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 2012- March 2013

Abuse is Everybody's Business
Safeguarding is our Responsibility

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This annual report covers the fourth year of operations as two unitary councils for Bedford Borough and Central Bedfordshire. It outlines the progress made during the year from April 2012 to March 2013 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

- Improvements in safeguarding practice and recording required as a result of an independent audit and peer review.
- Reviewing the high volume of alerts that do not require a formal safeguarding investigation
- Improving the sharing of learning with other organisations and Councils
- Focus on 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.

Over the coming 12 months we will be focussing on

- Hate crime, discrimination and harassment of people with disabilities
- Mental Capacity Assessments and Deprivation of Liberty Safeguards including the use of Independent Mental Capacity Advocates to raise awareness and improve practice within these areas
- Respond to national focus on care quality by continuing to work in partnership with key agencies and commissioners to improve quality in health services, learning disability services and with adult social care providers.

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

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

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

Safeguarding is our Responsibility

1. The Developing Context for Safeguarding

1.1 Draft Care and Support Bill

The draft Care and Support Bill proposes a single, modern law for adult care and support that replaces existing outdated and complex legislation. The Bill proposes a number of changes to safeguarding adults at risk which will lead to a number of changes in practice over the coming two years. These are:

- A duty to make enquiries where the local authority has reasonable cause to suspect abuse or neglect of an adult at risk
- Safeguarding Boards will be placed on a statutory footing with a minimum core membership of the local authority (which retains the lead for adult safeguarding); the police, and the clinical commissioning group.
- Safeguarding Adults Reviews will be statutory and will replace serious case reviews
- Section 47 of the National Assistance Act 1948 (which gives a local authority power to remove a person in need of care from home) will cease to apply to persons in England
- Provisions are made within the Bill for protection of property

1.2 Statement of Government Policy on Adult Safeguarding May 2013

The statement of government policy on adult safeguarding provides an update on the Government's policy on safeguarding adults vulnerable to abuse and neglect. It includes the statement of principles for Local Authority Social Services and housing, health, the police and other agencies to use, for both developing and assessing the effectiveness of their local safeguarding arrangements. It also describes, in broad terms, the outcomes for adult safeguarding, for both individuals and organisations. It reinforces the government's six principles for safeguarding:

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

1.3 Association of Directors of Adult Social Services: Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services March 2013

This ADASS (Association of Directors of Adult Social Services) advice note is intended to fill the vacuum until the introduction of the Care and Support Bill by bringing together the effects of recent changes, what has been learned, and anticipates forthcoming changes, in order to give Directors a common approach. It complements but does not replace the ADASS/LGA (Local Government Association) National Framework of Standards, Department of Health Guidance, No Secrets and its later update. The key messages for Directors are:

- A focus on people and the outcomes they want, valuing the difference that is made; process is an important means of achieving good outcomes but is not an end in itself.

- Collaborative leadership - supporting, integrating and holding partners to account – is key to cross agency engagement and effectiveness.

- Effective interfaces are essential - with developing Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards.

- Responsive specialist services need to be in place and have a portfolio of responses to support people with difficult decision making.

- Ensure that concerns are addressed proportionately so that systems are not swamped and serious concerns are not missed.

- Commissioning, contracts management, care management review and safeguarding intelligence must be fully integrated.

1.4 Key developments within the NHS

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 has profound implications for the NHS and social care system in terms of improving dignity and quality of care. The extensive recommendations by Robert Francis QC set out the following aims:

- Foster a common culture shared by all in the service of putting the patient first

- Develop a set of fundamental standards, and evidence-based means of compliance with these

- Ensure openness, transparency and candour throughout the system about matters of concern

- Ensure the focus of the healthcare regulator is on compliance with these standards

- Make all those who provide care for patients properly accountable for what they do

- Provide for a proper degree of accountability for senior managers and leaders

- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare

- Develop and share means of measuring and understanding the performance of individual professionals, teams, units and provider organisations

The Department of Health report *Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report* December 2012 is an in-depth review, set up in the immediate aftermath of the Panorama programme in May 2011. The report focuses on

- Strengthening accountability and corporate responsibility for the quality of care;

- Monitoring and reporting on progress;

- Tightening the regulation and inspection of providers;

- Improving quality and safety.

It sets out a range of 63 national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging.

The NHS Commissioning Board *Safeguarding Vulnerable People in the Reformed NHS - Accountability and Assurance Framework* March 2013 aims to:

- Promote partnership working to safeguard children, young people and adults at risk of abuse, at both strategic and operational levels
- Clarify NHS roles and responsibilities for safeguarding, including in relation to education and training
- Provide a shared understanding of how the new system will operate and, in particular, how it will be held to account both locally and nationally
- Ensure professional leadership and expertise are retained in the NHS, including the continuing key role of designated and named professionals for safeguarding children
- Outline a series of principles and ways of working that are equally applicable to the safeguarding of children and young people and of adults in vulnerable situations, recognising that safeguarding is everybody's business.

1.5 LGA and ADASS Adult safeguarding and domestic abuse: A guide to support practitioners and managers, April 2013

This is a guide for practitioners and managers in councils and partner agencies engaged in working directly or indirectly with people who have care and support needs, whose circumstances make them vulnerable, and who may also be victims of domestic abuse. The guide aims to:

- improve recognition and understanding of the circumstances in which adult safeguarding and domestic abuse overlap
- contribute to the knowledge and confidence of professionals
- offer good, practical advice to staff and managers to ensure that people in vulnerable circumstances have the best support, advice and potential remedies
- identify some of the organisational developments which can support best practice in this area

1.6 LGA, ADASS and SCIE (Social Care Institute for Excellence) Making Safeguarding Personal March 2013

This is the final report of a project run by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) to undertake some small scale development work in relation to Making Safeguarding Personal. It draws together the findings from four test bed sites and other councils that are using or developing person centred, outcome focused responses to safeguarding adults. The report focuses on process, outcomes, impact on practice and cost effectiveness.

1.7 SCIE At a glance 62: Safeguarding adults: Mediation and family group conferences September 2012

This briefing summarises SCIE's new web resource Safeguarding adults: Mediation and family group conferences. The resource explains the use of mediation and family group conferences for adults who are – or may be – at risk from abuse. These approaches are both 'family-led' approaches based on the principle of empowerment and focus on problem-solving rather than blaming; involve a competent, trained mediator or Family Group Conference coordinator who helps participants to find solutions to the issues that divide them; place the person at the centre of the decision-making process; may prevent abuse by empowering families to address tensions at an early stage.

1.8 ADASS, Prisoners and Safeguarding Briefing Note, April 2012

This briefing aims to ensure that Directors of Adult Social Services (DASSs) are aware that local safeguarding teams may be contacted by inspectors if they identify possible abuse of adults at risk within prisons. The underlying principle is that No Secrets does not exclude prisoners. The recent Law Commission consultation suggests that the omission of explicit reference to prisoners should not prevent them from being safeguarded under the same principles as adults at risk in the community.

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

2.1 An Overview of Safeguarding Improvement Work in 2012/13

2.1.2 The operational sub group of the Safeguarding Board has reduced membership making it smaller and more focussed. This has directed the work of the pan Bedfordshire sub group meetings and has resulted in:

- Facilitated development session for partners on the Equality and Human Rights Commission Hidden in Plain Sight recommendations for safeguarding
- Training sub group focus on developing guidance for safeguarding training
- Task and finish group to ensure the smooth transfer of deprivation of liberty safeguards arrangements from the NHS to the local authorities
- Regular cases studies of safeguarding cases presented by each partner
- Task and finish group to look into self neglect and identify good practice
- Ongoing reporting on quality audits and activity from each partner

2.2 Prevention and raising awareness

2.2.1 Both councils have continued ongoing safeguarding publicity campaigns including:

- A biannual mail out and letter to service providers
- A variety of literature including keeping safe handbooks, easy read leaflets, folding “z” cards, and posters
- 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
- Internal Council publicity campaign raising awareness to several thousand Council staff who live and work locally
- Contributions to the Council newsletter sent to all care providers
- Updates to Council websites with information on keeping safe online and financial abuse
- Safeguarding awareness presentations to a number of service providers and agencies

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

2.2.2 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 has resulted in improved joint working arrangements. The safeguarding teams are represented on the anti social behaviour risk assessment conferences, and the domestic abuse multi agency risk assessment conferences, and the sexual assault risk assessment conferences.

2.2.3 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.

2.2.4 Both councils have identified that further 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.

2.3 Workforce development and accountability

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:

- Holding workshops and focus groups with staff to test their level of understanding and confidence with safeguarding, and identify areas for improvement and training.

- Central Bedfordshire Council continue holding weekly practice surgeries with a senior practitioner visiting each team for a day. Feedback from these sessions is collated and informs practice development. These have been welcomed by social workers and their team managers in assisting with the improvement of practice.

- Bedford Borough Council have held a number of peer group reflection sessions for workers to share good practice and learning from safeguarding cases.

- Developing guidance for staff in Central Bedfordshire based on the outcomes of audit work including risk assessment, the quality of strategy meetings, HR guidance for employers when staff are involved in safeguarding concerns and guidance for when to report safeguarding alerts following medication errors.

- 1:1 training sessions and observation of practice by an independent trainer for individuals and teams within Bedford Borough has taken place. Learning outcomes are identified and feedback is given to the individual and their manager, to improve practice.

- Development of an intranet based "safeguarding handbook" for staff in Central Bedfordshire, which breaks down the policies and procedures and provides sections on Risk Assessment, Protection Planning, Investigation, Complex Cases, and the Mental Capacity Act. This makes the policies and procedures and guidance accessible for all staff.

- Bedford Borough continue to hold a series of bite size training sessions which are based on sessions that workers request and include risk assessing, domestic abuse, safeguarding and mental capacity.

- Developing the role of the safeguarding support workers, who are working with all care homes within Central Bedfordshire to raise awareness of safeguarding and provide a liaison role to improve understanding and reporting of safeguarding

- Both Councils hold regular meetings with the Learning and Development Team and the Safeguarding trainers to ensure the training is meeting the needs of workers and the required standard. Members of the safeguarding teams attend training courses to monitor the quality of provision. Courses have been commissioned as a result of feedback from workers and independent auditor including financial abuse and safeguarding and the law.

