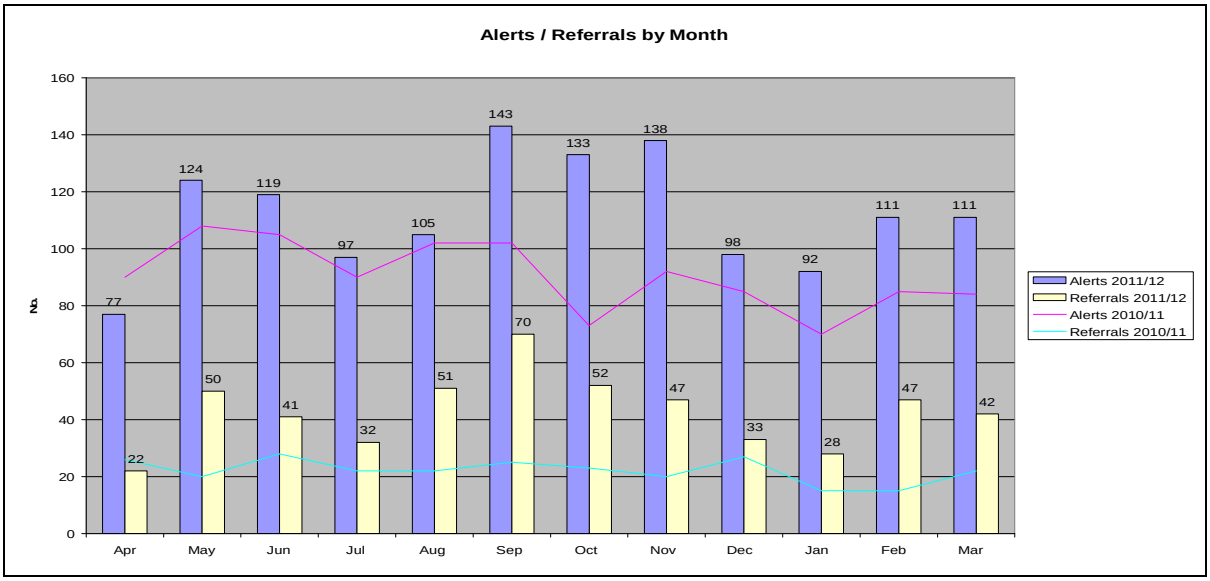
## 3. Safeguarding Activity April 2011 – March 2012

### 3.1 Number of alerts and referrals

**Bedford Borough**




**Central Bedfordshire**

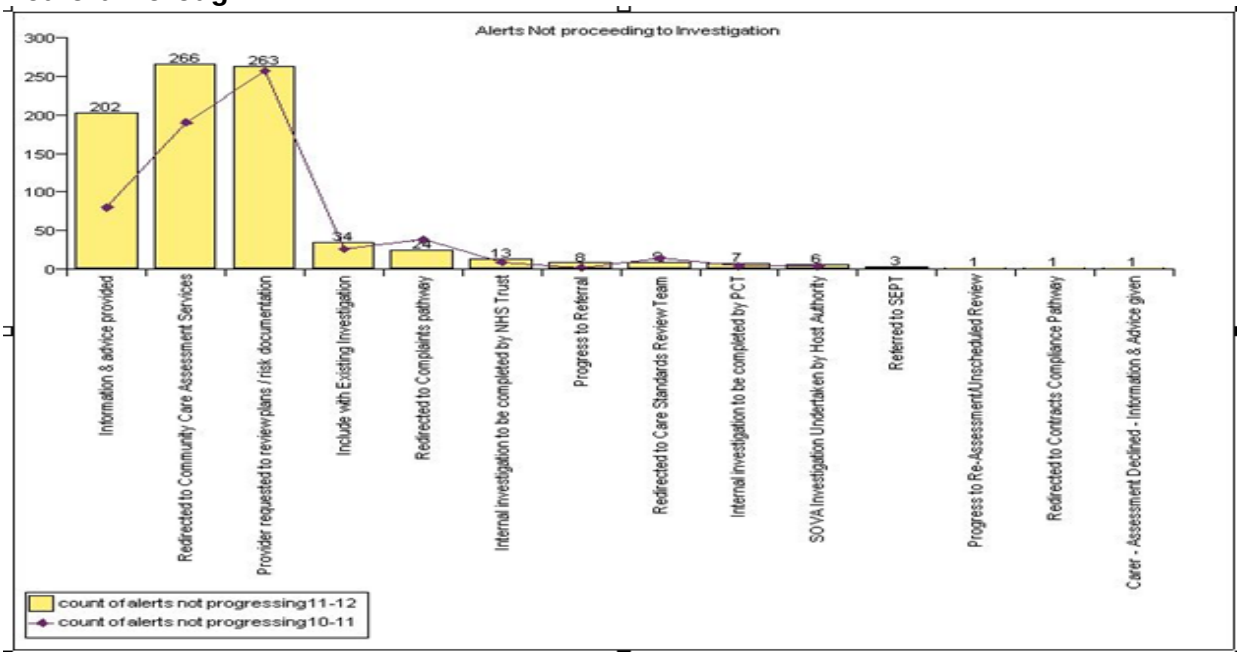



4.1.1 Bedford Borough Council received 1233 alerts in comparison to 966 in 2010-2011, an increase of 267 alerts. In comparing month for month between both years, August and December are reflecting significant increases. During 2011-2012 the total number alerts which progressed to an investigation were 395, an increase of 61 from 2010-2011. This is the third year of continued increases in the number of alerts and referrals which can be attributed to the ongoing safeguarding awareness campaign which commenced in 2010.

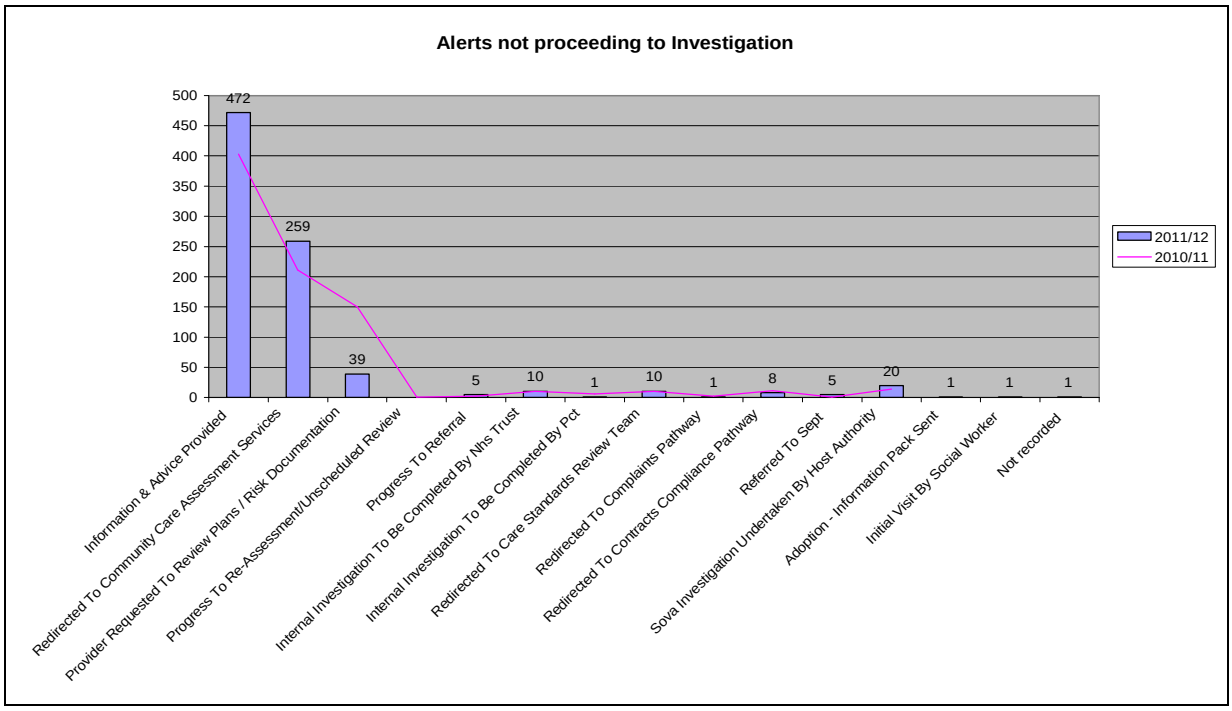
4.1.2 Central Bedfordshire Council received 1348 alerts during the year. 515 (38%) progressed to a referral. This is an increase from the previous year by 262 alerts. This increase has doubled from the year 2009/10, showing an upward trend over three years. The number of alerts progressing to referral has doubled from 265, and represents a greater proportion in percentage terms – from 24% to 38%. This is showing increasing appropriateness of alerts. Higher numbers and higher proportion of alerts progressing to investigation suggests that the significant awareness raising that has been carried out since 2010 is having an effect.

## 4.2 Alerts not proceeding to referral (investigation)

### Bedford Borough




### Central Bedfordshire



4.2.1 The number of alerts received which did not result in an investigation totalled 838 in 2011-2012, an increase of 206 from the previous reporting year. It is worth noting that of the 838 alerts received:

- 202 resulted in information and advice being provided, an increase of 123 from the previous reporting year
- 263 alerts resulted in providers being requested to reviews plans and risk documentation, an increase of 6 from the previous reporting year
- 266 alerts were re-directed to community assessments team, an increase of 76 from the previous reporting year

4.2.2 Over half of the safeguarding outcomes make up information and advice as well as requesting providers to review risk assessments. The fact that the safeguarding outcomes consume a significant amount of time to process also demonstrates a high level of alerts being raised of a low key nature which are being managed by routes other than safeguarding. This requires a review of the current safeguarding thresholds in order to establish whether the thresholds are causing the high volume of alerts not requiring a formal safeguarding investigation.

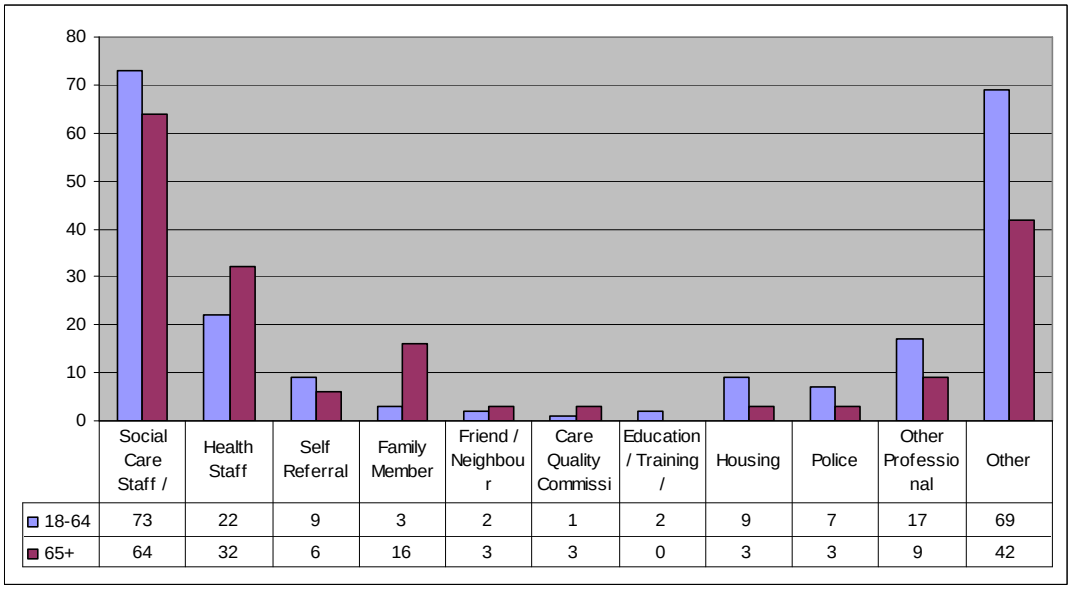
4.2.3 In addition to this a review of the 266 alerts re-directed to community assessment teams requires further analysis as most of these alerts should have been directed towards first point of contact. Brief analyses so far indicate over reporting on what constitutes a safeguarding alert and inappropriate use of safeguarding procedures.

4.2.4 Central Bedfordshire received 833 alerts which 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. This is similar in number and pattern to the previous year. The majority, 62% of alerts, do not progress to investigation, and the safeguarding team continues to identify areas where understanding of what constitutes a safeguarding alert could be developed.

4.2.5 A significant number of alerts are made by social work or related professional staff. A relatively low proportion of these alerts progress to a referral. A significant factor in these referrals is that safety or vulnerability concerns have been correctly identified by the worker who has responded appropriately to the issue, but may be using the safeguarding alert system as a “safety net” to record concerns.

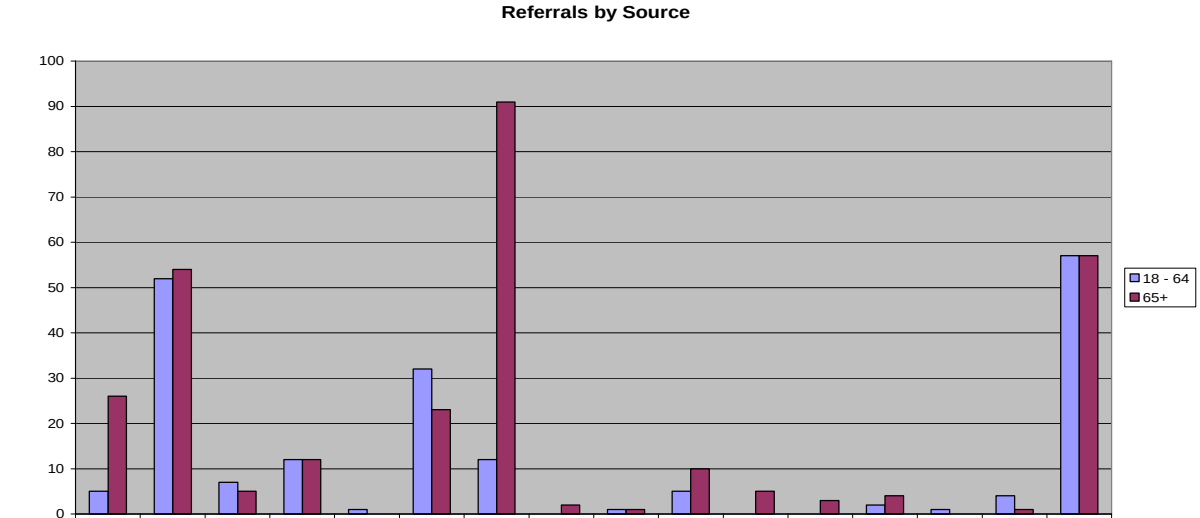
## 4.3 Source of referral

### Bedford Borough




| | Social Care Staff / | Health Staff | Self Referral | Family Member | Friend / Neighbour | Care Quality Commissi | Education / Training / | Housing | Police | Other Professional | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 18-64 | 73 | 22 | 9 | 3 | 2 | 1 | 2 | 9 | 7 | 17 | 69 |
| 65+ | 64 | 32 | 6 | 16 | 3 | 3 | 0 | 3 | 3 | 9 | 42 |

## Central Bedfordshire




| | Domiciliary Care Staff | Residential Care Staff | Day Care Staff | Social worker/Care | Other Social Care | Mental health staff | Primary/Community | Secondary Health Staff | Self referral | Family member | Friend/neighbour | CQC | Housing | Education/Training/Workp | Police | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 - 64 | 5 | 52 | 7 | 12 | 1 | 32 | 12 | 0 | 1 | 5 | 0 | 0 | 2 | 1 | 4 | 57 |
| 65+ | 26 | 54 | 5 | 12 | 0 | 23 | 91 | 2 | 1 | 10 | 5 | 3 | 4 | 0 | 1 | 57 |

4.3.1 In Bedford Borough it is evident that the majority of referrals are sourced from social care staff (as defined, in the "*Abuse of Vulnerable Adults Collection (AVA)).* The breakdown of social care staff range from residential, day care, domiciliary and social workers reporting an alert. This is not surprising as Bedford Borough currently hosts 149 regulated social care providers within its area. Figures for this report show a slight reduction in the number of referrals for alerts raised from Social Care Staff from last year, 146 reduced to 137; this is likely to be as a result of more robust screening at the alert stage from the Safeguarding Team, where alerts not progressing to the referral stage are signposted through other routes. These figures also demonstrate a clear awareness of reporting an alert within the social care provider arena but it is the nature of the reported alerts as previously mentioned requires further analysis as to the constant high volume of alerts that do not require a formal investigation.