- Bedford Borough Council team managers and senior practitioners meet on a quarterly basis to discuss issues relating to safeguarding, to share good practice and incorporate into teams.
- Both Councils use performance monitoring to identify trends and patterns of safeguarding activity. Where a concern is identified action is taken such as directly working with the service providers and information sharing with other agencies and partners to ensure appropriate action is taken to address the concern.

- Regular correspondence with community teams regarding updates on safeguarding information such as changes in the disclosure and barring scheme, pertinent legal cases such as the West Sussex case and articles of interest.

2.4 Partnership working

2.4.1 The pan-Bedfordshire safeguarding sub groups continue to run on a quarterly basis. 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, policies and procedures and the implementation of the Mental Capacity Act 2005. The sub group has been successful in developing one safeguarding alert form across the three local authorities in the county to the benefit of all partners.

2.4.2 Both Councils continue to facilitate a Providers Forum as a platform for information sharing and safeguarding is a permanent agenda item at these forums. Safeguarding surgeries have recently been set up for care providers to meet with the safeguarding managers to discuss cases and good practice. This included a provider presenting to colleagues on a safeguarding case that they were involved with.

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

2.4.4 The Councils have attended two regional conferences with partners, on safeguarding in the Eastern Region and the Crown Prosecution Service and its role within safeguarding procedures.

2.4.5 Both Councils have introduced encrypted email facilities to improve confidential information sharing between partner agencies

2.4.6 Both Councils have attended a new police steering group forum which is convened for children's and adults safeguarding. Topics for discussion have included thresholds, domestic abuse reporting and the Mental Capacity Act. This has resulted in improved understanding and working arrangements following the reorganisation of Bedfordshire police in 2011.

2.4.7 Both Councils meet with advocacy groups POhWER and Advocacy for Older Persons to ensure that the safeguarding agenda is incorporated at every opportunity into service user groups that are facilitated by advocacy support.

2.4.8 Both Bedford Borough Council and Central Bedfordshire Council have completed their Winterbourne View joint Improvement Programme and an Initial Stocktake of Progress against Winterbourne Concordat Actions with the Bedfordshire Clinical Commissioning Group. The plans outline the key areas and the timescales for actions to be made to improve the lives of people with Autism, Learning Disability, Mental Health and behaviours that challenge.

2.4.9 The Winterbourne View Joint Improvement Programme asked local areas to complete a stocktake of progress against actions made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1st June 2014. An important action in the plan is to ensure that all key agencies know their responsibilities and duties regarding safeguarding and that each authority is engaged with local safeguarding arrangements in line with the ADASS protocol and has working links between the Care Quality Commission, contracts management, safeguarding staff and case managers to maintain alertness to concerns.

2.4.10 Local Authorities were to lead the stocktake process and the responses were developed within the Bedfordshire Clinical Commissioning Group and were signed off by the key representatives of the Councils and the Clinical Commissioning Group representing the Health and Wellbeing Boards

2.5 Quality Assurance and protection

2.5.1 Both Councils have continued to develop their quality assurance programme.

2.5.2 Central Bedfordshire Council undertakes quarterly audits of case files from all teams including SEPT and has commissioned one independent external audit 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:

- Good initial holistic assessments with clear evidence that person is at the centre
- Good understanding of continuity of care
- Evidence of multiagency working
- Evidence of investigation reports becoming clearer in telling the story

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

- Risk assessments only take into account the main risk and do not always take into account strengths and protective factors. This can mean missed opportunities in identification of risk and early intervention.
- In some cases clearer documentation is required regarding the person's views and outcomes particularly when there are mental capacity issues.
- Chair of safeguarding meetings should provide clear leadership in assuring that person centred approached is considered and reviewed and in challenging care providers where appropriate.
- Lack of evidence that the person is aware of the protection plan and poor evidence that protection plans are being shared more widely with the multi disciplinary team.

2.5.5 The Central Bedfordshire safeguarding team have reviewed a sample of 27 alerts that had not progressed to investigation to ensure decision making is consistent. The ADASS advice and guidance note for Directors (March 2013) draws attention to the need to ensure that services are not "swamped by demand or that cases of serious harm will not fall through the net". The safeguarding team has identified that inappropriate alerting falls into one of the six categories below and has developed an approach to ensure that appropriate alerts are prioritised and that referrals through to the locality teams are proportionate. All information received receives a response and is forwarded to the correct route but those identified in the categories below will not be processed as safeguarding alerts.

- Complaint
- Referral for assessment of need
- Quality assurance info for contracts management
- Disciplinary process for provider
- Information sharing about a vulnerable person requiring no further action
- Inappropriate contact

2.5.6 Bedford Borough Council have commissioned two independent audits from an ex regulatory inspector in August 2012 and February 2013. Cases were selected at random and for each case staff were required to write a case summary and critique. The outcomes from the audit are fed back to Managers and teams to strengthen safeguarding practice.

2.5.7 The Auditor noted the following strengths and achievements across the cases analysed:

- High quality and consistency of threshold decisions which exceeded anything he had seen in other local authorities
- High quality, skilled and robust management oversight
- A focus on quality
- The capacity of staff to learn from feedback and self reflection
- Critiques prepared for the audit were of an exceptional and high quality standard
- The investment made in improving the effectiveness of case conferences has led to tangible improvements
- Committed and skilled staff
- Good quality case conference minutes
- Adults at risk were involved in the safeguarding process
- The practice of completing mental capacity assessments where there were doubts about a person's capacity to participate in the safeguarding process was highly commended.

2.5.8 Areas of improvement and development identified:

- New set of recording tools not yet implemented
- Small number of cases demonstrated a difficulty in distributing case conference minutes in a timely manner
- There was a difficulty in completing the internal audit process in a timely way in some cases
- Cases demonstrated the difficulties of safeguarding people where financial abuse was an issue

2.5.9 The Auditor concluded that Bedford Borough Council were "delivering a high level of performance in relation to safeguarding case work" and "some of the case work interventions were carried out under difficult circumstances.

"Performance was in the range of good to excellent and reflects positively on the skills and commitments of frontline staff and their managers / supervisors"

2.5.10 The independent Auditor also analysed 9 randomly selected safeguarding alerts that had not progressed to investigation, in order to provide an independent evaluation of these decisions. The Auditor judged the decisions to be safe and secure commenting that the decisions

- Were clearly articulated and robustly recorded
- Were recorded who had been consulted, what information was gathered, factors taken into account and the rationale of the decision.

His recommendations included scope for even more robust recording around intelligence checks and discussion with Bedford Borough Council Care Standards Team and the Care Quality Commission.

2.5.11 Both Councils have implemented action plans based on the six priority areas of prevention, workforce development and accountability, partnership, quality assurance and protection, involving people and empowerment and outcomes and proportionality.

2.6 Involving people and empowerment

2.6.1 Bedford Borough Council has commissioned POhWER to run "Keep Safe" training course for service users with a learning disability who have been subject to a safeguarding investigation. Bespoke programmes are delivered to very small groups and cover the topics of assertiveness and confidence, friendship and relationships and communication. The training has the potential to develop and meet different needs. Refresher courses are held to go over issues and evaluate

what learning has occurred and to obtain service user feedback. 28 service users have attended and feedback has been positive from service users and the Adult Learning Disability Team.

2.6.2 Central Bedfordshire Council has developed a new information leaflet in consultation with user groups and the learning disability partnership board. It is designed to be accessible to a range of people how may have sight or cognitive impairments.

2.6.3 In both Councils 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 continue to report an increase in referrals to their services. Advocacy services have introduced safeguarding as a regular topic in their "Voices" groups.

2.7 Outcomes, improving people's experience and proportionality

2.7.1 Both Councils continue to operate 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 Both Councils have continued to seek feedback from people who have been involved in safeguarding interventions. This involves visits from safeguarding support workers and involves advocacy services. Both Councils have identified that there is a need to develop different ways of gaining feedback as visits and questionnaires are not always suitable.

2.7.3 Central Bedfordshire Council has reviewed the way we gather information about safeguarding and has developed a new process of evaluation that is built into the work completed by the social workers. Comments arising from visits to people who have been through safeguarding have included:

"The social worker was pretty good to me, and she wouldn't do enough for me."

"The advocate kept me informed throughout the process I thought that they were going to pull the advocate out and not visit me again but I feel at ease as they still gave me advocacy support."

2.7.4 Bedford Borough Council also uses the feedback process to gain the views of carers and family members when they have been involved in a safeguarding investigation. Comments from Bedford Borough service users and carers include:

"Process explained fully and kept informed at all times"

"Views and opinions were listened to"

"Would approach the social worker again if needed"

"Outcomes and actions were printed and sent to family members which was very much appreciated"

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 Bedford Borough Council has initiated the serious concerns procedure in relation to a residential/nursing home for older persons. Serious safeguarding concerns were raised about the standards of care within the home and their ability to meet the needs of the service users. As a result a number of service users were identified as being high risk and moved to new placements. CQC placed a limit on the maximum number of service users within the home of 15 and an embargo on all admissions.

2.8.3 There has been ongoing multiagency support to improve the standards of care within the home and a high level of monitoring by the Bedford Borough Safeguarding Team, Care Standards Team, Complex Care Team and by the Care Quality Commission. Bedford Borough Council actively worked with the provider to improve standards by implementing an improvement plan to address specific issues.

2.8.4 Following a CQC inspection where the home was deemed to be complaint in all areas the embargo has been lifted and the home is working with Bedford Borough Council on a planned schedule of new admissions. The home is no longer being monitored under the Bedford Borough Council serious concerns procedure.

2.8.5 Central Bedfordshire Council has initiated the serious concerns procedure in relation to one domiciliary care service in 2012-13. The concerns related to ongoing missed or late care calls with significant impact on people's lives for example, medications and food. There were numerous concerns and complaints raised and there were also concerns about the response of the agency to those individual's concerns.

2.8.6 The Council suspended the start of any new care packages and undertook reviews of 300 people using the service. In some cases these reviews resulted in a new care provider being found. The Council initiated a robust action plan which was closely monitored and resulted in a significant improvement in the service, so that new packages of care were able to recommence.