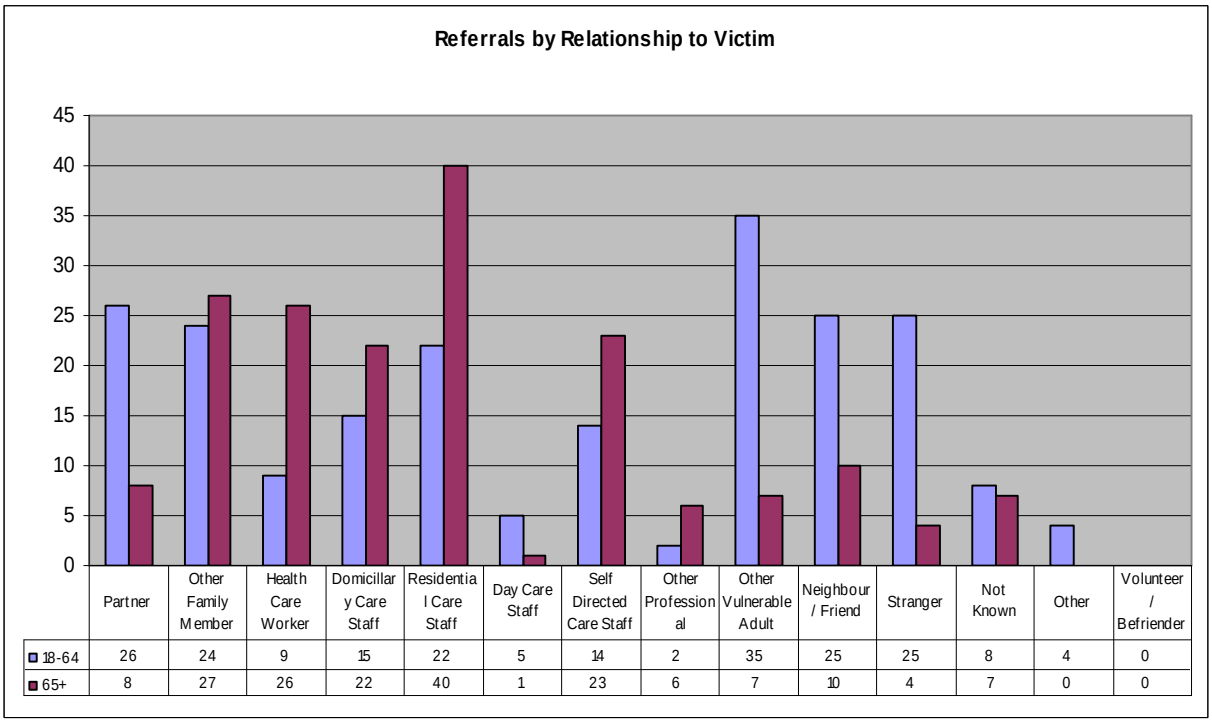
4.3.2 The social care staff category includes 16 alerts from day care staff, 38 alerts from domiciliary staff, 96 alerts from residential staff, 10 alerts from social worker/care manager and 3 alerts from social services/other. This is followed by alerts from health care professionals and others, which would include voluntary organisations, probation and other local authorities. The main source of referrals within social care is predominantly from residential staff and nursing care staff and domiciliary care staff, which equates to 137 referrals out of the 163 for the social care category. A high proportion of referrals relate to the over 65 age group, this is not surprising given that the majority of people in residential care will be from the over 65 age group, and a significant proportion of people receiving care in their own home will be over 65. The increased level of reporting is likely to be a result of ongoing training and the impact of the Dignity in care campaign.

4.3.3 However it is worth noting the low number of 24 alerts received from individuals in the community signifies that more community work is required to raise safeguarding awareness to marginalised communities in Bedford with a clear focus on more outreach work in terms of awareness and accessibility should be considered for action in 2012-2013.

4.3.4 In Central Bedfordshire almost one quarter (22%) of referrals came from residential and nursing care staff. This is consistent with last year's trend. Half of all referrals come from community professionals, such as social workers and health care staff. A significant figure to note is the large proportion of referrals in relation to people over the age of 65, made by primary or community health care staff. This trend was notable in the previous year's figures. This is likely to be in response to the significant awareness raising undertaken within the health care sector during the past two years; also that community health care workers are likely to be those who come in to most contact with older people living in the their own homes. Given that there has been a sharp increase in incidents within people's own homes, it is also notable that reports by family members remain low, meaning that social services remain reliant upon the community professionals that work with people's homes

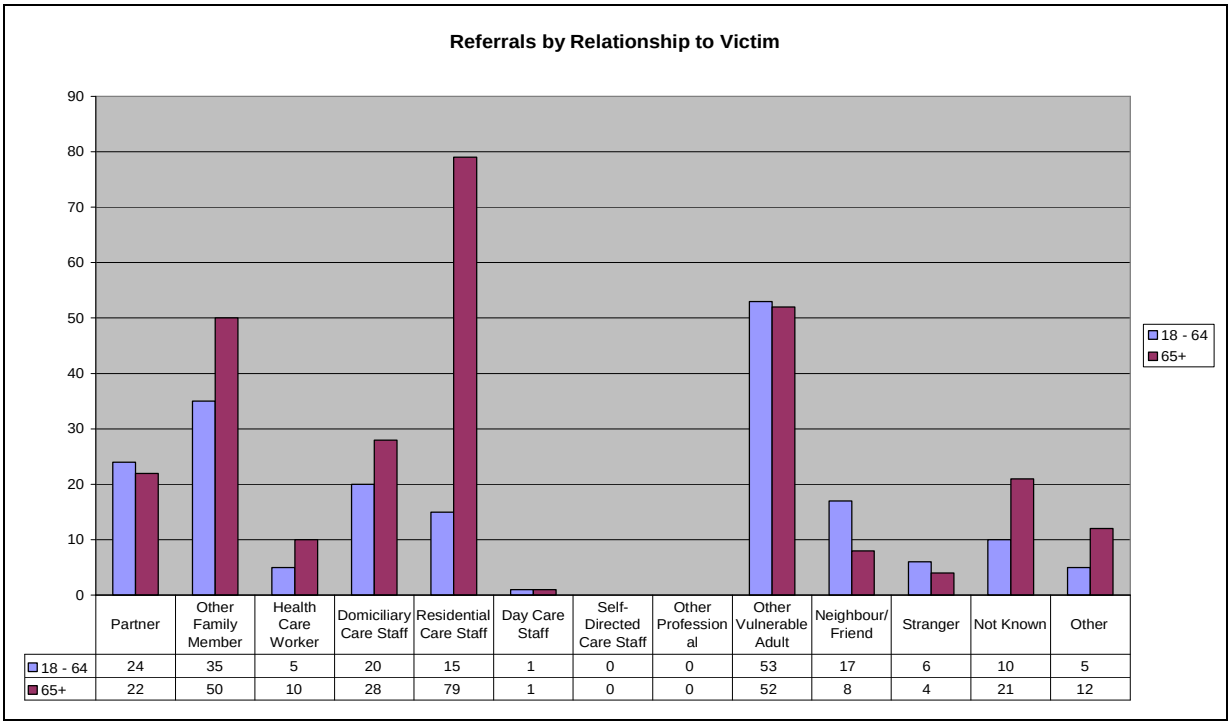
## 4.4 Relationship to victim

### Bedford Borough




| | Partner | Other Family Member | Health Care Worker | Domicillary Care Staff | Residential Care Staff | Day Care Staff | Self Directed Care Staff | Other Professional | Other Vulnerable Adult | Neighbour / Friend | Stranger | Not Known | Other | Volunteer / Befriender |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18-64 | 26 | 24 | 9 | 15 | 22 | 5 | 14 | 2 | 35 | 25 | 25 | 8 | 4 | 0 |
| 65+ | 8 | 27 | 26 | 22 | 40 | 1 | 23 | 6 | 7 | 10 | 4 | 7 | 0 | 0 |

## Central Bedfordshire




| | Partner | Other Family Member | Health Care Worker | Domiciliary Care Staff | Residential Care Staff | Day Care Staff | Self-Directed Care Staff | Other Professional | Other Vulnerable Adult | Neighbour/ Friend | Stranger | Not Known | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 - 64 | 24 | 35 | 5 | 20 | 15 | 1 | 0 | 0 | 53 | 17 | 6 | 10 | 5 |
| 65+ | 22 | 50 | 10 | 28 | 79 | 1 | 0 | 0 | 52 | 8 | 4 | 21 | 12 |

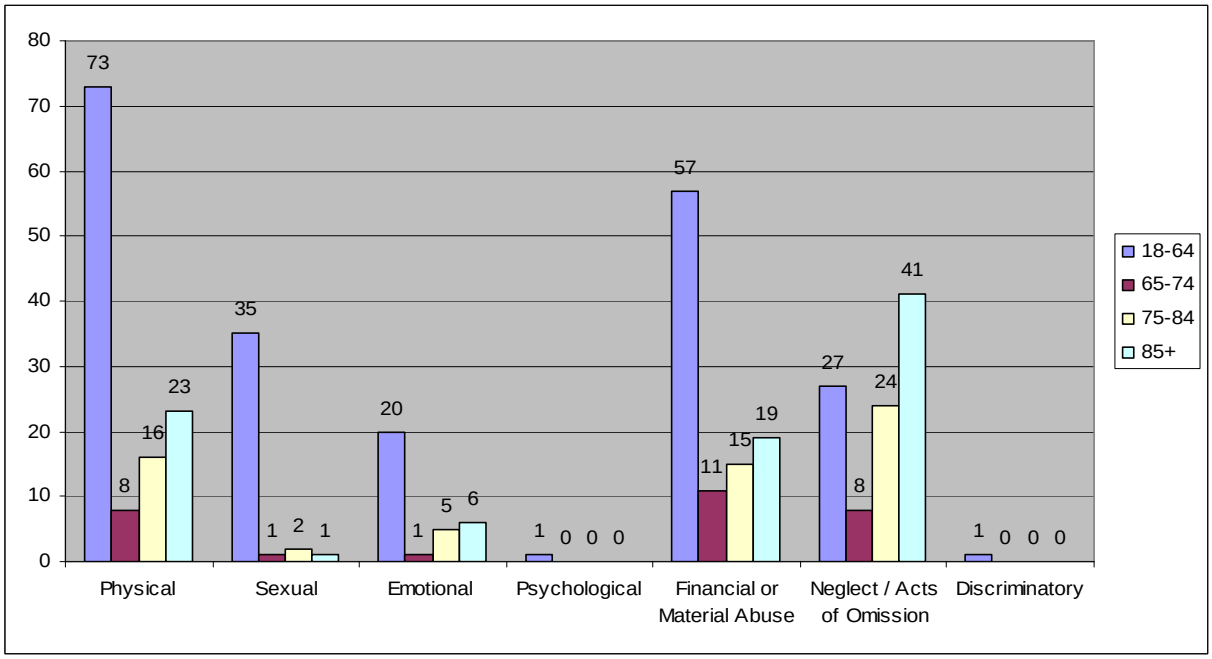
4.4.1 In Bedford Borough the relationship of the alleged perpetrator to the alleged victim is predominately paid carers as where the evidence suggests that the location of the abuse tends to occur more within the persons own home followed closely by care homes by paid care providers. This is not surprising as the number of individuals remaining supported in the community are supported via social care providers and through self directed support via a personal assistant who could also be a member of a family. In addition to this Bedford Borough also hosts and supports 149 regulated providers within its area through its Care Standards Monitoring and Review Service who actively work and engage with social providers through site visits, improvement plans, provider forums and safeguarding awareness. Furthermore as previously mentioned there is clear evidence linked to the number of high alerts from social care providers with an awareness of safeguarding.

4.4.2 In Central Bedfordshire 33% of alleged perpetrators of abuse are the family or known to the person; 33% are paid carers, and just under one quarter (22%) are other vulnerable people. This is consistent with trends from the previous year.

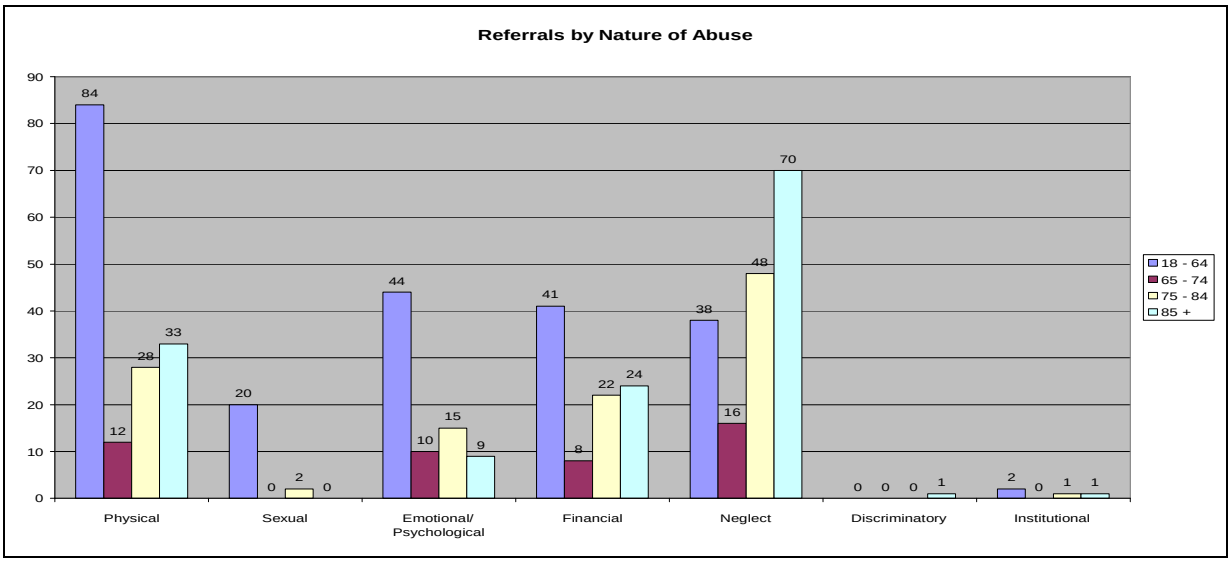
4.4.3 Both Councils note that the category of “other vulnerable person” usually refers to other people living in the same residential, nursing or supported living accommodation or user of a day service. Many of these incidents refer to incidents of violence or aggression between people living in the same place. These incidents would progress to an investigation if the incidents are severe, repeated or there are concerns about the way the care provider or supporting staff have responded to the incident.

## 4.5 Types of abuse

### Bedford Borough




### Central Bedfordshire




4.5.1 In Bedford Borough physical abuse remains the most common form of abuse reported across all age categories. This is followed closely by reported financial abuse and neglects/act omission of care. In the over 65 categories the most common forms of alleged abuse are neglect and acts of omission and examples of this include medication administration errors, poor hospital discharges, missed or poor domiciliary care support and incidents within residential care. Trends and patterns are monitored and care providers are offered a safeguarding awareness presentation if appropriate, or sign posted to further safeguarding training. Across all the types of abuse for the 85+, it is neglect that remains the biggest category. Financial abuse has increased slightly with the largest increase within the 18-64 group. As more self directed support is commissioned, the opportunity for financial concerns increases in vulnerable groups. This situation has to be taken alongside the current financial recession and the impacts on family life.

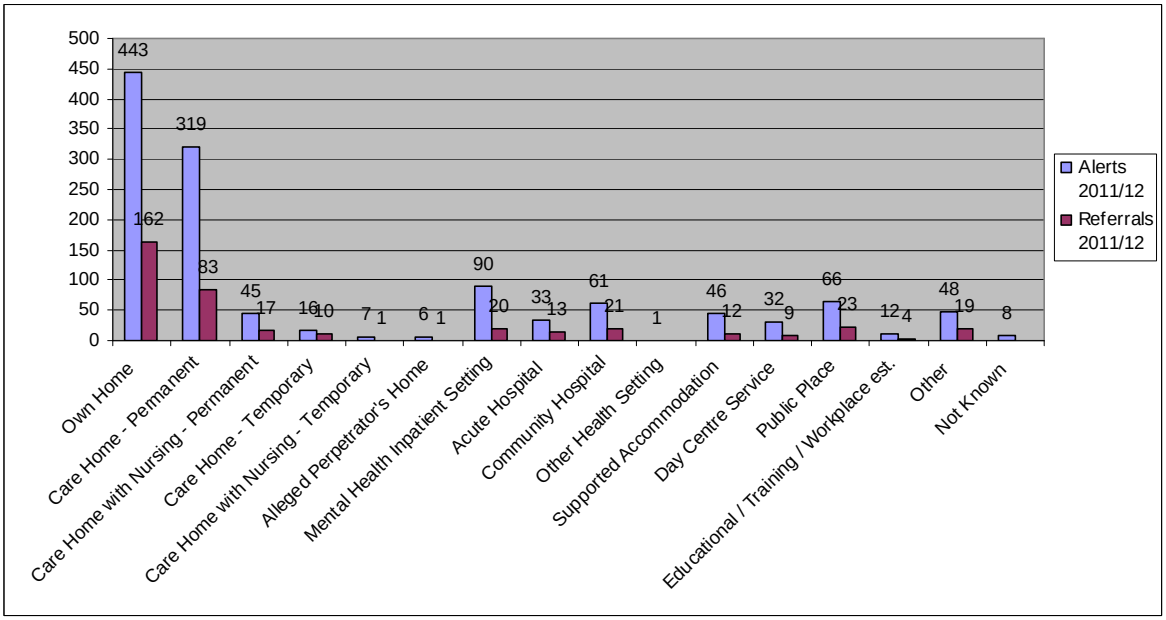
4.5.2 For people under the age of 65 in Central Bedfordshire, physical abuse is the most common form of referral, and sexual abuse is far more prevalent than with people over the age of 65. A high proportion of these figures relate to incidents between people with a learning disability living in supported living (see 4.4). Where risk is assessed to be relatively low, staff are considering more creative responses to these incidents than has previously been the case. For example: An alert

was made to report that a person with a learning disability had been hit by a peer while at church. The social worker visited the alleged victim while at home in her supported living accommodation. The alleged victim stated that she did not wish to contact the police or engage the service provider in protecting her. She stated that she wished to convene a meeting with the perpetrator who she was friends with, and some the elders from her church, and her advocate. This meeting went ahead without the social worker present, who then met the alleged victim afterwards to ensure it had gone to plan. This was documented using the safeguarding process but without the need for formal professionals meetings. The outcome was that the two people concerned were able to discuss the issue with the support of people they trusted.

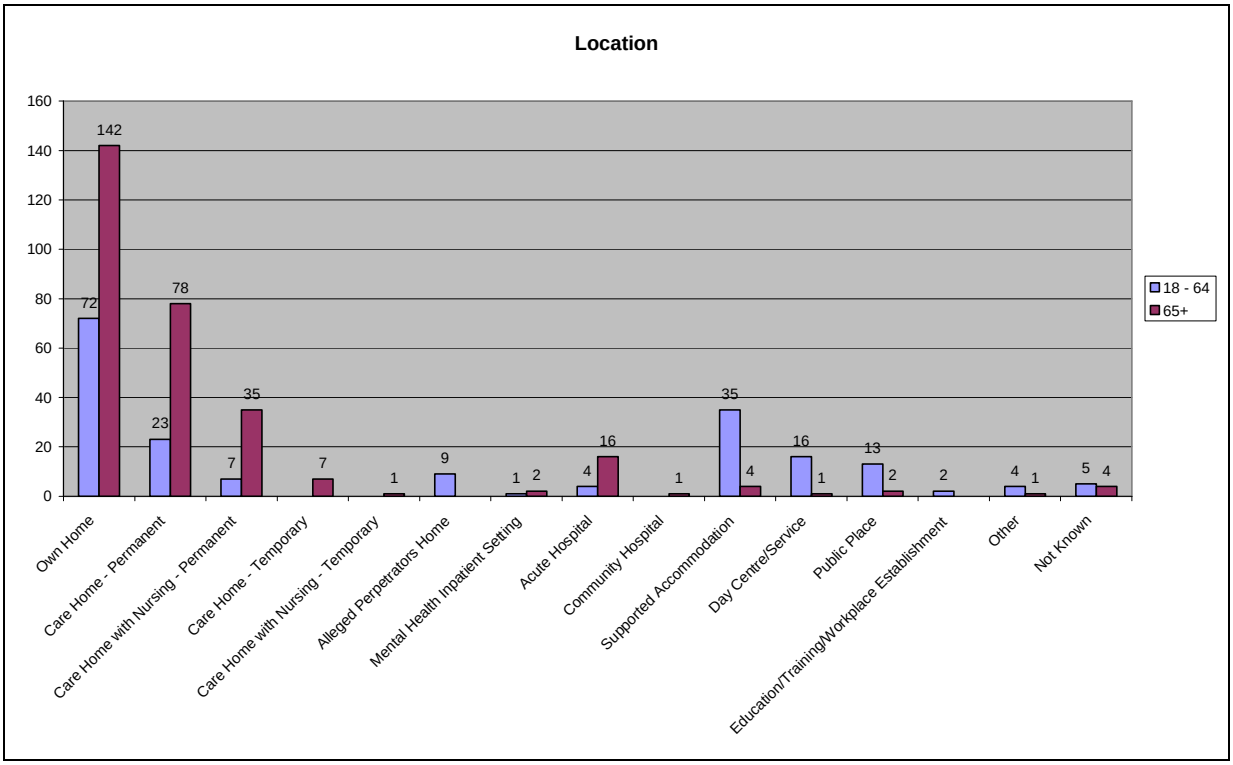
4.5.3 For people over the age of 65, neglect is the most common form of referral. This may relate to older people in care homes, as well as older people living in their own homes. There are higher incidents of physical, financial abuse and neglect for the age group over 85 than for those aged between the ages of 65-85. The figure for financial abuse has increased in this age group from the previous year. In all areas, referrals have increased, but by different proportions. It is notable that emotional/ psychological abuse and neglect have seen the greatest increase in referrals since 2010/11, with an increase of over 100%, whereas referrals for financial and physical abuse have increased by between 60-70%.

## 4.6 Location of abuse

### Bedford Borough



**Central Bedfordshire**




4.6.1 In Bedford Borough the location of alleged abuse continues to support the notion of agencies/social care staff reporting on abuse within the persons own home where the alleged perpetrator is a paid carer. In Bedford Borough in 2011-2012, the number of allegations which took in a person's own home is 162, an increase of 34 (26.5%) on the previous reporting year. This is likely to be linked to a number of factors such as more paid support being provided within the home environment combined with a greater awareness of safeguarding by agencies and increased level of reporting. An increasing number of self neglect referrals being received where a professional has raised a concern about the environment and lifestyle choices that a person has made and is deemed to have capacity.

4.6.2 The number of alleged abuse which took place in care homes has risen to 111, an increase of 14 from the previous reporting year. This is likely to be linked to a number of factors such as a greater awareness of safeguarding by care home providers, high proportion of care home providers located within Bedford Borough reflect the proportionate number of alerts received combined with an ageing population and increasing number of alerts where service users are the alleged perpetrator.

4.6.2 In Central Bedfordshire there has been a notable increase in referrals relating to people living in their own home. There are several possible factors that may all be contributing to this change in alerting patterns:

- The success of the safeguarding awareness campaigns during the past 18 months
- The increased awareness of professionals that "unwise decision making" could be treated as a safeguarding concern even when the individual has mental capacity. 26 alerts were received during the year in relation to "self neglect" which would fall into the category of neglect.
- The increased number of people being supported at home rather than using residential care, and relying on family carers
- The current economical climate leading to situations where families are financially stretched or feeling stressed

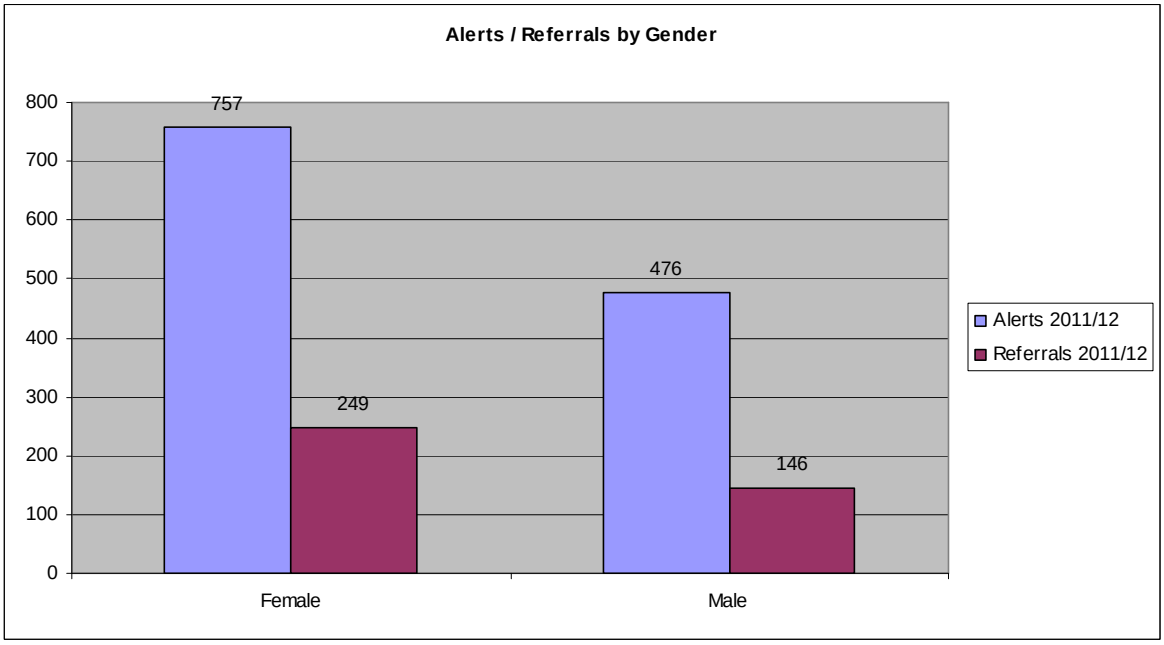
4.6.3 There is some credence to the last two points given that there has been such a sharp increase in neglect and emotional/ psychological abuse compared to the previous year, and the proportion of families who are involved in incidents. For example, where family carers are feeling stretched this may inadvertently lead to challenging situations giving rise to neglectful or emotionally stressful

behaviours. In audit work, complex family relationships have been identified as a significant factor in safeguarding cases taking longer than 35 days.

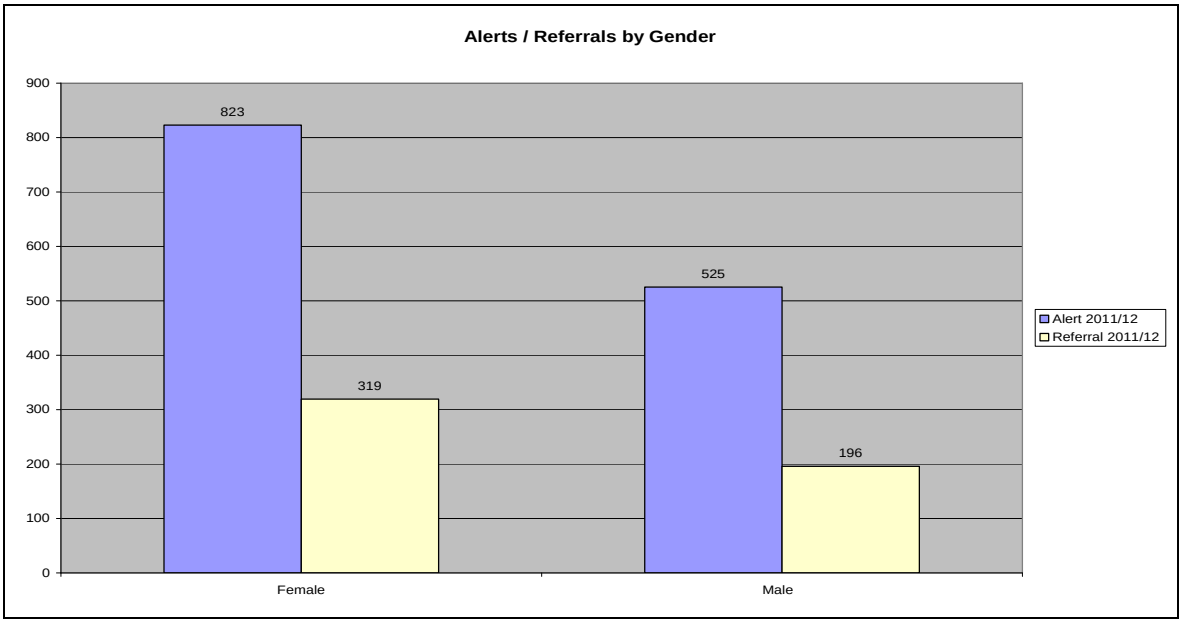
4.6.4 The greater proportion of alerts relating to people in their own home progress to referral. This may be because at the point of assessment the risk may be deemed as higher because the person may not have the monitoring or support expected in other settings. This may also be because the alerts are more appropriate.