2.9 Serious Case Reviews

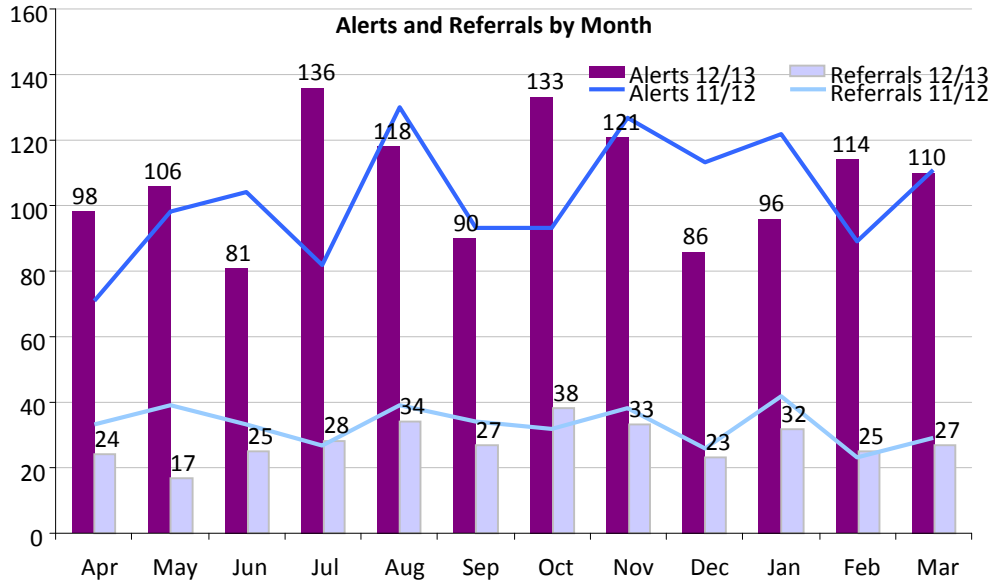
2.9.1 The purpose of a Serious Case Review is to establish the lessons learnt from a case about the way in which local professionals and organisations work together to safeguard and promote the welfare of adults at risk. It is used to identify clearly what those lessons are, how they will be acted on, 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 There were no serious case reviews in Bedford Borough or Central Bedfordshire in 2012-13.

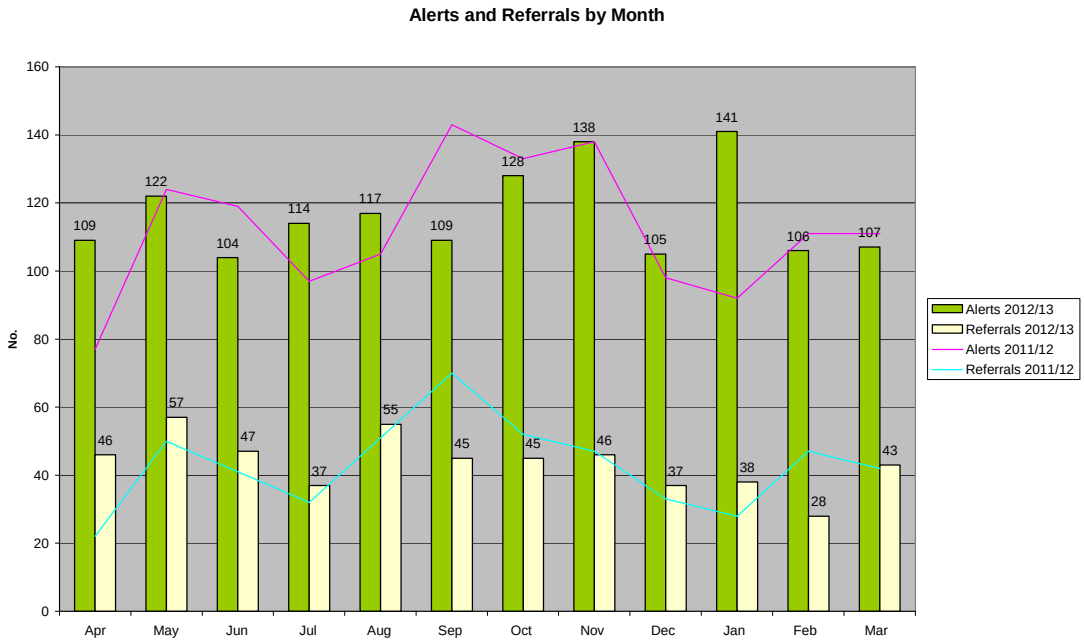
3. Safeguarding Activity April 2012 – March 2013

3.1 Number of alerts and referrals

Bedford Borough



Central Bedfordshire



3.1.1 In 2012+ – 2013 Bedford Borough Council received 1289 alerts, an increase of 56 alerts compared to 2011 – 2012. In comparing month for month between both years, July and October are reflecting significant increases, there appears to be no obvious reason for these increases.

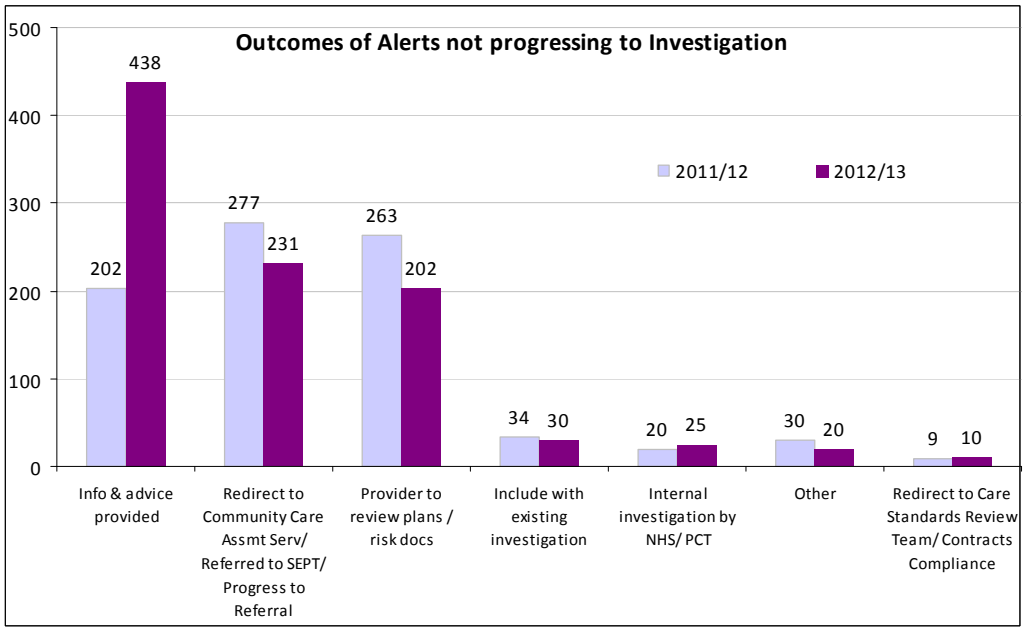
3.1.2 During 2012 – 2013 the total number of Bedford Borough alerts which progressed to referral were 333 which equates to 26% of alerts received. This is a decrease compared to the previous year when 32% of alerts progressed to referral. This can be attributed to better screening at the alert stage and a high level of reporting of minor issues.

3.1.3 This is the 4th year Bedford Borough has seen continued increases in the number of safeguarding alerts received which can be attributed to the ongoing safeguarding awareness campaign.

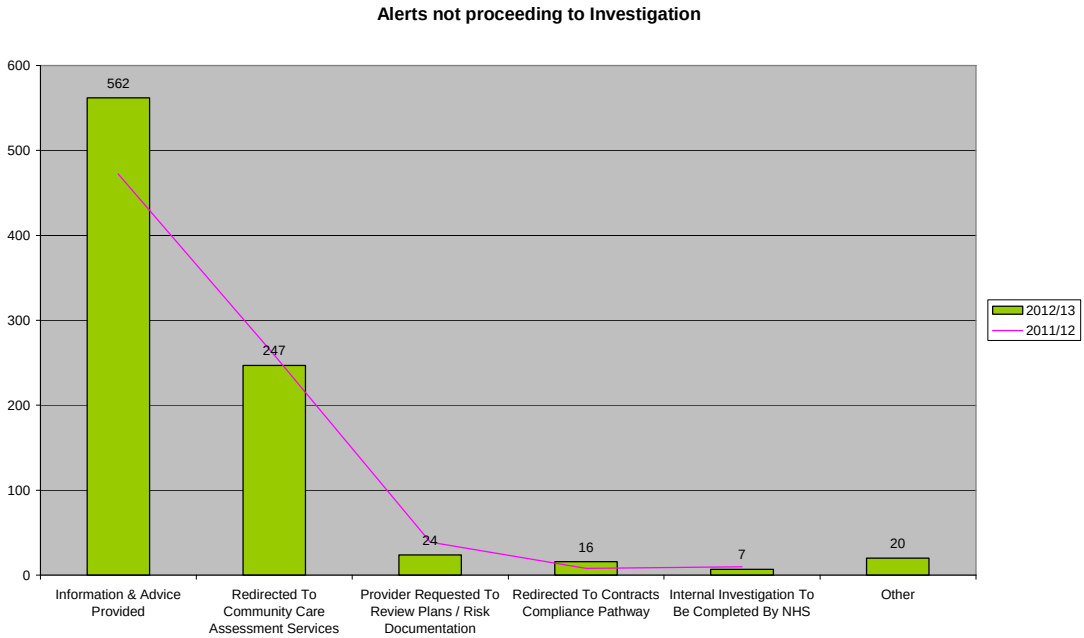
3.1.4 Central Bedfordshire Council received 1400 alerts during the year, a small increase of 52 from the previous year. There has been an increase in alerts year on year over the last three years, but the increase this year is much smaller. 524 alerts progressed to investigation, 37% of the total alerts. This is a similar percentage of alert to referrals as last year (38% 2011-12), and could be indicative of a plateau in volume of alerts and referrals following a period of increase.

3.2 Alerts not proceeding to referral (investigation)

Bedford Borough



Central Bedfordshire



3.2.1 In Bedford Borough Council the number of alerts received which did not progress to the referral stage totalled 956 in 2012 – 2013, and increase of 121 from the previous year. Of the 956 alerts received:

- 438 (46%) resulted in information and advice being provided, an increase in 236 from the previous reporting year.

- 231 (24%) were redirected to community assessment teams, this is a decrease in 35 from the previous reporting year
- 202 (21%) alerts resulted in providers being requested to review plans and risk documentation, a decrease of 61 from the previous year

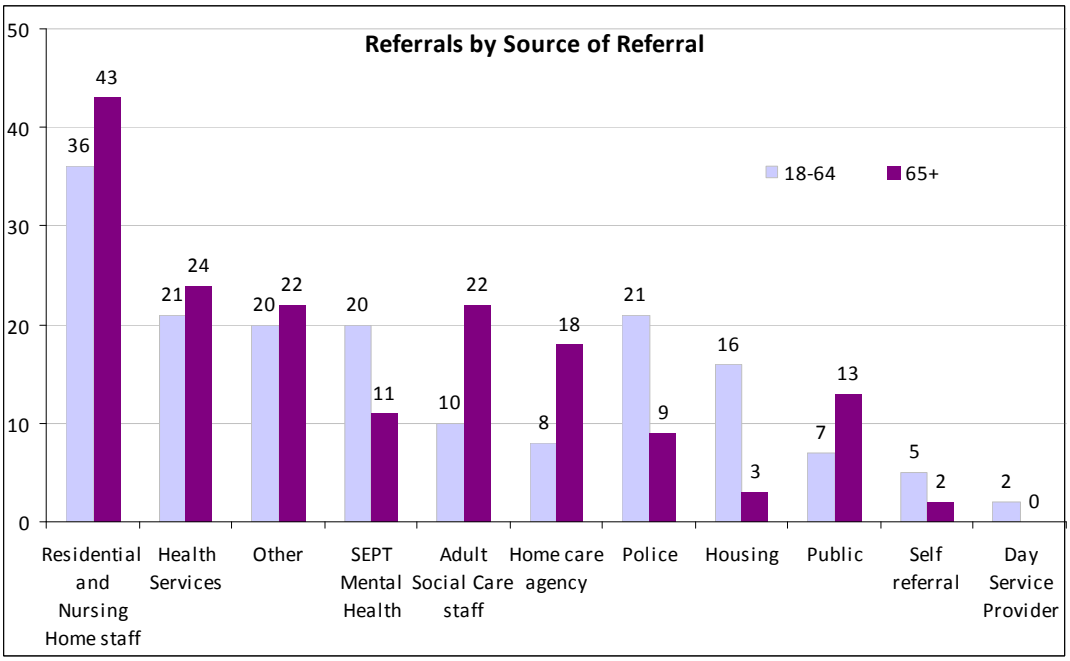
3.2.2 Two thirds of the safeguarding outcomes make up information and advice along with providers to review risk assessments, this demonstrates a high level of alerts being received that indicate a low level of risk that can be managed by providing advice and information or reviewing risk assessments and support plans by the provider. In these alerts the referrer may have correctly identified safety or vulnerability concerns but may be using the safeguarding alert system as a safety net to record concerns. The safeguarding team continues to work with providers to develop understanding of what constitutes an inappropriate safeguarding alert.

3.2.3 The number of safeguarding alerts in Central Bedfordshire not progressing to safeguarding investigation totalled 876, a small increase from the previous year. The trend in responses to these alerts mirrors 2011-12, with the majority (64%) of responses being advice and guidance. A significant proportion (28%) is referred to the community assessment and care management teams for a response. This means that 65% of all safeguarding alerts receive formal response from adult social care.

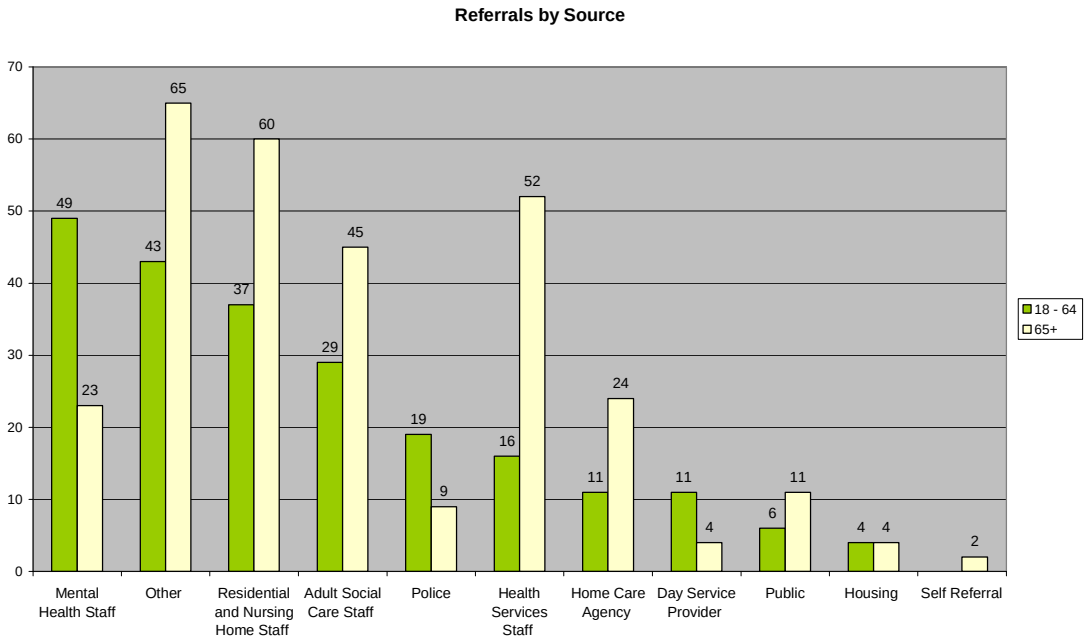
3.2.4 Last year it was identified that high levels of alerts are being raised that should be managed by routes other than safeguarding, prompting a review of the current safeguarding thresholds. Section 2.5.4 details the approach within Central Bedfordshire Council towards alerts that are not considered to be appropriate.

3.3 Source of referral

Bedford Borough



Central Bedfordshire



3.3.1 In Bedford Borough Council the main source of referrals continues to be from social care staff which includes residential/nursing staff, domiciliary, day care and social workers reporting an alert. Most alerts are received from residential and nursing homes and Bedford Borough hosts 124 regulated service providers within its area. Figures for this report show the number of referrals raised from social care staff remain at a similar level to last year.

3.3.2 In Bedford Borough there has been an increased level of alerts received from the police, housing and the other category which includes voluntary organisations, probation, prison, advocacy services and CQC. This demonstrates that an increased awareness of safeguarding across a range of agencies (and they continue to work in partnership with groups within the voluntary sector and advocacy to raise awareness of safeguarding and how to report concerns).

3.3.3 In Bedford Borough there is a similar level of referrals for the 16-64 and 65+ group, with referrals with residential / nursing care and health care agencies, social care staff, other and the public

being higher for the over 65 group. This is likely to be as a result of more people in residential care, receiving care at home and potentially receiving hospital treatment being over 65. The police, SEPT and housing have reported significantly more alerts for the 18-64 group, which may be a result of people within this age group being in the community and having more contact with or receiving more services from these agencies.

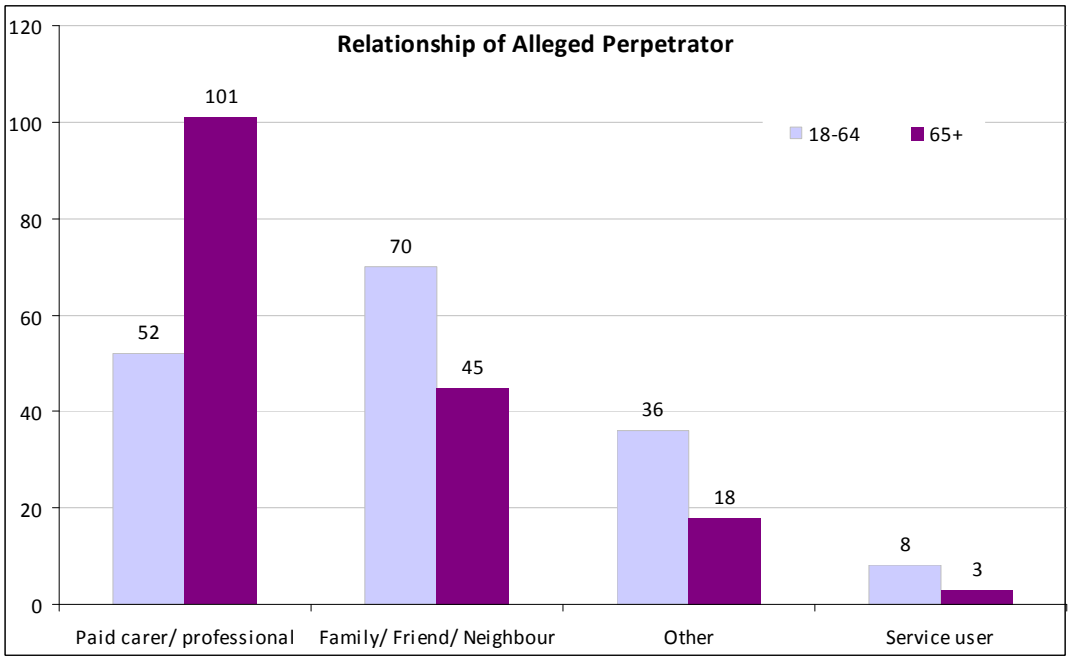
3.3.4 The low number of 20 alerts received from the public indicates that more community work is required to raise safeguarding awareness to communities in Bedford.