### 4.7 Alerts and referrals by gender

**Bedford Borough**



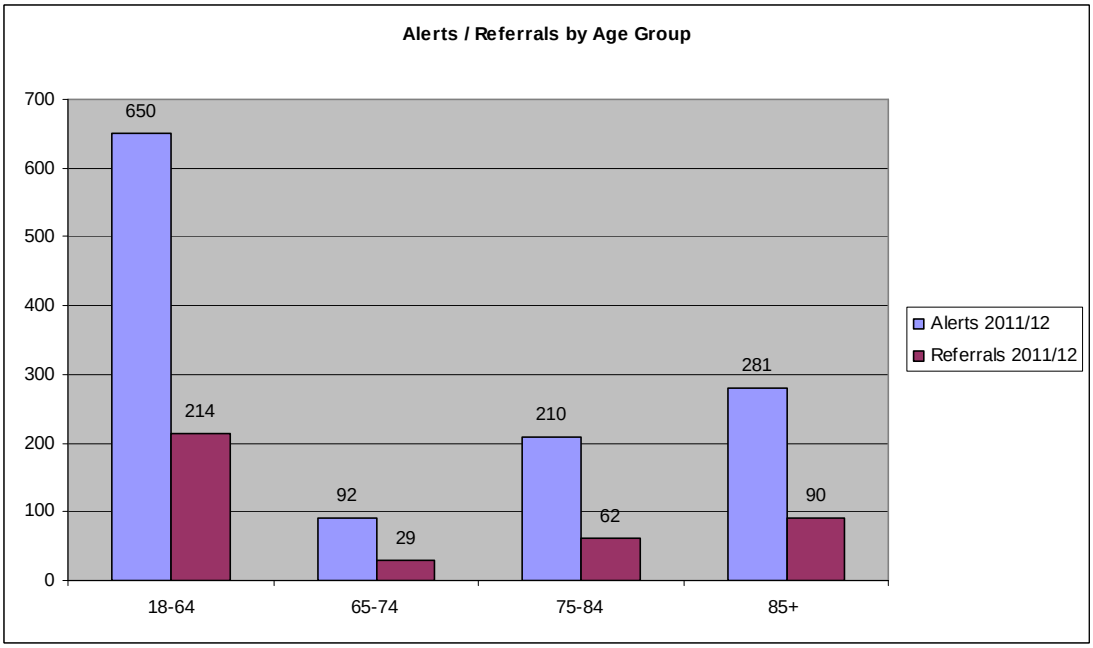

**Central Bedfordshire**



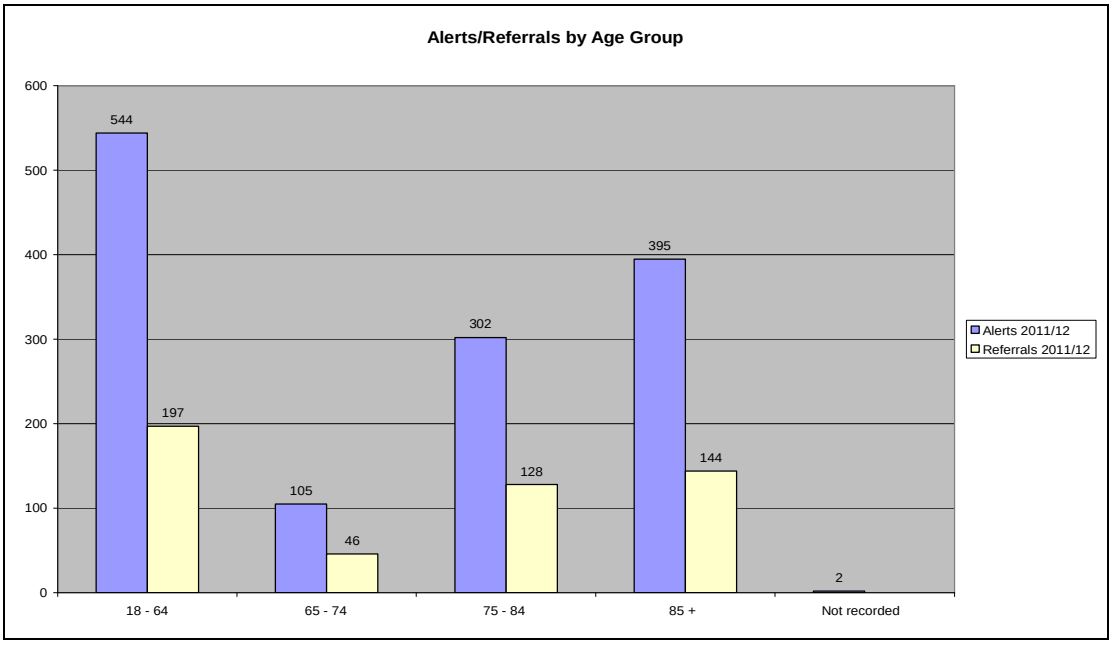

4.7.1 Both Councils report that the larger proportion of alerts and referrals relate to women. This reflects the national trend were female life expectancy is significantly higher than males and therefore not surprising that there is a higher proportion of females being reported who use our services. Alerts come from residential and inpatient units, as well as people using domiciliary care services at home, where the perpetrator is a paid staff member. The overall numbers in relation to both men and women have increased from the previous year.

## 4.8 Alerts and referrals by age group

### Bedford Borough




### Central Bedfordshire



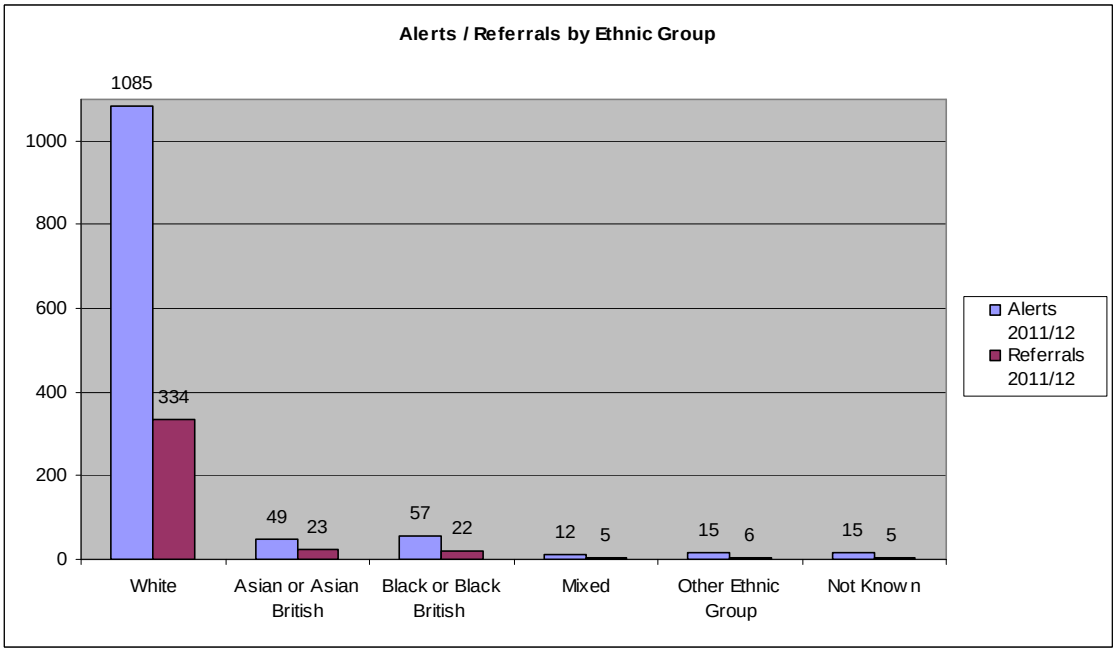

4.8.1 In line with the previous year for Bedford Borough, the majority of safeguarding alerts and referrals relate to people aged 18-64. Many of these alerts relate to incidents between people using services, a proportion of perpetrators are assessed as lacking capacity to be accountable for their actions.

4.8.2 Ongoing awareness of the Dignity in campaign continues to give the message that dignity is paramount and services should deliver it for their service users.

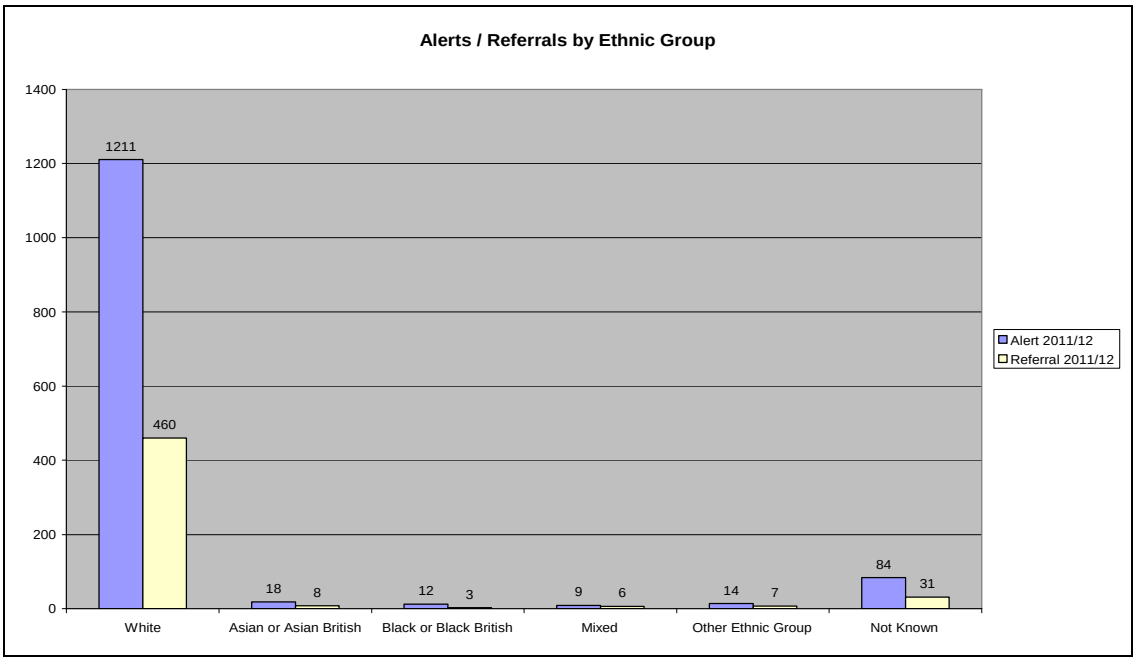
4.8.3 It is notable that as a proportion of referrals overall, 62% relate to people over the age of 65. This is a reflection of the population within Central Bedfordshire that receive support in relation to health and welfare. The proportion of alerts that progress to referral is the same whether the person is over or under age 65. Of those people over the age of 65, a slightly higher proportion is over 85.

## 4.9 Alerts and referrals by ethnic group

### Bedford Borough




### Central Bedfordshire



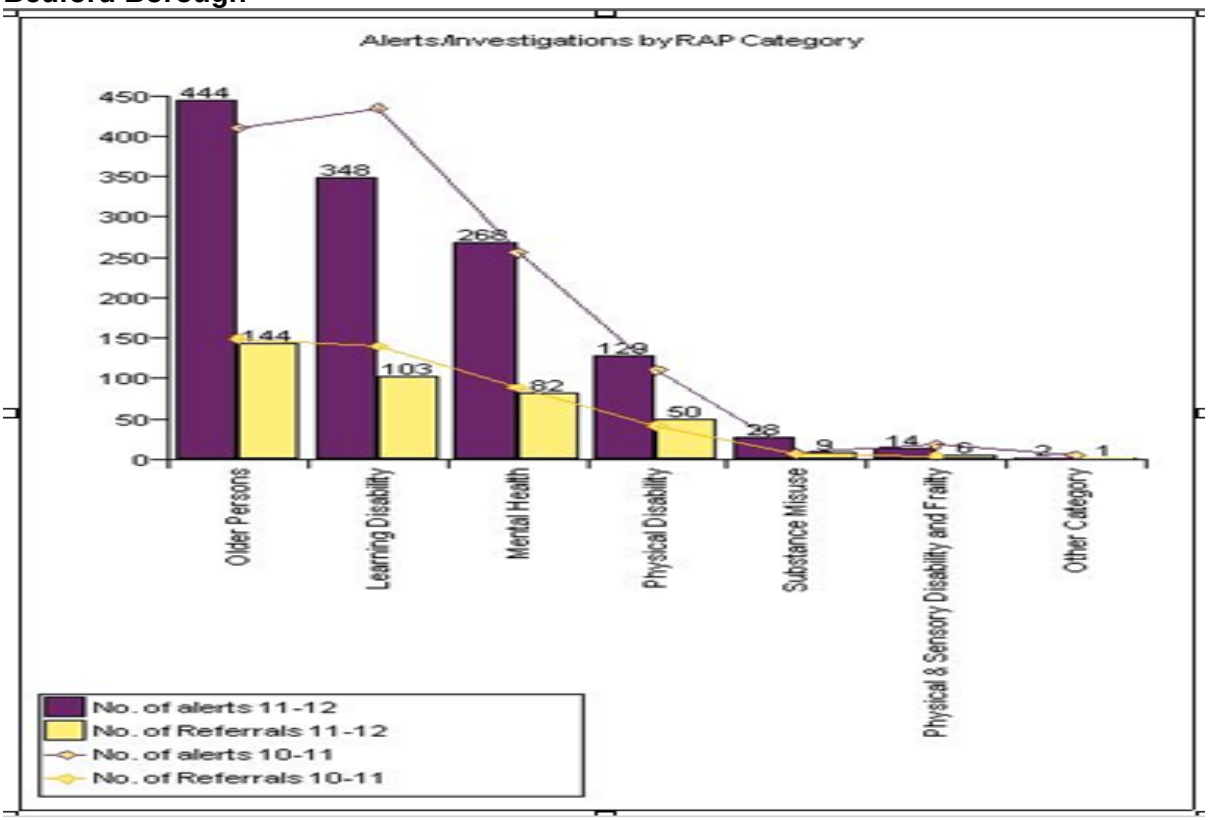

4.9.1 The number of alerts received by ethnicity in Bedford Borough continues to reflect the overall population mix of the local community. This is confirmed from the 2001 census where the population mix at the Borough reflected 82.2% as White British correlates with ethnic breakdown of alerts received. Although there has been some minor fluctuation in the numbers from different ethnic backgrounds there are no clear or established patterns or reasons for this. However it is worth noting the consistent low number of alerts received from individuals in other ethnic communities signifies that more community work is required to raise safeguarding awareness to such communities in Bedford with a clear focus on more outreach work in terms of awareness and accessibility should be considered for action in 2012-2013.

4.9.2 90% of alerts and referrals in Central Bedfordshire relate to White British people. 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. There has not been a change in

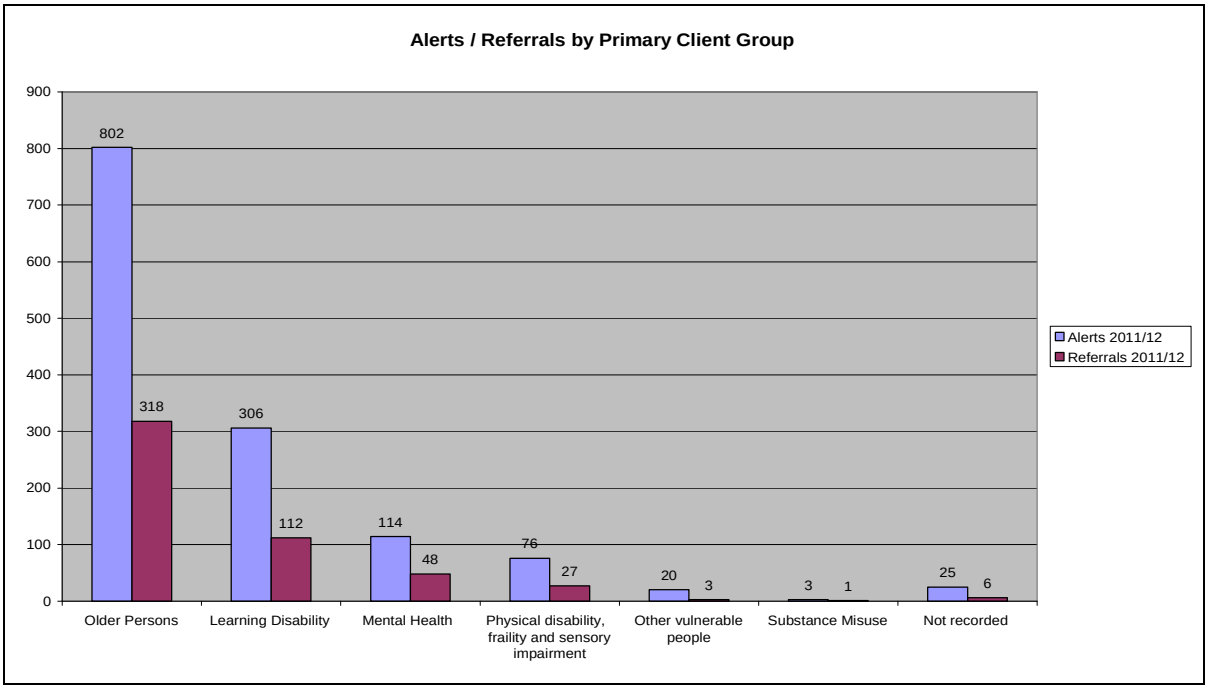
patterns over the previous two years. The proportion of alerts progressing to referral for White British people is the same as for people of other ethnicities, and there has not been a change over the previous two years.

## 4.10 Alerts and referrals by support need

### Bedford Borough




### Central Bedfordshire




4.10.1 The proportion of alerts received by client category continues to show older persons as the highest reporting client group, closely followed by Learning Disability and Mental Health which

have been consistent with previous year reporting. This is likely to be associated with the large number of alerts received from care providers in care settings and home care which a significant number of people supported are in the Older Persons and Learning Disability Category and where the service user is reported as the alleged perpetrator.