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

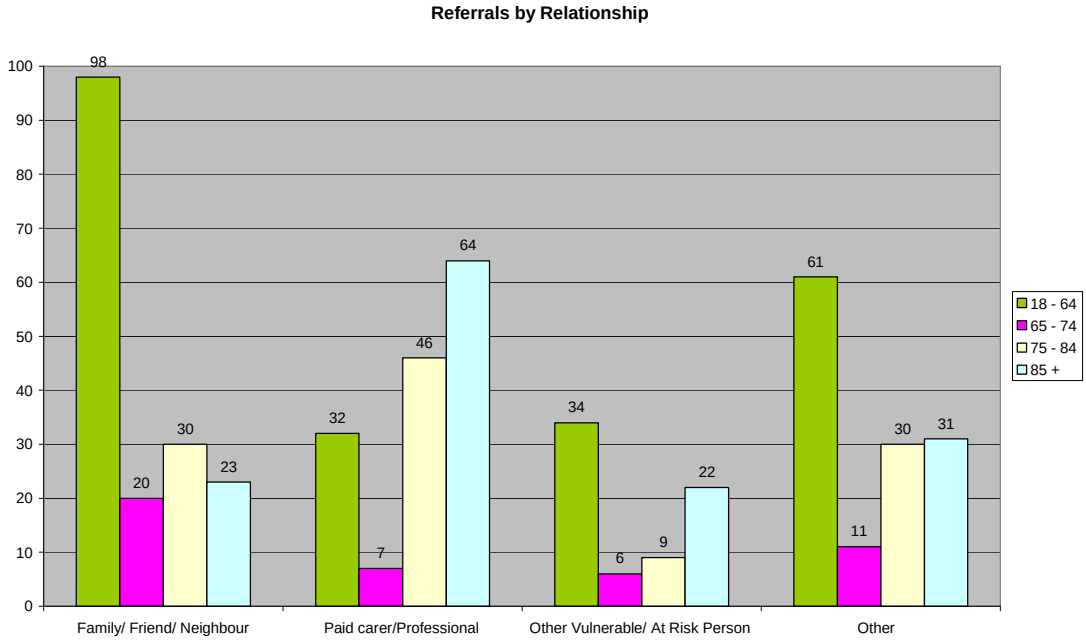
3.3.6 In Central Bedfordshire a significant figure to note is the large proportion of referrals in relation to people over the age of 65, made by primary or community health care staff. This trend was notable in the previous year's figures. It is likely that community health care workers will be those who come in to frequent contact with older people living in 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 safeguarding teams remain reliant upon the community professionals that work with people's homes - adult social care, domiciliary care and health services staff.

3.4 Relationship to victim

Bedford Borough



Central Bedfordshire



3.4.1 In Bedford Borough the relationship between the person causing harm and the person at risk is predominantly that of paid carers/professionals (45%). This is in line with reporting from the previous year. Evidence indicates the location of abuse tends to be within a persons own home, or a care home where a person is likely to be supported by a paid carer. The majority of referrals relating to the over 65 age group are more likely to be as a result of receiving residential nursing care or being supported to live in the community via social care providers and self directed support. The Care Standards Monitoring and Review Service actively work and engage with social care providers through site visits, improvement plans, provider forums to promote safeguarding awareness and good practice as well as addressing safeguarding concerns.

3.4.2 A significant number of referrals relate to friends, family and neighbours (34%). This is likely where the family member is the main carer as the location of abuse is more likely to take place within a person's home and be related to a financial concern.

3.4.3 Alerts for family/friends/neighbour category are higher for the 18-64 group and this is likely to be as a result of more service users within this group living within the community and being more vulnerable to friends, family and neighbours.

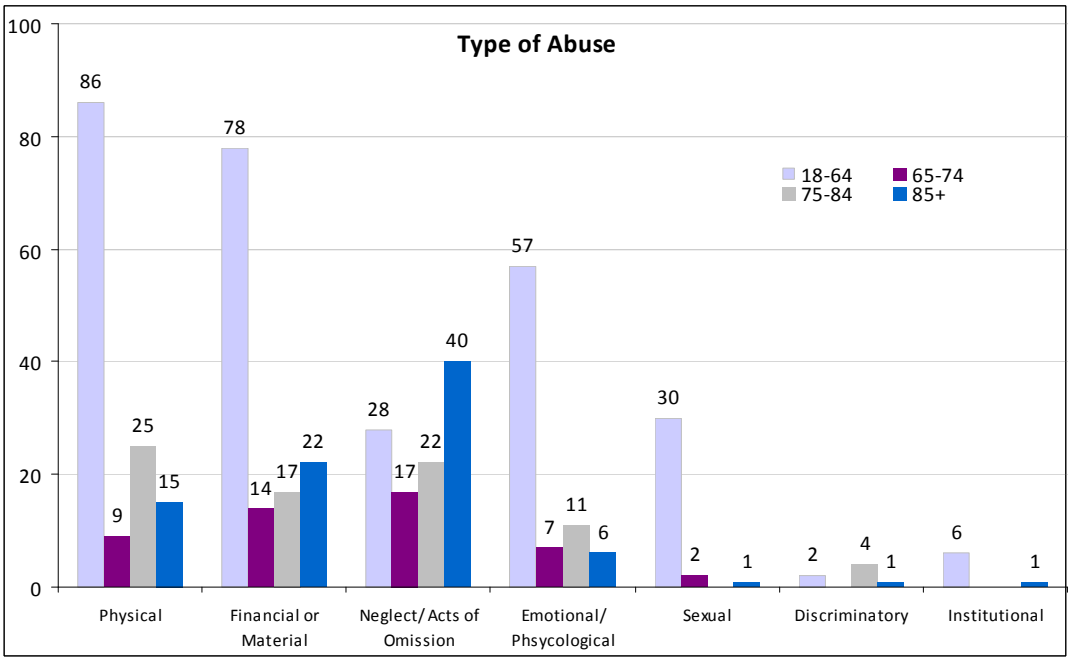
3.4.4 Similarly a higher proportion of the 18-64 referrals is related to 'other' which includes members of the public and strangers, which is likely to be as a result of living in the community and having more contact with members of the local community.

3.4.5 There is a low level of investigations involving other service users. This highlights the majority of alerts reported including service users do not meet the threshold for an investigation but are managed by reviewing support plans, care management involvement and advice given.

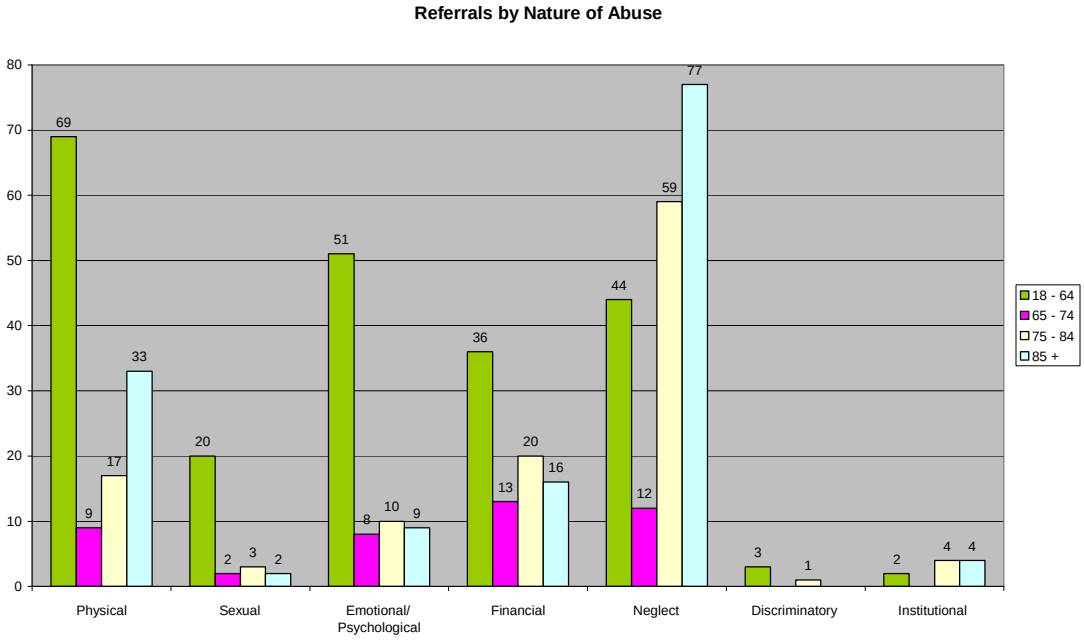
3.4.6 In Central Bedfordshire a significant proportion (44%) of referrals in relation to people under the age of 65 relate to incidents where the person causing harm is a family member, friend or neighbour. For older people, the person causing harm is a family friend or neighbour in 24% of cases, and a professional or paid carer in 40% of cases. The number cases where the person causing harm is a paid carer increases as people get older. Activity reports over the past year show a considerable rise in the number of alerts and referrals where the person causing harm is a paid carer. Analysis undertaken in quarter 4 indicates that where the person causing harm is a paid carer, the person at risk is likely to be over 85, living either in a care home or in their own home, and at risk of neglect or acts of omission. This is also demonstrated by chart 3.5 below. "Other" includes strangers and or that the person causing harm is unknown at the time of the alert.

3.5 Types of abuse

Bedford Borough



Central Bedfordshire



3.5.1 In Bedford Borough Council there has been an increase in all types of abuse. Physical abuse remains the most common form of referral this is consistent with the previous years reporting and the 18-64 age group remain the largest age group, with an increase from 112 to 135 referrals. 333 alerts progressed to investigation, within these alerts there was often more than one type of abuse recorded therefore, the overall figure for types of abuse will be higher than actual investigations due to multi recording.

3.5.2 Financial abuse has increased across all age groups. There is a growing trend with financial abuse, often relating to family members and taking place within a persons own home. Financial abuse is more prevalent within the 18-64 age group, this is likely to be because a larger population of this age group of vulnerable adults live in the community and manage their own finances, making them susceptible to abuse from family members, people known to them and the public. Recent benefit changes where housing benefit is paid directly to the individual rather than

the landlord may further impact on levels of financial abuse for this age group. The situation has to be monitored within the context of a current financial recession and changes to welfare benefits and housing assistance and the impact on family life.

3.5.3 Referrals for Neglect/Acts of omission has increased slightly with significantly more alerts raised for the 65+ age group compared to the under 65 age group, the biggest increase is in the 65 – 74 age group, which has increased from 8 to 17. This will include medication errors, poor hospital discharge, missed or poor domiciliary care support and incidents within a residential unit. Continuous monitoring of all safeguarding alerts takes place to identify trends and patterns amongst service providers, and also highlight issues with an individual provider. This will enable appropriate action to be taken, such as sign posting to further safeguarding training, care management action or involvement of the Bedford Borough Care Standards Team.

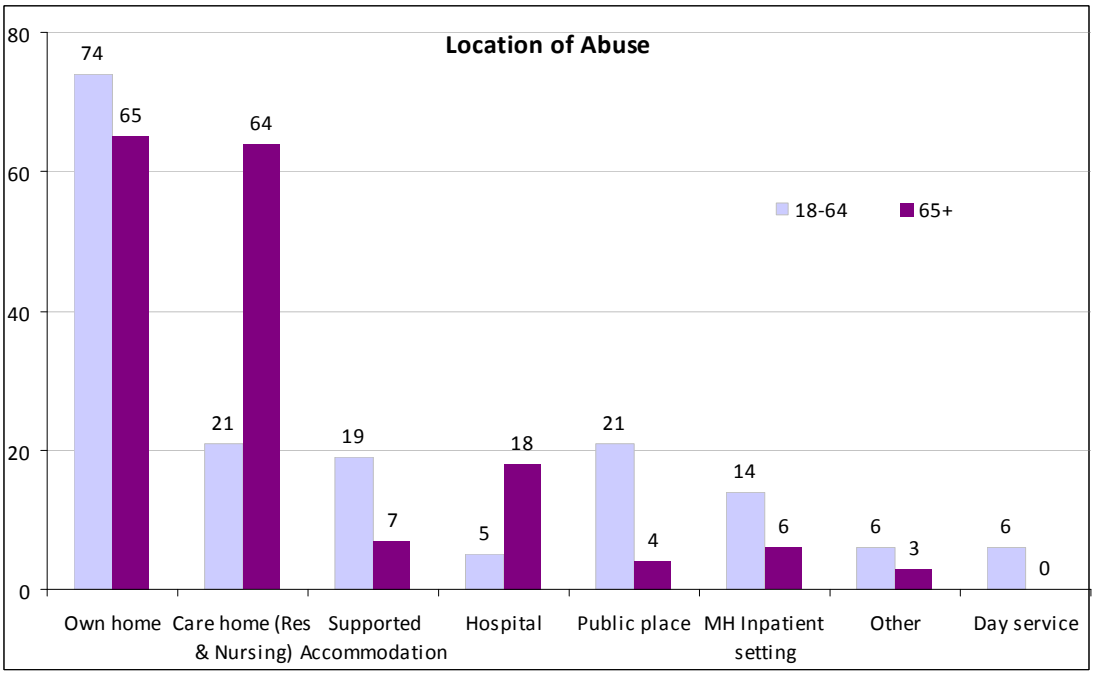
3.5.4 There has been an increase in emotional/psychological abuse, this category of abuse is often part of an alert relating to another type of abuse such as physical abuse or neglect or acts of omission where the referrer feels there has also been an emotional impact on the individual as well. The increase in this category is likely to be because many alerts now include emotional/psychological abuse along with the main alert. This is particularly evident in the 18-64 age group and demonstrates a more holistic approach to a safeguarding concern.

3.5.5 Central Bedfordshire's chart reflects last year's profile in that physical abuse is the most common in relation to people under 65 and neglect is the most common in relation to people over the age of 65. Since 2011-12, there has been a small drop in the number of referrals relating to physical, financial, discriminatory and institutional abuse. There has been an increase of 12% in referrals relating to neglect, which corresponds with the increase in referrals relating to paid carers. During 2012-13 the safeguarding team support workers have begun to work with local care homes to raise awareness of safeguarding and dignity, and this increase in alerts may be attributable to this activity.

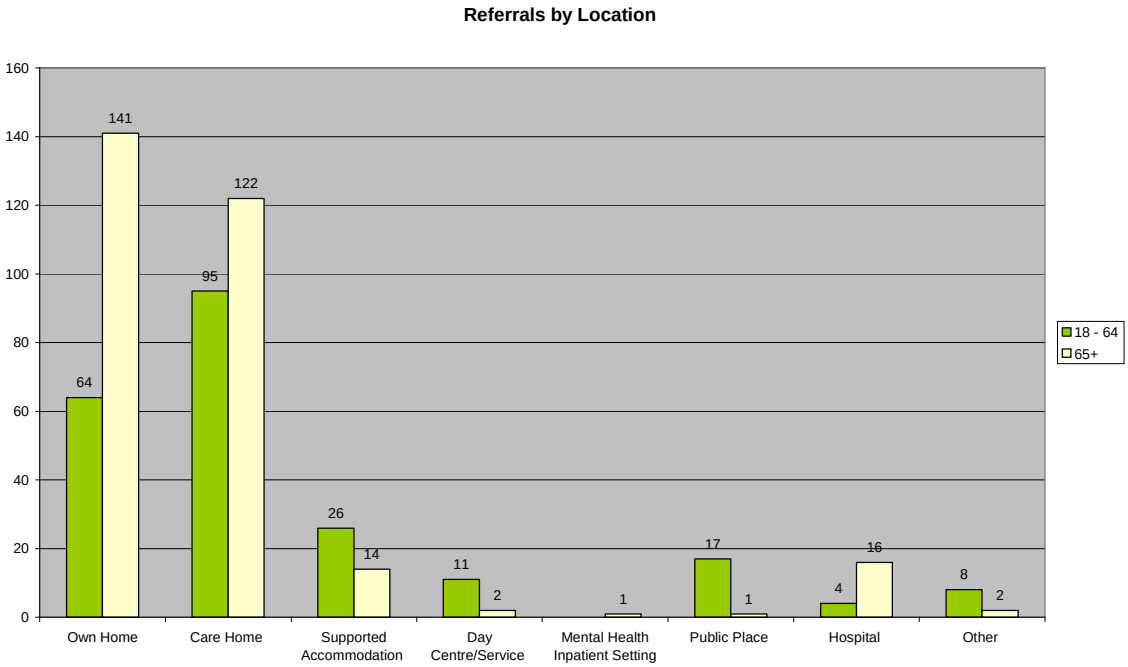
3.5.6 In Central Bedfordshire, a low volume of concerns in relation to discrimination is reported. Hate crime is an area of priority that has been identified through the course of 2012-13 and is prioritised in the learning section of this report.

3.6 Location of abuse

Bedford Borough



Central Bedfordshire



3.6.1 The highest number of safeguarding referrals relate to abuse taking place within a persons own home. In Bedford Borough in 2011-2012 139 alerts were raised to a safeguarding referral, this is a decrease of 14% on the previous reporting year. The decrease in levels of investigations is likely to be as a result of robust screening at the alert and involvement of care management and reviewing risk assessments and where individuals have wanted a lower level of involvement rather than a full investigation. The majority of abuse within a persons own home is likely to be related to a paid carer or family member and may include financial abuse. There has been an increase in complex financial abuse issues involving family members. Additional training is being commissioned for social care staff to highlight issues and address the increasingly difficult financial and family dynamics. As more people are supported to live at home, it is envisaged that this may be an area of increasing safeguarding concerns and reporting.

3.6.2 Referrals within care homes has decreased from 111 to 85. A high level of alerts is received from care homes, and the decrease in the number of alerts going on to a safeguarding investigation could indicate better practice within care homes, robust screening at the alert stage resulting in a high number of alerts being dealt with via reviewing risk assessments, support plans and care management involvement. The majority of referrals relates to the over 65 age group which is expected as the majority of people receiving residential care will be in this age bracket.

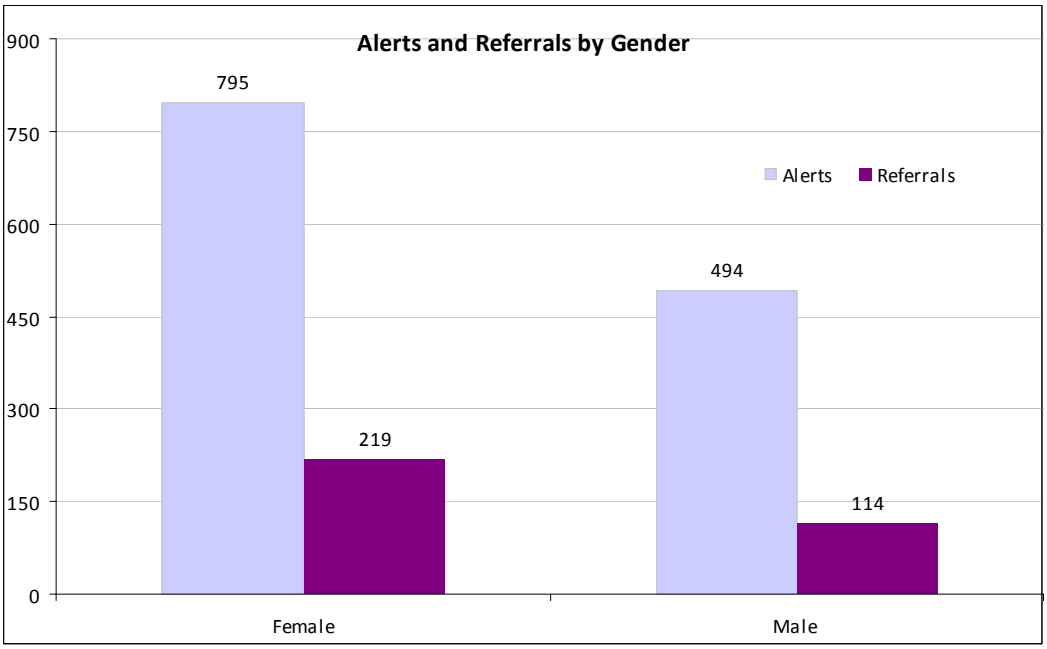
3.6.3 Referrals for supported accommodation has increased, this is likely to be as a result of more people receiving support in this type of accommodation. Service users within these services are likely to be more vulnerable to abuse when managing their own finances, or when dependant on support from care agencies which may result in missed domiciliary care calls and medication errors.

3.6.4 In Central Bedfordshire, the proportion of incidents over the year occurring in the persons own home and in a care home are the same (39% and 41% respectively). There was a notable increase in reports relating to incidents in the person's own home during quarter 3 of this year, but over the year numbers are broadly the same as last year. Last years annual report showed a significant increase in incidents in the person's own home compared to the previous year. A large proportion of incidents occurring in the person's own home relate to people over the age of 65. Based on the previous charts 3.4 and 3.5, a significant proportion of these will involve neglect or acts of omission by a paid carer.