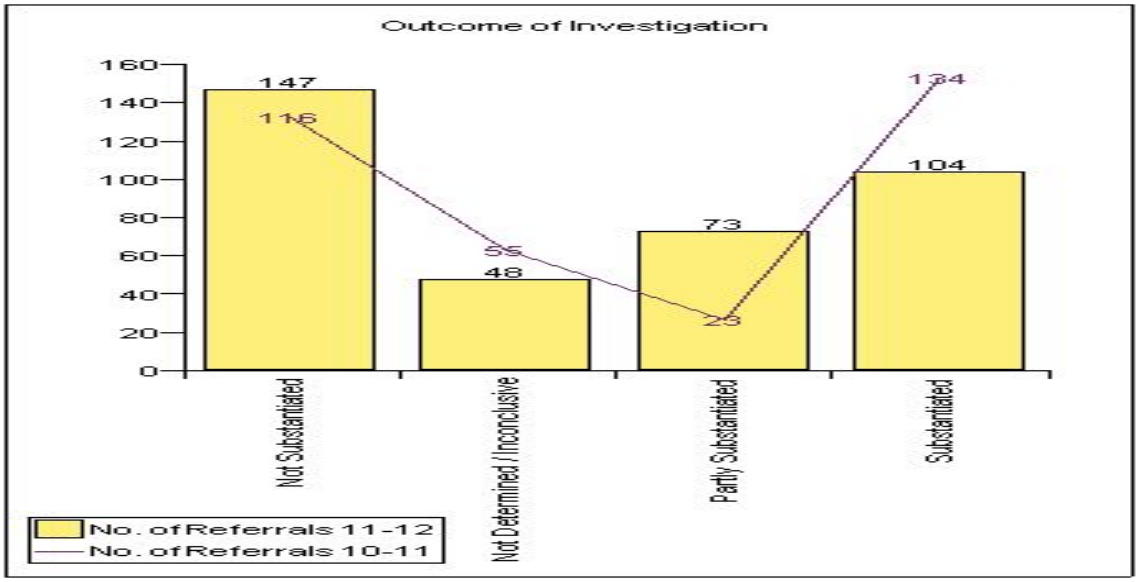
4.10.2 In Central Bedfordshire alerts relating to people with mental health needs remain low, with one third of these progressing to referral.

4.10.3 The majority of these alerts relate to people within their own home, acts of physical or emotional abuse perpetrated by someone known to the person in an unpaid capacity. Frequently these individuals have been supported to address the concerns themselves by accessing mainstream services such as the police or mental health services and have not required or requested further safeguarding interventions. However, there has been a notable increase in the proportion of alerts progressing to referrals from the previous year, from 26% to 42%. This may be an indication of more appropriate alerting in this area.

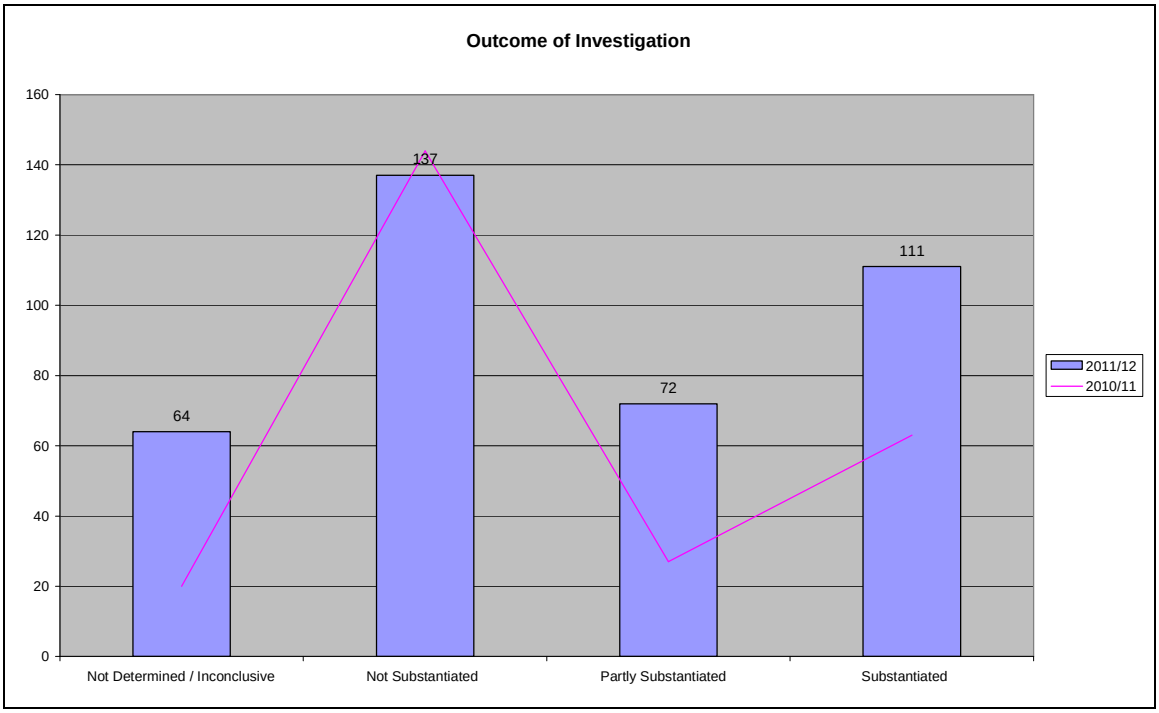
4.10.4 The larger proportion of alerts relate to older people. The proportion of alerts progressing to referral for each of the client groups is broadly the same, around one third.

## 4.11 Outcomes of investigations

**Bedford Borough**



**Central Bedfordshire**




4.11.1 In Bedford Borough we have seen a decrease in the not determined/inconclusive category and an increase in the partially substantiated category. The increase in the number of allegations partly substantiated reflects the number of multiple allegations undertaken during one investigation episode where one or more allegations are substantiated resulting in the overall outcome of partially substantiated. This is as a result of the training for staff regarding the appropriate use of outcome categories resulting in the changes below.

| | 2010/11 | 2011/12 |
|---|---|---|
| Not Determined / Inconclusive | 16% | 13% |
| Not Substantiated | 38% | 39% |
| Partly Substantiated | 8% | 20% |
| Substantiated | 38% | 28% |

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

| | 2010/11 | 2011/12 |
|---|---|---|
| Not Determined / Inconclusive | 8% | 17% |
| Not Substantiated | 57% | 36% |
| Partly Substantiated | 11% | 19% |
| Substantiated | 25% | 29% |

4.11.3 While this remains the greatest outcome to investigations, there has been a decrease in the number of cases being found as unsubstantiated. The reason for this remaining a high outcome along with “not determined” is often the lack of evidence available where people are not able to discuss what happened to them. In addition, due to the increase in concerns relating to people living in their own home, in some cases there has been a focus on resolving concerns to the satisfaction of the vulnerable person and devising an appropriate protection plan, rather than a focus on identifying an alleged perpetrator.

### 4.12 NASCIS007 Abuse of Vulnerable Adults 2010-11 Comparator Report

4.12.1 It is possible to compare the data from this year with the national data report from 2010-11. National data for 2011-12 is not available at the time of writing. Comparator group councils in the national data set are based on the CIPFA Statistical Nearest Neighbours (post April 2009) model with the default variables selected.

4.12.2 Bedford Borough Council shows a high volume of recorded alerts but a similar proportion of referrals to nearest neighbours. Central Bedfordshire Council shows a high volume of recorded alerts and a slightly lower proportion of referrals compared to nearest neighbours. The data provided shows considerable variation between nearest neighbours. It is worth noting that there is no agreed definition of “alert” and “referral” between local authorities so the resulting data may be misleading. A large difference in the number of alerts and referrals may indicate a good awareness among professionals and the community of safeguarding procedures. However it may also indicate poor understanding of safeguarding thresholds by alerters.

4.12.3 Bedford Borough Council record a lower number of alerts in relation to physical disability and higher in relation to younger adults and people with learning disability and mental health needs than nearest neighbours. Central Bedfordshire Council records broadly similar patterns to the nearest neighbours.

4.12.4 Central Bedfordshire Council record a slightly lower number of repeat referrals than nearest neighbours; Bedford Borough slightly higher. Repeat referrals is an in year count of repeats about the same vulnerable adult during the current collection period. A high figure may indicate that safeguarding measures put in place previously are not working.

4.12.5 Both councils report a higher number of completed investigations as a percentage of referrals than nearest neighbours, which indicates a robust decision making process and timeliness of completion.

4.12.6 Both councils report a slightly lower number of referrals from family self or friends than nearest neighbours; this indicates that further work is needed to raise safeguarding awareness in the wider community and ensuring that routes for reporting concerns are known. This may also indicate that local strategies around empowerment and putting the vulnerable adult at the centre of the process should be developed.

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

5.1 The local authorities have seen the applications for Deprivation of Liberty Safeguards reduce or level off during the year. However the NHS has seen a significant increase in the level of applications and authorisations. The main reasons for this has been challenges nationally to the legal rulings which has challenged the understanding of what constitutes Deprivation of Liberty and service users in mental health units need to either be an informal patient with capacity to consent to treatment, detained under the Mental health Act, or provided for under the Deprivation of Liberty Safeguards.

5.2 Bedford Borough Council received 27 applications for Deprivation of Liberty in 2011-2012, compared with 50 in 2009-2010, and 48 in 2010-2011. Of the 27 applications, 10 were authorised and 17 were not. This compares with 30 authorised and 20 not authorised in 2009-10, and 13 authorised and 35 not authorised in 2010-2011.

5.3 Central Bedfordshire Council received 25 applications for Deprivation of Liberty in 2011-12, compared with 25 in 2010-11 and 42 in 2009-10. Of the 25 applications, 7 were authorised and 18 were not. This compares with 2 authorised and 22 not authorised in 2010-11 and 21 authorised and 21 not authorised in 2009-10.

5.4 NHS Bedfordshire received 50 applications for Deprivation of Liberty in 2011-2012, compared with 14 in 2010-2011, and 11 in 2009-2010. Of the 50 applications, 23 were authorised and 27 were not. This compares with 5 authorised and 6 not authorised in 2009-10, and 4 authorised, and 10 not authorised in 2010-2011.

5.5 Overall together these figures indicate an increase in the number of requests over the three year period, 102 in 2011-2012, 62 in 2010-11 and 61 in 2009-10.

5.6 The Bedford Borough Mental Capacity Act Coordinator continues to work together with DoLS Managers in the Eastern Region to share ideas on practice and develop a consistent approach to decision making within the region.

5.7 The Bedford Borough Mental Capacity Act Coordinator has increased awareness and implementation of the Mental Capacity Act 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 increased awareness 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.

5.8 Ongoing audits of mental capacity assessments and best interest decisions in both local authority areas are completed on a regular basis, and through workshops and forums the increased standards of work can be evidenced and improved outcomes of those being supported. Whilst audits of assessments have highlighted there is further work required across all care settings in building confidence and understanding of how and when to assess an individuals, training will address this to ensure that we are adopting best practice and achieving continued good standards.

## 6. Learning from Safeguarding Activity

| **Learning Outcomes** | **Action To Ensure Learning** |
|---|---|
| Improvements in Safeguarding Practice and recording required as a result of Independent Audit and Peer Review | Bedford Borough Council Safeguarding Systems Review is currently underway and a pilot has been implemented for the month of July to test the Safeguarding Consent Matrix, new risk assessment and protection plan. Outcome of the pilot will feed into the independent audit in July/August 2012. The final safeguarding review report will be completed in August 2012.<br><br>Central Bedfordshire Council is reviewing safeguarding recording tool to include including a more robust risk assessment and focusing on outcomes. This will be completed by September 2012.<br><br>Both Councils will continue to use national guidance, tools and audits to improve outcomes and involvement for people who have been through safeguarding. Ongoing work with advocacy services to improve collection of feedback from people who have been through safeguarding investigation and involvement in service development |
| Improvements in our approach to learning and development to a more practice orientated format. | Independent feedback and findings from auditor and staff have resulted in a number of bespoke training courses offered to staff for Safeguarding. Both councils will continue to develop training on the back of continued |

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|---|---|
| | feedback from auditing and staff |
| Performance Management Information demonstrates a continued high volume of alerts received which do not require a formal safeguarding investigation. | Both Safeguarding Teams have established regular meetings with partnership agencies to review and evaluate the appropriateness of the alerts being reported and discussion currently taking place to focus on the current safeguarding thresholds. |
| Performance Management Information demonstrates a continued a low number of alerts relating to hard to reach communities such as ethnic minority groups and the travelling community. | Safeguarding Teams from both councils to develop a partnership approach to focus and target hard to reach communities, linking into existing campaigns run by community safety, community leaders and local media. |
| Performance Management Information demonstrates a continued low number of alerts sourced from individuals from members of the public. | Safeguarding Teams from both councils to develop a partnership approach to focus and target awareness raising with the public to include access to public information and forums. This will include promoting Dignity in care in public areas. |
| Safeguarding services have improved throughout the year due to the sharing of learning with other organisations and councils. | Continue to work in partnership through the sub groups with Luton Borough Council, and the sharing of outcomes of initiatives and projects for improving safeguarding in the area.<br><br>Both councils to continue to attend the Eastern regions Safeguarding Leads Network meetings to share learning and good practice. |
| Supporting the role of informal carer's is key in promoting safeguarding awareness in respect of keeping both the carer and cared for safe. | Both Safeguarding Team to engage with partnership Carer Groups and Commissioning to plan and expand safeguarding awareness to carers in Bedford Borough and Central Bedfordshire.. This will be achieved through awareness raising, focusing on individual investigations and working with carers groups. |
| National reports and analysis of local safeguarding information has shown that people with disabilities remain vulnerable to abuse and harassment, self neglect and financial abuse may become an increasing issue in relation to safeguarding. | Focus on disability related harassment in safeguarding and in conjunction with the Community Safety Partnership Board. This will be achieved through working with the social work teams, and raising public awareness. Targeting people with disabilities through resources and services such as advocacy services.<br><br>Focus on self neglect through the pan Bedfordshire sub groups, which may include awareness raising and development of guidance for staff when dealing with self neglect. The Safeguarding Policy Procedure and guidance |

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|---|---|
| | needs to be reviewed to include self neglect. |
| The panorama programme about Winterbourne and national Care Quality Commission reports have shown that a renewed focus on the quality of services for people with learning disabilities is needed. | Safeguarding Team in conjunction with Quality monitoring teams to monitor on quality of residential and nursing care for people with learning disabilities. Monitor and review the use of restraint in care homes through the work of the mental capacity act coordinators.<br><br>To continue to promote mandatory attendance at the Quality Assurance Safeguarding Steering Group/Adult Services Improvement group and request the input from external agencies with expert knowledge e.g. pharmacy |

**Appendix 1**

**Strategic Objectives for 2012-2013**

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

1 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.

2 <u>Prevention / raising awareness</u>

- Information to be made available identifying the steps individuals and communities can take to keep themselves safe, what abuse means and what everyone should do if they believe abuse may be happening.
- Information will be located in places that the public can access it.
- Access to support for 'excluded' people.
- Tackling the causes of abuse.
- Support for families, carers and perpetrators.
- Increasing the understanding of safeguarding in NHS resources.
- Promote awareness and actions to combat hate crime

3 <u>Workforce development</u>

- 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.

4 <u>Partnership working</u>

- Secure electronic information sharing arrangement - receive reports and monitor progress and management of information.
- Tissue viability issues addressed through the Harm Free Care group and actions to be put arrangements and NHS bodies to monitor.

- Mental capacity and unwise decision making – put mechanisms, guidance, training in place.
- Ensuring safeguarding remains a priority and that lack of continuity does not cause risk to vulnerable person through organisational change.
- Ensure links are maintained to the 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.