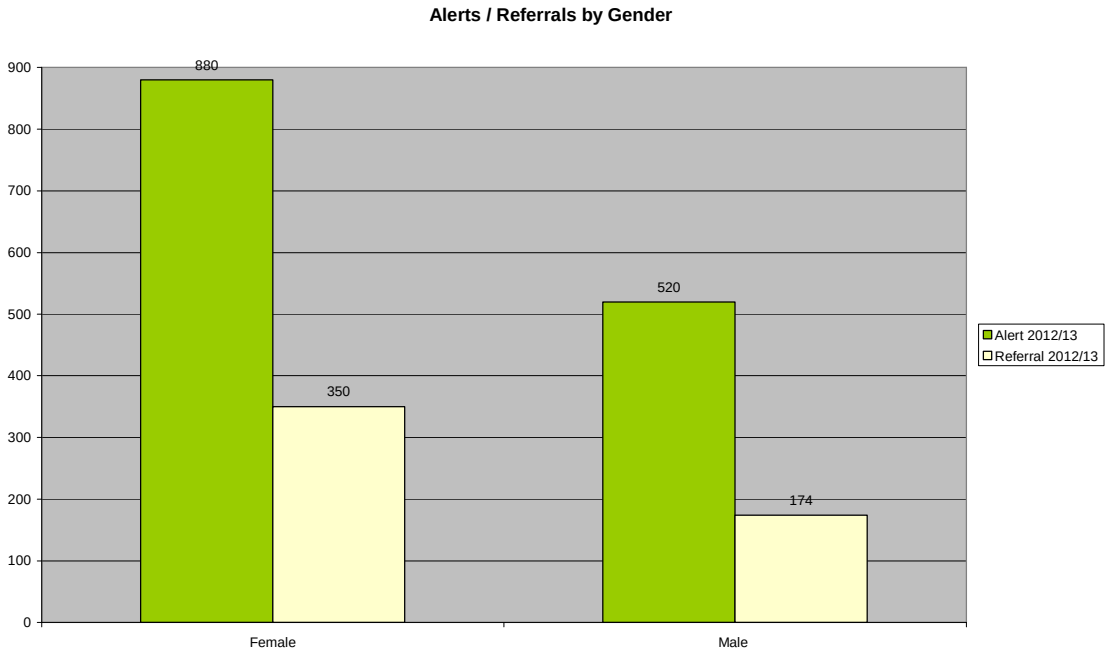
3.6.5 In Central Bedfordshire there has been a 44% increase in incidents taking place in care homes. As described in 3.5, during 2012-13 the safeguarding team support workers have begun to work with local care homes to raise awareness of safeguarding and dignity, and this increase in alerts may be attributable to this activity.

3.7 Alerts and referrals by gender

Bedford Borough



Central Bedfordshire



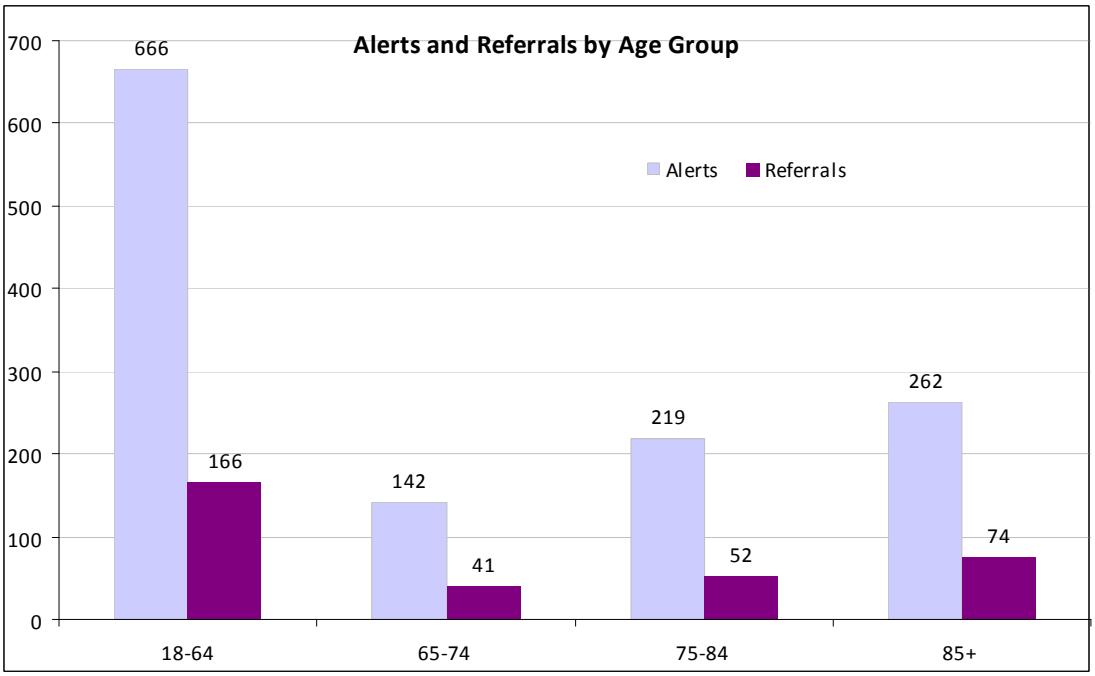
3.7.1 In Bedford Borough, as with previous years the larger proportion of alerts and referrals relate to women. This reflects the national picture where female life expectancy is higher than males and there is a higher proportion of incidents involving females being reported.

3.7.2 Approximately 60% of clients receiving a service within Bedford Borough are female, this is reflected in the above figures. The overall number of alerts for both females and males has increased from the previous year, however has decreased number of alerts progressing to referrals, 28% of alerts for females progress to a referral as compared to 23% of males.

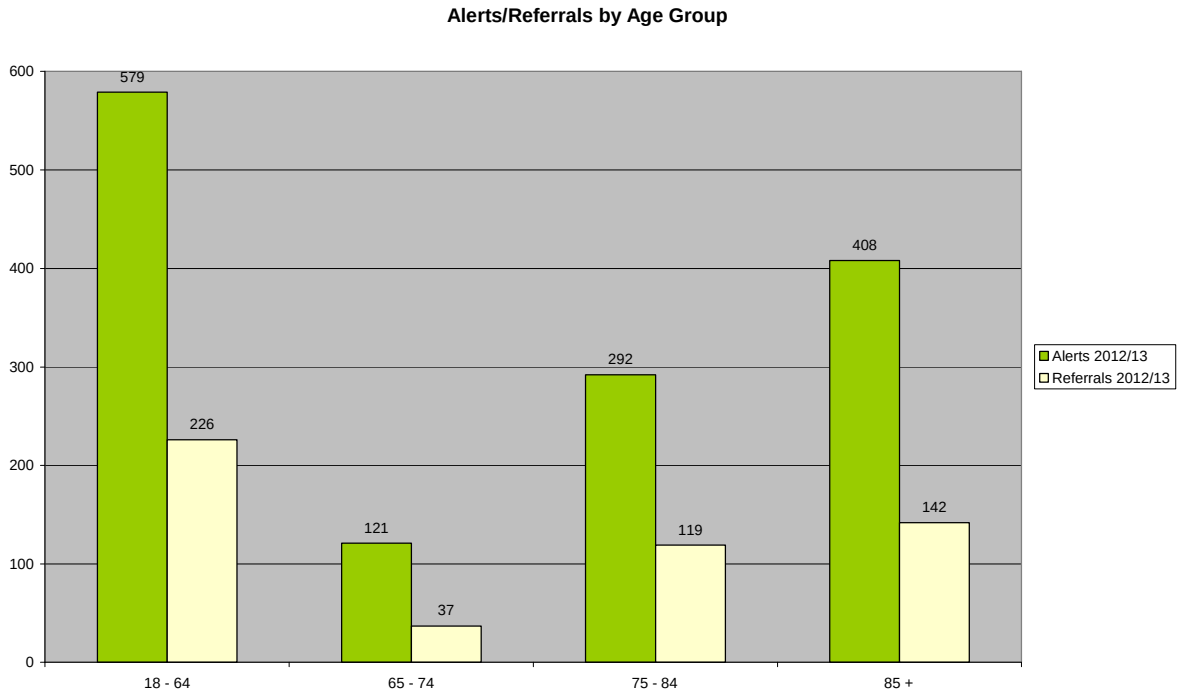
3.7.3 In Central Bedfordshire the ratio of male to female alerts and referrals is the same as the previous year, with the majority of people at risk being female.

3.8 Alerts and referrals by age group

Bedford Borough



Central Bedfordshire



3.8.1 In line with the previous year for Bedford Borough, the majority of safeguarding alerts and referrals relate to people aged 18-64. There has been an increase in the amount of alerts for this age group but a decrease in the proportion of alerts being raised to investigation (24.9%). The reduction in the amount of alerts progressing to referral is likely to be as a result of many of the incidents between service users which are managed by other routes such as care management and reviewing risk assessments. Physical and emotional abuse are noted as being the highest alerts amongst this age group.

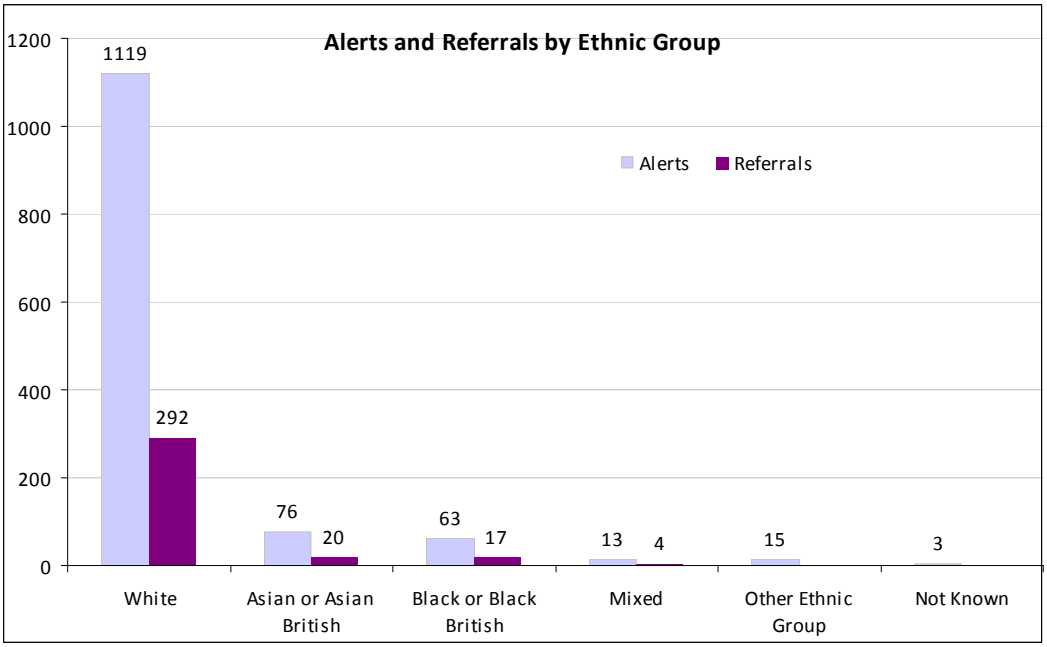
3.8.2 In Bedford Borough alerts for the 65+ have also increased, with 26.8% of alerts progressing to referral. This shows that a high number of alerts are screened out at the alerting stage. Neglect is highest in the 65+ category. This will include many alerts for missed medication and

domiciliary care calls where it was not deemed proportionate to instigate a safeguarding investigation but managed via review of services provided and care management involvement.