5 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 case file audits and what they tell us about the quality of practice improvement and service quality of different agencies.
- Commissioning by the NHS and local authorities in health and social care services builds in assurance that a quality framework is in place and is tested.

6 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.

7 Outcomes and improving people's experience

- Ensure people are empowered to drive safeguarding processes and find effective personal resolutions to harmful or abusive circumstances. The safeguarding team will work with victims of abuse through the personal use of the feedback forms as one means of improving the victim's experience during the safeguarding process.
- Ensure advocacy services are available for people who are unable to challenge or change circumstances that they experience as abusive or harmful.
- Involve service users during the investigation process.
- Continue to promote communication literature to the public via information leaflets about 'what is abuse' in different format and languages.
- Build confidence in the process of investigating concerns by making people feel comfortable at the start of a safeguarding process.

**Appendix 2**

**Partnership Contributions to the Adult Safeguarding Agenda 2011/12**

## 1. NHS Bedfordshire

NHS Bedfordshire has retained safeguarding as a high priority during the year. Achievements include the launch of the Partnership Excellence Palliative Care Service (PEPS), targeted the reduction of avoidable Pressure Ulcers within acute settings, completion of an audit of GP safeguarding leads with the identification of training needs and free training for qualified nurses on clinical skills has been provided in partnership with Bedfordshire University.

### 1.1 Improvements Made In Adult Safeguarding During 2011/12

Audits and Training:

The main focus for NHS Bedfordshire and Luton following the results of the GP Safeguarding audit was on providing appropriate training to GP practices. NHS Bedfordshire and Luton has arranged a workshop to identify what training for safeguarding adults and children is required, all safeguarding leads, GP tutors and CCG clinical directors have been invited to attend and will discuss what needs to be delivered and how it covers national and local requirements.

As part of Quality Assurance, NHS Bedfordshire and Luton undertook a gap analysis of qualified nurses working in nursing homes in Bedford and Bedfordshire. The review identified the gaps for which training has been commissioned in catheter care, NG tube care, syringe driver, slips trips and falls, pressure care, nutrition and hydration, wound care and Venipuncture. These courses are being delivered by the University of Bedfordshire.

Serious Case Review:

An action plan from Central Bedfordshire Council serious case review has been developed which is being monitored internally by the Integrated Clinical Governance and Safeguarding Committee. Progress has been made against the action plan and the new PEPS service, which addresses partnership working to facilitate effective quality care for patients needing end of life and palliative care, will help prevent a similar incident from occurring.

Serious Incidents:

NHS Bedfordshire report quarterly to the SOVA Board on themes or areas of concern, this has included reviewing the risk profile of Mental Health service users, numbers of pressure ulcers and discharge planning risks and inpatient falls.

A sub group of the Prison Partnership Board has been set up to review and monitor implementation and compliance against Ombudsman's recommendations.

Following a number of inpatient falls at the L&D, NHS Bedfordshire and Luton undertook a review of all inpatient falls leading to severe harm over the last 18 months. The review found that routine risk control measures needed to be improved. The hospital has reviewed their falls protocol as a result.

Pressure Ulcers:

Thematic analysis of 2011/12 health related safeguarding alerts shows that neglect and pressure care are the highest areas of concern. Within the health and social care economy pressure sore reduction is a priority (SHA ambition / DH requirement) therefore raised awareness may have increased the number of alerts, providers are noted to be reporting pressure sores within their own service. There is a countywide pressure sore group (multiagency) who analyse all information from reported pressure sores and ensure learning is disseminated and practice improved.

During Quarter 4 2011/12, slight decreases in numbers were reported from the previous quarter and early signs of a decline of the upward trend seen throughout the year.

Throughout the year, the majority of cases being reported remained within the community where a patient is referred to the district nursing services via their GP or carers supporting

patients to live at home. In the majority of cases, these patients are new to the District Nurse service caseload and the damage to the patient's skin has already occurred.

Health Service SOVA Alerts:

There has been a rise in physical abuse alerts the majority of which are service user against service user mainly in services care for patients with dementia. Where NHS Bedfordshire and Luton funded patients are involved a review of their care package is undertaken to ensure appropriate care and support is being provided.

Quality Assurance:

In February 2012 the SHA commissioned an external consultant to audit safeguarding adult processes within PCTs. There were no specific recommendations for NHS Bedfordshire and Luton, areas of good practice were identified and these will be shared across the region.

Good practice areas included the independent trigger tool and quality account email address to enable providers to share soft intelligence with the PCT.

NHS Bedfordshire and Luton's annual work plan for safeguarding is monitored through the Integrated Clinical Governance and Safeguarding Meeting, work has progressed against the plan and there are no outstanding issues, a head of safeguarding adults for Bedfordshire has now been recruited.

### 1.2 Improvements Planned in Adult Safeguarding During 2012/13

Improvements to include the delivery of a primary care training package, monitoring the roll out of the training, and the head of safeguarding adults for NHS Bedfordshire to commence work, with a dedicated safeguarding facilitator. This will enable more strategic and preventative work to be identified and to continue and build on information sharing with local authorities with serious incidents, pressure ulcers and health related issues and ensure Clinical Commissioning Groups (CCG's) are fully aware of safeguarding adult's agenda and are involved in all aspects of improvement. In addition to this the completion of the annual safeguarding process audit will ensure any gaps are identified are then added to the PCTs annual work plan. Work will continue to assist the Strategic Health Authority with provider focussed safeguarding audit and ensure all providers achieve the harm free care targets and that this is rolled out to nursing homes.

## 2. South Essex University Partnership NHS Trust (SEPT)

A series of preventative and awareness raising initiatives have been implemented this year and audits have evidenced that staff awareness and response to safeguarding issues has improved in the timeframe, process and quality of investigations. Within the Community Health Services (CHS) a series of training programmes have been developed. Integrated policies with the CHS were developed and ratified in August 2011.

The Training strategy outlines the expectation that 100% of staff are expected to receive training. A weekly report to the Trust Executive Team and a monthly report to the Trust Board outline the assurance of Safeguarding activity. The Trust Safeguarding Group monitors the Safeguarding action plan for assurance. The Trust has presented monthly reports to the Partnership Management Group and quarterly reports to each Joint Bedford/Central Bedfordshire Safeguarding Adult Board. The Trust has been involved in four audits commissioned by Bedford Borough Council and one by Central Bedfordshire Council in the past year.

The Trust has developed a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Safeguarding leaflets have been developed with the Trust Service User Group and the outcomes of Independent Audits and Service User Questionnaires demonstrate an improved service has been delivered and experienced by service users.

### 2.1 Improvements Made In Adult Safeguarding During 2011/12

The numbers of referrals this year has risen by 17% and reflects the training programmes delivered which aim to raise awareness of safeguarding issues. Routine assessments now contain an assessment of risk and safeguarding issues which aim to identify potential

concerns at an early stage thus preventing Safeguarding investigations being required. The Quarterly reports to the Bedfordshire Safeguarding Board now include information on Serious Incidents.

All relevant staff in the mental health service have received a series of specific training programmes this year including:

- Reflective practice
- Investigations training
- Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

The Safeguarding Competency Framework continues to be implemented within all teams. The Trust continues to be active members of the Bedfordshire Safeguarding Board, Operational Group and other sub groups which include Trust staff taking part in quarterly Safeguarding Peer Group Forums with Bedford Borough Council staff and quarterly peer audits with Central Bedfordshire Council staff. The Trust has reported consistent improvements in the safeguarding process and outcomes of audits. The independent auditor in Bedford Borough stated '*The turnaround seen this year in the performance of SEPT has been impressive and these cases demonstrated how improvements are becoming consolidated'.* The independent auditor in Central Bedfordshire stated '*There are demonstrable improvements since the last audit in May 2011.'*

The Trust Service user Group has been involved in the development of Safeguarding Leaflets. The process for investigating cases has improved and now 97% of Strategy discussions and Closures comply with the Local Authority procedures. The result has meant that service user concerns are responded to and processed effectively and that all service users are involved in the process where appropriate.

### 2.2 Improvements Planned In Adult Safeguarding During 2012/13

Improvements will be implemented by delivering a series of training sessions for the Community Health Service and by continuing to introduce the Competency Framework throughout the Trust workforce where relevant.

SEPT will continue to work closely with the Safeguarding Teams from both council's and with the Peer Review Forums and audit programmes. A meeting with the Service User Group is planned for July to discuss their further involvement in the development of the service and improve the process in obtaining feedback from Service users subject to a safeguarding investigation

## 3 Bedfordshire Police

During the last 12 months Bedfordshire Police have gone through a full restructure with the focus being on maintaining the ability to Fight Crime and Protect the Public. Within this restructure the safeguarding of both adults and children remains a priority and the Safeguarding Units were well supported.

The Safeguarding Adult Unit has been subsumed into a wider Safeguarding Team dealing with both adults and children, who have been geographically positioned in a north and south location. This has increased our capacity and resilience to deal with issues of safeguarding throughout a longer working day. It has also enabled more experienced Detectives within the safeguarding team to mentor and coach those less experienced officers who were deployed on the Vulnerable Adults Investigation Unit. An extended Central Support Team now deals with all referrals and provides a single point of contact and enhanced capacity to better manage obligations to support safeguarding issues and statutory requirements.

A dedicated MARAC (Multi Agency Risk Assessment Conference) team has been formed to deal with those most seriously affected by Domestic Abuse (DA) issues, improving both service and working with partner agencies. A DA champion continues to progress DA initiatives such as Crime Stoppers and Vodaphone. A SARAC (Sexual Abuse and Rape Advice Centre) has been developed which reflects current practice with victims of DA (MARAC). This is a force wide capability between partner agencies which offers intensive support to victims of serious sexual assaults. The Home Office have recently attended

Bedfordshire to review this concept and how it is operating and have deemed this to be best practice. This is currently within an extended trial period.

The Emerald Centre (SARAC) is now fully functional and all police referrals go direct to these premises. This service has proved to be very successful and remains a 'one stop shop' for all victims. In addition, ISVAs (Independent Sexual Violence Advocates) have been recruited and now offer additional 24/7 support for victims of sexual assault. The inaugural Force Vulnerable Adults Steering Group took place in November 2011. Business leads from all three Unitary Authorities were invited and representatives from Luton and Central Bedfordshire attended. The Improvement Plan was ratified and subject to ongoing monitoring and review.

### 3.1 Improvements Made In Adult Safeguarding During 2011/12

Internal and multi-agency joint training has been implemented to improve knowledge of working processes between partners after the Force restructure. All Constables within the Safeguarding units have now completed the ICIPD Detective development training and there are improved levels of supervision and investigative management with the increase in the number of Sergeants.

A dedicated Missing Persons Unit is in place to support and improve services towards missing vulnerable adults. There has been participation in Serious Case Reviews with the sharing and implementation of lessons learned.

Referrals and investigations are now managed on the CATS database (Case Allocation and Tracking System). There is a monthly dip-sampling audit undertaken by a manager to ensure the quality of investigations and joint working are maintained. An increased Central Referral Team now ensures a sustained and consistent response to safeguarding alerts. Over 100 cases have had the use of the SARAC and ongoing support of ISVA's thereby providing a much higher level of service to these vulnerable victims.

### 3.2 Improvements Planned In Adult Safeguarding During 2012/13

Honour Based Violence (HBV) awareness and support network is to be further developed with HBV referrals being handled within the Central Referral Unit in line with all other safeguarding alerts.

A further Force Operational review has commenced. The outcomes of this review will be monitored and managed to ensure that Safeguarding services are maintained. There will be continued work with partner agencies to ensure the inter-agency referral processes are effective and efficient to the needs, role and expectations of all involved partners.

It is planned to re-instigate the Vulnerable Adults Steering group with attendance across all 3 unitary areas.

Standard Operating Procedures for Safeguarding Adults, Missing Persons, and Domestic Abuse will be subject to update in line with the Operational Review. Consultation with partners in light of their own organisational restructures will be essential to ensure consistency, understanding and accuracy.

The SARAC is currently looking to extend the referral base to allow third party reporting. This can only progress through full multi-agency agreement.

## 4 Bedford Hospital NHS Trust

Monthly Safeguarding of Vulnerable Adults Operational Group meeting chaired by Safeguarding Lead are held, which highlights safeguarding issues and lessons learned from individual cases. A Safeguarding Adults micro site is available on the Trust staff intranet for all staff to access.

A Safeguarding Adults session is included in the annual clinical update for all clinical staff, providing increased awareness beyond the mandatory 3 yearly requirements for training. Ongoing work continues with the training department to provide training for all staff groups within the mandatory framework. Bi-monthly safeguarding progress meetings are held between Bedford Borough Council, Director of Nursing and Trust Safeguarding Lead.

Partnership work continues with the Safeguarding Adults Lead attending the Pan Bedfordshire meetings, the Safeguarding Operational Group and a Safeguarding Conference arranged by Bedford Borough and Central Bedfordshire Councils, where wider links have been forged.

The SKIN + bundle (a standardised document/assessment tool) was introduced ahead of the Strategic Health Authority's SSKIN bundle (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition). There has been a reduction in the incidents of pressure area damage following the implementation of SKIN+ bundle

Following receipt of a Care Quality Commission (CQC) warning in April 2011, a detailed action plan was implemented and the warning was promptly removed. As a result of a Serious Incident (SI), an action plan addressing lack of knowledge around Mental Capacity Assessment (MCA) and DoLS was implemented. Safeguarding is discussed on a regular basis at the Trust Board and a patient leaflet has been developed to provide patients and their carer's with information about the Safeguarding process and contact details.

The role of the dedicated Safeguarding Lead within Trust enables the Safeguarding Adults agenda to be driven forward and has improved partnership working.

### 4.1 Improvements Made In Adult Safeguarding During 2011/12

Online training links for MCA are highlighted in the staff bulletin, appear on the Trust screensaver and together with MCA and DOLS 'easy guides' are included on the Safeguarding Adults intranet and in staff training materials. Safeguarding Adults content was included in the Dementia Awareness study day.

A substantive Safeguarding Adults Lead in post has been in place from November 2011, and the visible presence and accessibility of Safeguarding Adults Lead within Trust has led to an increased liaison with ward staff regarding safeguarding concerns. In the absence of matrons, staff members are sent to represent CBUs at Safeguarding Operational Group meetings.

There has been overall improvement in partnership working including the Mental Capacity Coordinator for Bedford Borough Council and NHS Bedfordshire giving a presentation at the Trust Safeguarding Operational Group Meeting and the Professional Forum for Senior Nurses. Independent Mental Capacity Advocates and representatives from the Carers Lounge attended the Trust Safeguarding Operational Group Meeting to explain their roles and services.

The Executive Safeguarding Lead has contributed to a Serious Case Review (SCR).

Improvements have been made to the discharge process with a revised Trust wide discharge checklist to be signed off by 2 nurses and follow up telephone call the day after discharge. This is linked to a Commissioning for Quality and Innovation (CQUIN) in 2012/13.

Safeguarding adults training materials have been revised to reflect lessons learned following Serious Incident's and feedback is given to matrons at their meetings and through Hospital Safeguarding Operational group to ensure a wider cascade of lessons learned and safeguarding developments. There is a wider awareness throughout the trust embedding the principals involved in safeguarding adults, mental capacity and DOLS.

The Trust Safeguarding Adults Lead had received positive feedback from external partners regarding improvements in joint working.

### 4.2 Improvements Planned In Adult Safeguarding During 2012/13

The Organisational Development Team is updating the format of staff induction and clinical update to develop the format and time allocated to Safeguarding Adults. A new Trust intranet is also being implemented with improved access to the safeguarding page.

The Executive Lead for Adult Safeguarding will report back to the Trust Board the findings of the SCR with a report detailing the Trust response.

Other improvements include the implementation of the discharge pathway (CQUIN) to further improve discharge, and the implementation of the 'safety thermometer' (CQUIN) to reduce pressure ulcers and continued training on pressure ulcer prevention. Grading

discrepancies of pressure ulcers (PUs) between the hospital and community have been identified. It is hoped the roll out of the most recent SHA grading tool by the community Tissue Viability Nurse will address these discrepancies. The NHS Calderdale's protocol has been adopted by the Tissue Viability Nurse and Safeguarding Adults Lead, to structure assessment related to pressure ulcers. There has been expansion of the infection control and Tissue Viability Nurses to support the delivery of 'Harm Free Care' and the 2012/13 CQUIN regarding the elimination of category 2, 3 and 4 pressure ulcers.

Mental Capacity training is being rolled out to all Doctors and Consultants with an external provider planned for September 2012. Information regarding the Mental Capacity Act and the IMCA referral process is being included in the junior Doctors handbook and compulsory online Safeguarding Adults training is being introduced as part of their induction. Medical staff are actively involved in making the MCA requirements user friendly for acute care.

Within the Trust the Safeguarding Team will be developed to ensure cover for Adult and Children's services in the absence of safeguarding leads.

There has been an audit of staff safeguarding competencies based on the competencies agreed by the PAN Bedfordshire Group.

Continue to support the nursing professional forum for ideas for continuous improvement There will be ongoing work to ensure appropriate referrals relating to Safeguarding teams relating to pressure and tissue damage and improved processes relating to assessment of mental capacity and referral to the IMCA service/

## 5 Luton and Dunstable Hospital NHS Foundation Trust

For the purposes of fulfilling the reporting requirements of a number of internal groups as well as partner expectations, a summary of the year's activities in support of progress made with safeguarding of patients cared for within Luton and Dunstable Hospital is presented at this time of year.

In February 2011, a safeguarding alert was raised against the Trust that was investigated by the Police. At the beginning of the year 2011-2012, the Trust was therefore beginning a process of understanding more about their safeguarding issues. More robust reporting and action processes were put in place.

A 2011 CQC report had also highlighted various areas for improvement including documentation in relation to the Mental Capacity Act (MCA). An action plan was agreed at this time (the Trust subsequently submitted evidence to CQC of examples of improvement in January 2012). In June 2011, an external consultant additionally carried out a piece of work within the Trust and provided a report detailing areas for improvement.

In total there were 614 safeguarding alerts raised between April 2011 and March 2012; of these 72 were raised against the Trust.

An unannounced CQC inspection took place in June 2012, specifically focusing on safeguarding and learning disability needs. The draft report has confirmed full compliance against all outcomes.

Key activities undertaken in 2011 / 2012 included a seconded Safeguarding Lead Nurse was appointed in August 2011, and in October 2011 a Lead Clinician for Adult Safeguarding was appointed. Ward and department-based champions were then recruited throughout September and October 2011. In July 2011 all policies were revised and issued and from July 2011, safeguarding and learning disability folders were made available on wards. In August 2011 an intranet site was launched and display boards advertising safeguarding and learning disability posters and other relevant information were also established and all forms in relation to MCA and Deprivation of Liberty patients have been revised in partnership with the PCT MCA/DoLS Lead.

In January 2012, a system was put into place to highlight alerts, which identifies vulnerable patients with past adult safeguarding concerns and/or dementia. In February 2012, a Strategy Meeting Internal Report Form was devised in partnership with the LBC Safeguarding Manager.

A process for care plans to be in place in a timely manner was implemented and this now forms one of the key performance indicators. To reduce disparity between processes in different organisations, a pilot process was agreed by the Safeguarding Board to bring the Trust's processes more in line with Central Bedfordshire's process. Finally, the Safeguarding and MCA Competencies have been revised in conjunction with all relevant partners and stakeholders as part of a joint PCT and Trust led initiative.

From May - July 2011, 87% of all patient contact staff (95% of clinical patient contact staff, that is 6323) were trained either through face to face two hour sessions or nationally accredited e-learning. For clinical and non-clinical staff ongoing training, a predetermined schedule was prepared; this training covers all safeguarding issues and learning disabilities. A six month Leading in Safeguarding course has also been developed in conjunction with the University of Bedfordshire through a successful bid for £30,000. Eighty places were also allocated for Promoting Excellence in Dementia Care and 86 staff members attended, this was done in conjunction with the University of Bedfordshire.

Specific challenge (1) - Prevention of Pressure Ulcers
The SHA launched the first of five ambitions on 28th February 2012 – to eliminate all avoidable Grade 2, 3 and 4 pressure ulcers by December 2012. The Trust has acted accordingly, which has included: relaunching intentional rounding on all wards and ensuring Waterlow and MUST scores completed and reported against; Route Cause Analysis (RCA) for Grade 3 & 4 pressure ulcers with targeted action plans and a clear process for reporting; an intense, regular training plan with attendance numbers logged; undertaking a hospital wide mattress audit and subsequent replacement action plan.

Specific challenge (2) - Learning Disabilities
In January 2012, SEPT employed a full time band 5 nurse to assist the Band 7 Learning Disabilities Liaison Nurse; both are based in the Trust. Patients with learning disabilities being a priority for the Trust has led to a number proactive steps including: guidance for carers of patients with easy read information; development of a new Learning Disabilities strategy by the Trust Learning Disabilities Task Group; learning disability patient pathways in place; "All about me" folder/booklet/passport promoted; Caldecott Agreement in place which has allowed for the sharing of patient information with Luton Borough Council

In summary a number of improvements have been made and will continue to be a focus and priority for the Trust. Safeguarding alerts continue to be monitored and investigated carefully, with a fall in those made against the Trust anticipated and well as an improved patient experience noted in surveys being undertaken.

## 6 East of England Ambulance Trust

All staff and volunteers working within the Trust receive safeguarding awareness/training and Equality and Diversity on induction and updates at regular intervals. This includes the Trust Board members. We have a Safeguarding Training strategy and Plan which is competency focused and based upon ADASS recommendations.

All staff have access to line managers and clinical mangers who have received training in safeguarding, as well as access to the named professionals. A programme of specific safeguarding training for senior managers is nearing completion to enable them to champion safeguarding issues at local level. All staff who access the public either by phone or in person receive safeguarding child/adult training as part of their preparation for duty. This training is monitored and delivered by the Safeguarding Team for the Trust. The Safeguarding Team remains an integral aspect of the quality service the Trust provides.

The Trust has a specific Capacity to Consent policy which is integral to the safeguarding policy which includes the MCA code of practice and sections on DoLS. Specific training on

capacity and consent particularly in relation to conducting capacity assessments has been undertaken across the Trust. The Trust has a Board Champion the Director of Clinical Quality; two Named Professionals and Named Doctor.

Key local senior managers (Safeguarding Assistant General Managers) within operational to provide supervision to staff. The Trust's Named Professionals and Safeguarding Board champion work in multi-agency setting and attend regular meeting with multi agency partners and have an integral role in the strategic development of Safeguarding within the Eastern Region and Nationally through the Ambulance Safeguarding forum. Key Trust staff including the Safeguarding Assistant General Managers as local leads, named professionals and Executive lead attend Local Safeguarding Adults Boards where appropriate. The notes of those meetings are retained for CQC evidence.

The Board receives quarterly reports from the Executive lead and this is supplemented by regular dash board reports of safeguarding referrals and trends. All referral information is collated monthly to identify trends and emerging themes. The Trust has a comprehensive safeguarding Policy and Clinical Guidelines for staff these documents are available to staff via the Trust intranet, public web pages or in and copy accessible to them in their place of work. All Trust contracts for commissioned services have a safeguarding commitment and clearly outline the Trust expectations of all staff working in or on behalf of the Trust. The Trust monitors all commissioned services through audit of records and polices.

The Trust undertakes regular internal audits of the Trust referral process; this is done in several different ways:

- An audit of the referrals numbers made by staff and what areas of the Trust they have been made by
- The quality of the referrals made by the Out of Hour (OOH) call handlers regarding data entry and accuracy of information
- Tracking the referral from 999 call through to the patient care record completed and referral data entered, the audit looks to see if the information ties up together and if environmental issues are recorded
- Feedback from the Local Authority (LA) and the General Practitioner (GP) is obtained
- Auditing of the pathway selected by the Trust practitioners and to ensure that any referral made to the GPs for a vulnerable person has been made appropriately and does not need to be a safeguarding concern requiring the LAs focus
- The safeguarding team will check these referrals within three working days to ensure that the GP has been the correct option and that there are no concerns that may require action from the LA
- A sample of PCRs relating to referrals are also audited

Results from these audits are reported to the Safeguarding Group and to the Trust Board. The Trust participated in external audits last year, this included the following:

- Adult Safeguarding Audit of practice from Regional Adult Safeguarding Forum
- Learning from any audits has been incorporated into the Safeguarding Teams Action plan and wider Trust agenda.

The Trust has an active patient/public involvement group which actively seeks the views and wishes of patients and service users. The Trust encourages the participation of carers in patient public engagement groups and is particularly working on identifying carers from vulnerable groups to be representative. Patient views on the performance of the Trust is also sought from patient surveys. Patient and public information leaflets about safeguarding and how to make a referral are available via the Trust web site. Service users have a chance to influence procedure or practise via service user audits and survey e.g. users with mental health problems. This is supported by our PALS team to ensure regular feedback is gained and acted upon.

### 6.1 Improvements Made In Adult Safeguarding During 2011/12

The Trust has provided awareness training for over 2000 operational staff in relation to dementia patients and has run master classes in capacity assessments. The Trust has

also provided guidance for staff in relation to pressure ulcer development, and Trust training to ensure that all staff are comfortable with the Trust system, Trust expectations and the role of the GP in safeguarding.

The Trust has had a strong focus regarding mental capacity, consent and capacity and restraint education and training. This training is integral to the safeguarding training within the Trust; further work has been completed from road show work and workshops

The Trust has ensured better engagement with LSABs through the introduction of key local senior managers Safeguarding Assistant General Managers. The Trust has engaged with local forums in relation to pressure ulcer prevention

Significant progress on internal audits have taken place and associated feedback to staff. Monthly audits are now in place.

The Trust has further improved guidance for staff on capacity assessments, it has also improved the management of pain from feedback received from service users

### 6.2 Improvements Planned In Adult Safeguarding During 2011/12

- Further awareness raising planned for staff in relation to patients with dementia and learning disabilities and pressure ulcer prevention
- Further multi agency training for senior staff
- Enhanced engagement where requested through Safeguarding Assistant General Managers
- Further development of the QA process in relation to referrals
- Improvements for pain management for people with dementia, which is a quality priority for the Trust

## 7 H M Prison Service

HMP Bedford continues to enforce its commitment to safeguarding and is constantly looking at ways in which we can embed safeguarding awareness into as many of our policies as possible. There is a safeguarding committee who meet regularly to develop strategy and key personnel have been identified to act as “champions” in both adult and child safeguarding.

### 7.1 Improvements Made In Adult Safeguarding During 2011/12

A safeguarding “what to do if” card was attached to the payslips of all directly-employed Prison Service staff at HMP Bedford.

A single point of contact for both adult and child safeguarding has been identified.

An e-folder resource has been created for all staff to access and includes information such as how to identify safeguarding issues and where to report them.

A referral tracker has been devised to monitor the progress of referrals.

### 7.2 Improvements Planned In Adult Safeguarding During 2012/13

Incorporate Safeguarding into staff SPDR’s (Staff performance and development record)

Deliver awareness sessions to staff

Devise strategy for recording safeguarding concerns on our case management system.

## 8 Bedfordshire and Luton Fire and Rescue Service

BFRS has ensured the appropriateness and effectiveness of its Community Safety activities through improved analysis and greater evidence led approaches.

BFRS has trained all new recruit frontline firefighters in safeguarding and instilled an understanding that ‘doing nothing is not an option’.

BFRS has developed its partnership approach towards risk reduction and exploited opportunities where there is cross over of organisational aims and objectives and/or where service provision can be improved.

BFRS has completed and publicised evaluations of community safety initiatives and activities to ensure sharing of best practice and lessons learned across the organisation.

### 8.1 Improvements Made In Adult Safeguarding During 2011/12

Improved understanding of target groups achieved through Customer Insight ensuring the most relevant messages have been communicated in the most effective ways based on the needs of our local communities.

The continuation of enhanced CRB checks for all frontline, operational and key staff.

A growing number of partnerships have been developed including training of staff from Social Services, Adult Services, Sheltered Housing Officers, The Re-enablement Team, Bobby Van and Age UK.

The BOC Breatheasy partnership ensures BFRS are informed of all oxygen cylinder use in domestic premises. This not only allows the BFRS to improve operational safety through the updating of relevant incident information and notification but also to provide priority Home Fire Safety Checks in the homes and signpost the occupiers for further support where required.

Formal partners have delivered nearly 400 Home Fire Safety Checks.
16% of all completed Home Fire Safety Checks included occupiers over 65 years old.
10% of those the BFRS came into contact with during the 'Fit For Life' event (targeting those with poor health and long term health problems including diabetes and respiratory disease) self referred for the NHS 'Stop Smoking Course' and nearly 40% were signed up to Bedford Borough Councils 'Re-Activ8' scheme.

BFRS has made 12 safeguarding children, young people and vulnerable adult referrals Learning points and best practice is communicated across the organisation and has supported the dissemination of both quantitative and qualitative data.

### 8.2 Improvements Planned In Adult Safeguarding 2012-1

Completion of Firefighter Safeguarding training.

Arrangements to minimise foreseeable risks to both staff and 'at risk' members of the community by ensuring increased information relevant to specific individual risk is available to Firefighters en-route and in attendance at relevant incidents.

Some of the key concerns will include (but are not limited to):-

a) Oxygen cylinder use;
b) Bariatric patients;
c) Biohazards; and,
d) Sanctuary/Safe Rooms.

The approach also provides BFRS the opportunity to assess the presence of linked issues and relevant concerns and thus build a risk profile of the individual and property. For example the mobility issues linked with oxygen cylinder users may result in other health associated issues that could ultimately present biohazard risks to the crews and/or other property users indicating a possible need for further partner agency support.

The completion of a vulnerable adult audit to identify gaps between current practice, safeguarding commitments and identify responses to mitigate risk. Outcomes will be available to all staff and outstanding tasks will be visibly allocated to specific roles for completion.

## 9 Bedfordshire Probation Trust

2011/2012 saw the introduction of policy and research related to hate crime and in particular disability hate crime, working with victims to look at their perceptions of the criminal acts they have been subject to and to find out if they perceived the offences against them to be hate crime or disability hate crime related, motivated by hostility or prejudice. BPT are looking at definitions of crime that maybe related to disability or mental health taking into account recommendations from Luton Adult Serious Case Review.

BPT has introduced the Caring Dads and Integrated Domestic abuse programme for Non Statutory perpetrators male of domestic abuse in response to the need for early intervention work as identified by recent safeguarding OFSTED reviews in Luton and Central Bedfordshire (although there is no funded provision in Bedford borough) . This supports domestic abuse prevention work and supports women and children as vulnerable victims who are then linked with women safety officers and IDVA and MARAC support.

Mental health services as agreed in SLA with NHS were due to go live June 2011, these are yet to be rolled out, BPT are currently in discussions with NHS and SEPT to clarify commissioning arrangements and resources.

Women's high risk Approved Premises in Bedford has noticed an increase over the last six months of suicide attempts and self harm serious enough for hospitalisation, approved premise managers have been working with staff to increase vigilance and indicators identification in the women accommodated, but have also introduced a counselling service for staff to look at the impact the behaviour has on their ability to work in the demanding environment.

Luton has developed working arrangements with Stepping Stones third sector organisation to supervise all Luton Women offenders within a women only environment, 82 women offenders will be supervised within the Stepping Stones project and will have interventions tailored to meet their needs, women offenders will be able to access registered childcare 5 days per week so they can attend their interventions and free hot meals are provided on site everyday for children to link in with child poverty strategy. Two fulltime Probation Officers have been seconded to the project and outcomes regarding reducing reoffending will be researched by Bedfordshire University Women's studies department, project to be expanded into Bedford and Central Bedfordshire in 2013/2014.

Bedfordshire University and local Central Bedfordshire children and family units and leisure centres have also supported BPT initiatives with free use of accommodation to run interventions, this has cut costs in intervention delivery and has allowed for additional service delivery.

BPT MAPPA has introduced a dip sampling model for high risk offenders. This is followed up with qualitative evidence from approved premise managers regarding residents' vulnerabilities and mental health status and looking at proximity of and support packages for victims and Offender risk assessments OA Sys (standard assessment tool). This does address and question both offender and victim vulnerabilities and linking to safeguarding of children regarding the adults' ability to parent and offenders coming out of Prison and how their vulnerabilities are identified and managed whilst on their community licence period.

Victim satisfaction questionnaires have scored highly. 97% of victims are satisfied with the services they have received and BPT are introducing customer/offender surveys and focus groups for women offenders and stakeholder surveys to look at how successful joint working has been on designated intervention projects

### 9.1 Improvements Planned in Adult Safeguarding During 2012/13

Integrated Offender Management (IMO) has health trainers in post carrying out basic assessments of offenders regarding health and as part of their role they have an awareness of local services and have links with GP's practices. As key workers, the health trainers are escorting offenders to their health appointments and link in with health care professionals. Langley house Trust are working with BPT on a voluntary basis, identifying offenders who maybe suffering from mental health and disabilities which may affect their employability and resettlement.

BPT will further develop women's services within Bedfordshire and successful meetings with multi faith organisations have aims and objectives to mentor black and ethnic minority

offenders in Luton. This is to include youth transitions, linking with CSP objectives of managing anti social behaviour and vulnerable young offenders joining gangs. BPT has seconded a staff member to the PREVENT project and we continue to work in identification of local extremism and the possible enrolment of vulnerable adults into extremism groups.

Serious further offending reports now look to identify vulnerabilities in both the offenders and the victim. Group and Public Protection teams in Probation Trusts across the east of England are working together to look for common themes in how to identify and manage offenders vulnerabilities, and to look at the impact of these vulnerabilities on further offending. Key trend data is being identified and practice guidance notes developed for staff information and note.

## 10 Voluntary and Community Action

Voluntary and Community Action (working in the Central Bedfordshire area) has consistently highlighted to the Adult Safeguarding Board the need to raise awareness of safeguarding issues with voluntary organisations and community groups, and for organisations and groups to have in place adequate Safeguarding Policies so as to improve practice within the sector, particularly in smaller groups that are run by or used by volunteers and/or part-time members of staff.

### 10.1 Improvements Made In Adult Safeguarding During 2011/12

Voluntary and Community Action have provided information, advice and guidance on safeguarding or developing safeguarding policies to three voluntary and community organisations and provided safeguarding training to all our staff. Three staff members also undertook an on-line Safeguarding training module through Bedfordshire Adult Skills and Community Learning.

Voluntary and Community Action have contributed to all Adult Safeguarding Board meetings held during 2011/12 and participated in the Central Bedfordshire Safeguarding Peer Review and contributed to discussions at the Safeguarding Board Focus Group.

In response to the Central Bedfordshire Council Adult Safeguarding Peer Challenge, we designed and submitted to the CBC Safeguarding Manager a programme of activity to raise awareness of safeguarding issues with voluntary organisations and community groups. This highlighted the need for adequate Safeguarding Policies and training (endorsed by the Safeguarding Board) to improve practice within the sector, particularly in smaller groups that are run by or used by volunteers and/or part-time members of staff. Discussions on how this work could be resourced were unresolved as at the end of the year.

We undertook an extensive review of our Safeguarding Policy and procedures to ensure that they met the Board's multi agency Safeguarding Policy and the requirements of the Adult Safeguarding Audit Tool. Following consultation with staff, a revised Policy received our Trustee Board's approval in July 2011. Following the implementation of a new Safeguarding Policy and procedures, we reviewed, completed and submitted to the CBC Safeguarding Manager a new Safeguarding Audit Tool assessment.

### 10.2 Improvements Planned In Adult Safeguarding During 2012/13

We need to review and update our Better Care resource pack to ensure that it is consistent with the Board's multi agency Safeguarding Policy. We want to get the learning materials for our Safeguarding Vulnerable Adults Training Workshop endorsed or accredited by the Safeguarding Board and will meet with the Learning and Development Manager for Central Bedfordshire to take this forward.

We will continue discussions with CBC to ensure that work is commissioned to raise awareness within the voluntary and community sector of safeguarding vulnerable adults. This is to help build the capacity of the sector to put in place adequate Safeguarding Policies and to provide training to improve practice within voluntary organisations and community groups, in particular the smaller groups that are run by or used by volunteers and/or part-time members of staff.

All newly appointed staff will undertake Safeguarding Training.

We will continue to attend and contribute to all Adult Safeguarding Board meetings during the year.

## 11. Community and Voluntary Service

Community and Voluntary Service (CVS) (working across the Bedford Borough area) has worked over the last year to raise the overall awareness within local voluntary and community sector organisations of the adult safeguarding agenda. Hundreds of local community group and charities work with or come into direct contact with adults who are vulnerable. We have used our various communication methods such as newsletters, websites and at various events that we host throughout the year. Our funding and development service provided one-to-one advice to hundreds of organisations, providing an opportunity to discuss safeguarding arrangements and offer support as required.

Most voluntary and community sector organisations have robust policies, training and systems in place to manage safeguarding, with CVS supporting others to develop the appropriate infrastructure.

### 11.1 Improvements Made In Adult Safeguarding During 2011/12

Over the past year CVS has developed and successfully piloted a workshop aimed at those very small voluntary and community organisations. Often these are organisations coming into contact with both adults and children, but in a very limited way, and therefore need broad safeguarding arrangements. Often these organisations have no staff and are fully operated by volunteers. The workshop in part uses an online learning programme, combined with more custom support and information that is appropriate for a small community group, allowing the participant to then cascade the learning to other volunteers within their organisation. Last year 38 staff and volunteers attended the workshops.

### 11.2 Improvements Planned In Adult Safeguarding During 2012/13

CVS will continue to promote and raise awareness of the safeguarding agenda. We are planning a broad awareness campaign to continue getting the message to the hundreds of small voluntary and community groups out there.

CVS will continue to offer workshops on safeguarding issues, aimed at those organisations with no staff and often no formal link with the traditional adult services within the local statutory sector. Three further workshops are scheduled during the remainder of 2012.

## 12. Advocacy for Older People (AOP) and POhWER

There are now approximately 20 “Voice” groups across Bedford and Central Bedfordshire, which have been established by the POhWER Community Development Workers. The aims of these groups is to engage service users in issues which have a common theme; the groups represent people with learning disabilities, mental health issues, autism and those young people who are in transition. These forums can provide a platform for any common safeguarding issues to be discussed, with guidance from the Safeguarding teams.

All POhWER advocates have completed refresher safeguarding training during July.

Case Study

One of our advocates was involved with a long-standing case involving the need to protect two vulnerable adults in Central Bedfordshire from a family member. After 2 years of regular advocacy support and much joint working with other agencies, a High Court order has now been obtained by the Local Authority to protect the couple who were pleased that they could now get on with their lives. The advocate concerned was complemented by the Central Bedfordshire social work team for his commitment to supporting these individuals.

Throughout the year AOP has offered to provide bespoke Safeguarding training to 17 establishments dealing with the elderly. 8 training sessions have been delivered to a combination of private and public sector employees/managers/ proprietors and directors.

Sessions have included: - Safeguarding awareness/accurate record-keeping/preserving evidence/recognition of pressure ulcers.

AOP Volunteers and Staff team receive Safeguarding training throughout each year through induction courses, Training and Support Programmes and access to POhWER Training and Development.

AOP and POhWER are part of Bedfordshire Safeguarding strategic groups with close working links with local Safeguarding teams.

AOP and POhWER advocates and staff continue to provide regular support to service users and often their families at various hospital units and homes across the county. The afore-mentioned provides for many opportunities for service user engagement with a view to improve service provision. Advocates also carry out one-to-one interviews with service users and where possible and appropriate share the findings with partner agencies. AOP is participating in revised Bedfordshire and Central Bedfordshire joint Service User project.

Outcomes achieved for clients included:

- securing reimbursements for their clients where financial abuse has taken place;
- financial safeguarding measures were put in place by advocates for their clients to prevent further abuse
- sustained physical and verbal abuse of clients/service users by carers has been halted through immediate intervention jointly by AOP and Social Services.

### 12.1 Improvements Made In Adult Safeguarding During 2011/12

The AOP Safeguarding Action Plan includes a programme of presentations on advocacy and Safeguarding in specific residential homes, day centres, specialist mental health units aimed at reaching residents, relatives groups and staff teams. AOP is going to incorporate Safeguarding training available through POhWER as additional to in-house training programmes.

An AOP aim for this year is to expand the Safeguarding volunteer base and we are working with the Alzheimer's Society co-ordinating joint support for people with dementia, including recognising their potential additional vulnerability.

There will be review monitoring of outcomes and evaluation of cases; as part of joint AOP/POhWER partnership.

AOP submitted an expression of interest to the Silver Dreams Lottery programme, outlining proposals to improve service user engagement locally and harness existing work in that field. AOP were 1 of only 15 successful submissions in the first round nationally. Project focuses on service user involvement, raising awareness and prevention; includes opportunity for input into design and delivery of Safeguarding support; is a collaboration with partner agencies including national advocacy agencies, Bedfordshire Safeguarding teams and Bedfordshire Police. Unfortunately, despite positive feedback, the project was felt to be too far outside the remit of the funding programme and therefore could not be funded. Silver Dreams project remains priority area and AOP are to seek additional independent funding in 2012/13.

Additional funding was secured for AOP Safeguarding Lead post until 30/11/12. All AOP staff and advocates have received Safeguarding awareness, pressure ulcer and record-keeping training. The latter training is part of an on-going process delivered to each new volunteer and member of staff. Recognising that pressure ulcers are a key concern across the county, future internal training will also include presentations by a Tissue Viability Clinical Nurse Specialist.

### 12.2 Improvements Planned In Adult Safeguarding During 2012/13

The AOP Safeguarding action plan is to be reviewed and refreshed. The continuation of development programme as above.

Further funding is being sought in order to retain the AOP Safeguarding Lead post for the longer term and expansion of Volunteer Advocates team, to link to Volunteer development for AOP and POhWER advocacy services.

The continuation of on-going partnership work, including Bedfordshire Safeguarding structures and securing funding for the Silver Dreams project.

The involvement of people in development of safeguarding services with other avenues currently being explored, to determine suitable methods of delivering the Service User Engagement Project

The improved monitoring of outcomes and evaluation; increased service user feedback; assess use of Star Outcomes tool and AOP involvement in Service User Project.

A new bespoke “Keep Safe” training programme has been designed to be delivered to people for whom it has been identified that this would be beneficial. Referrals are made from the social work teams. Currently the referrals are for people with learning disabilities but it is hoped that this will be extended to other vulnerable people who have been subject to safeguarding. The first programmes will be delivered in Bedford to Bedford Borough Council clients, but it is expected that once the programme has been piloted it will be offered both in Central Bedfordshire and in Luton.

## 13. Bedfordshire Care Group and Bedfordshire Home Care Providers

Awareness raising is carried out via the Provider Forums and the Bedfordshire Care Group Meetings; however this has been increasingly difficult this year due to the number of cancelled provider forums.

Safeguarding Competencies continue to be required of providers. Dignity in Care training is offered and emphasis placed on Dignity in Care during Dignity Week. Updates given at Partnership Forums and Boards and concern with respect to the operation of the Mental Health Partnership Board have been raised.

Each Provider has their own ways of Quality Assurance and Local Authorities Quality Teams and CQC feed into this process.

Involvement of service users in the development of safeguarding services is achieved through feedback received at various Forums under the Learning Disability Partnership Board, Mental Health Partnership Board, through Dementia Groups organised by NHS Bedfordshire and the Local Authorities and it is hoped this next year will implement some of the changes needed to continue to improve services.

Providers continue to feedback where there are there are concerns relating to people’s experience to the relevant Safeguarding leads with a view to learning from lessons.

### 13.1 Improvements Made In Adult Safeguarding During 2011/12

Outcomes of serious case reviews have been shared with Providers at Forums and meetings.

Emphasis on safeguarding continues via the use of Safeguarding competencies framework.

There has been joint working with other Boards, NHS and local hospitals to improve services and attendance at the Safeguarding Board Conference in February 2012.

Subgroups continue to discuss how to improve quality of safeguarding including providers giving feedback on relevant issues. Outcomes are discussed via feedback from providers at forums and care group meetings, and link in directly to the Safeguarding Leads.

### 13.2 Improvements Planned In Adult Safeguarding During 2012/13

Improvements will be achieved by looking at lessons learnt and to be learnt from recent safeguarding reviews which will be circulated and discussed with providers. Safeguarding as an agenda item is to be included at all Provider Forums. Commitment is needed to ensure that Forums take place.

The implementation of the Mental Capacity/DoLS competencies framework will be introduced alongside the existing safeguarding competencies framework.

Continued improvements will be achieved this year in the operation of The Mental Health Partnership Board and will continue to ensure good practice and more accountability to users and carers.

Quality assurance will be achieved through maintaining Safeguarding competencies and Quality Audits by Providers and Local Authorities. Providers will continue to feedback safeguarding items at Forums and Care Group Meetings and contact Safeguarding leads direct.

Feedback to continue to be sought from Service Users on the ground via Advocacy Groups, Service User Forums under the various Boards.

## 14 Central Bedfordshire Housing Service

The Bedfordshire and Luton Housing Partnership decided late in 2011 that the arrangements that had existed since 2003 were no longer required. This partnership had undertaken the Safeguarding audit process; established monitoring arrangements and developed an improvement plan. The arrangements for on-going monitoring do not now exist. Therefore, the approach to improving safeguarding practice will need to emerge on a locality basis, and in particular future representation on the Adult Safeguarding Board would need to be reviewed.

There should be consideration as to whether the Housing agenda should be embedded at the Operational Board level, currently a review paper, including specific proposals for future housing representation, is being written to present to the Operational Board. The arrangements in Bedford appear satisfactory. In Central Bedfordshire the focus is to embed safeguarding practice across housing organisations, including supported housing providers. A Vulnerable Persons Housing Group is being established, linked to wider representation from Supported Housing Providers. The focus is to share best practice and develop monitoring arrangements, linked to the existing Improvement Plan. It should be noted that lessons have been learnt from specific safeguarding cases with housing involvement. For example, a recent eviction case highlighted a gap in effective integrated working with social care, with regard to awareness of relevant issues and support being available for those affected.

### 14.1 Improvements Made in Adult Safeguarding during 2011/12

A process for monitoring safeguarding practice within housing organisations was put in place in the form of the Safeguarding Development Plan. The audit was completed. Partners engaged with the process to test whether safeguarding practice is embedded within the operational activity and processes of their organisations. Next steps are to build on that work, to share learning and to develop monitoring arrangements that are based on self assessment. The challenge is still to improve awareness and strengthen integrated working practices, to ensure a joint approach and support towards anyone who is vulnerable.

### 14.2 Improvements Planned in Adult Safeguarding during 2012/13

The importance of sharing best practice between housing partners is recognised, as well as connectivity with statutory services to ensure a joined up approach to assisting vulnerable people. A Vulnerable Persons Housing Group is due to hold its first meeting in Central Bedfordshire; its purpose being to review, share and develop best practice on tenancy sustainment, homelessness prevention and other issues affecting vulnerable tenants, such as self neglect and social exclusion.

Work is underway to develop a Supported Housing Strategy for Central Bedfordshire. Central Bedfordshire is engaged with providers to develop a common understanding of safeguarding practice. A key performance indicator relates to the percentage of vulnerable (socially excluded) people successfully moving from supported to settled accommodation, performance level is currently at 83%.

# 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)

Care Quality 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

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