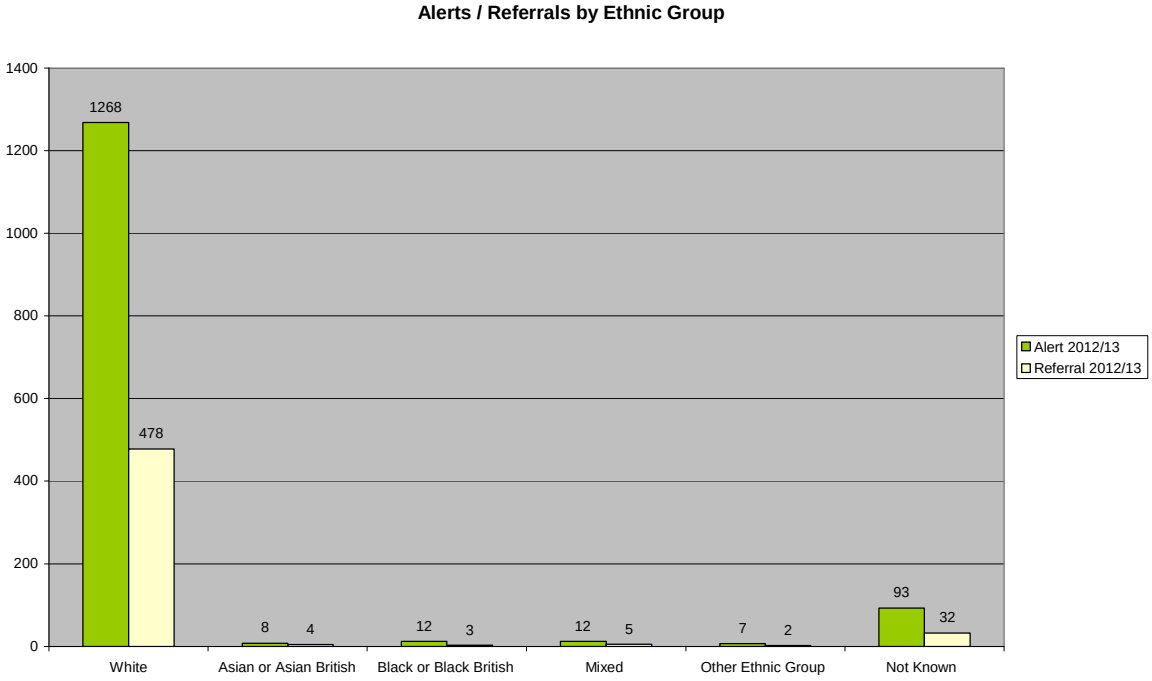
3.8.3 In Central Bedfordshire, the ratios of ages and alerts and referrals is the same as the previous year, with 50% of alerts relating to people over the age of 75. The proportions of alerts progressing to referral have not changed from last year.

3.9 Alerts and referrals by ethnic group

Bedford Borough



Central Bedfordshire



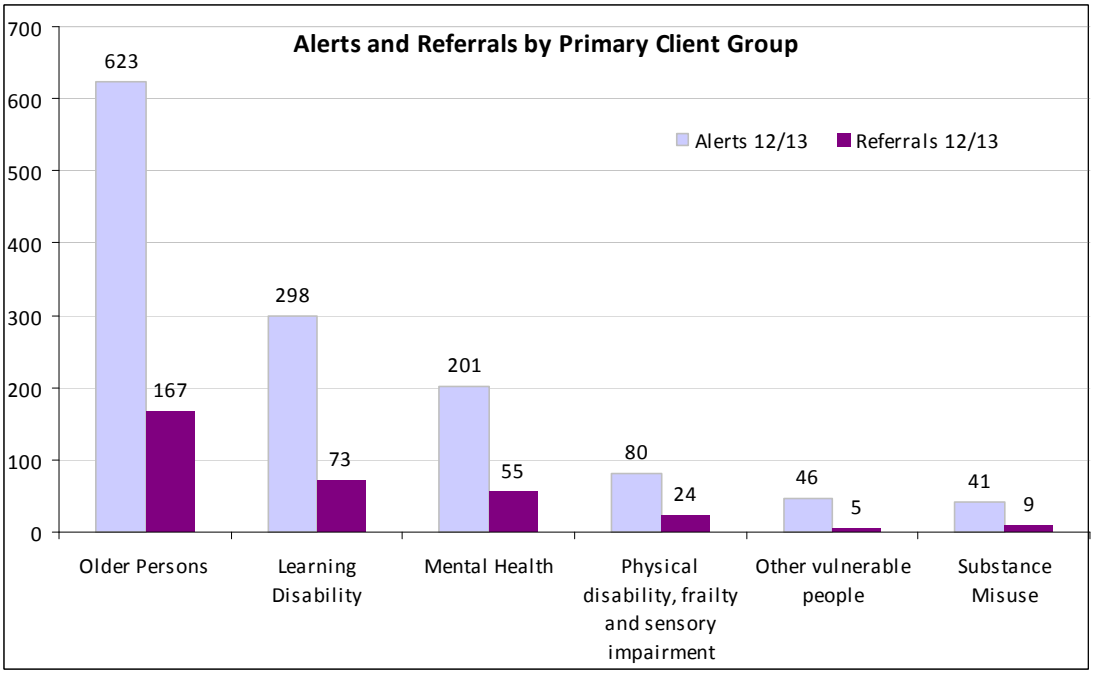
3.9.1 In Bedford Borough the number of alerts relating to ethnicity remains similar to the previous year with the largest category being white. This reflects the overall population mix of the local community. The 2011 census shows 83.88 of adults are white British which is a similar level to the 86.8% of alerts for white British people. Alerts for people with Asian ethnic backgrounds were

5.9% compared to 10.1% in the adult population. Alerts for people with black ethnic backgrounds were 4.9% compared to 3.88% in the adult population.

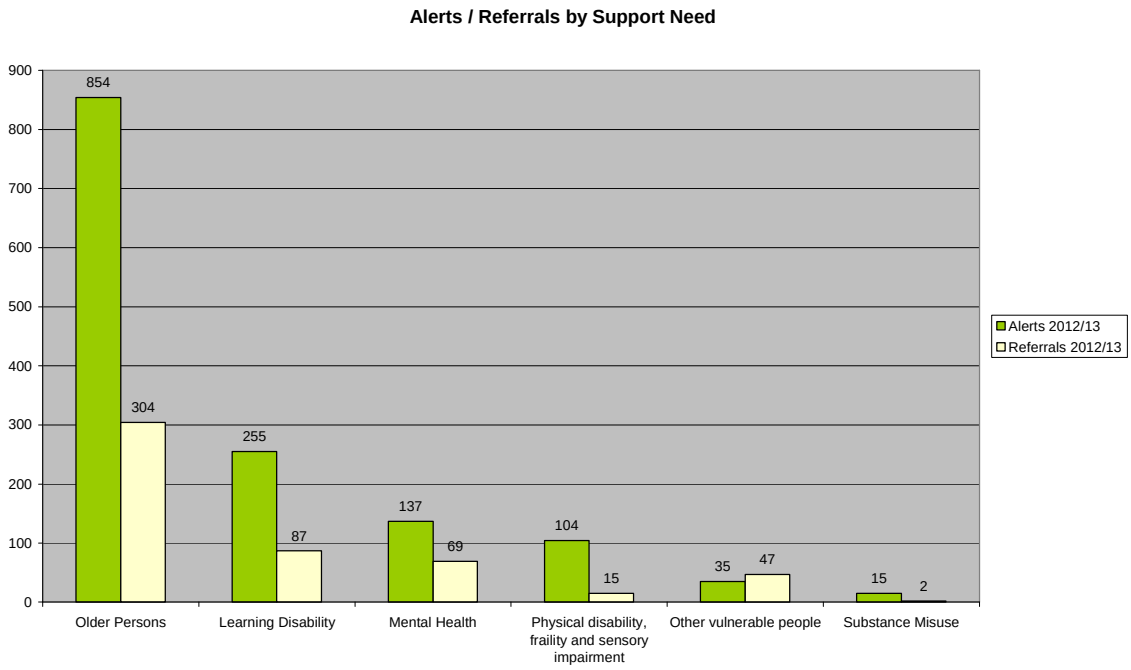
3.9.2 90% of alerts and referrals in Central Bedfordshire relate to White British people. The low number of alerts within Central Bedfordshire is a reflection of the communities within the locality and the presenting population which is predominantly White British. There has not been a change in patterns over the previous three years. The proportion of alerts progressing to referral for White British people is the same as for people of other ethnicities, and there has not been a change over the previous three years.

3.10 Alerts and referrals by support need

Bedford Borough



Central Bedfordshire



3.10.1 The older person's category continues to be the one with the highest alerts followed by learning disability and mental health. There has been an increase in alerts received in older persons client group from 444 to 623 (39%), and an increase in alerts progressing to referral from 144 to 167 (16%).

3.10.2 The high level of alerts for older people is a result of care homes and care agencies reporting where a risk or concern has been identified but does not meet the threshold for a safeguarding investigation. These alerts are managed by reviewing care plans, giving advice and information and care management involvement.

3.10.3 Alerts within the older persons group also relates to abuse within the persons own home by either a paid carer or persons known to the service user such as a family member. A high proportion of alerts will be as a result of missed calls or medication where no significant harm occurred. As more older persons are supported at home, it is likely that levels of reported concerns will increase in this area.

3.10.4 Learning disability and mental health client groups have seen a reduction in both alerts and referrals. Awareness raising and development work about appropriate raising of alerts has been completed with service providers in these areas and it is likely that this had an impact with more appropriate reporting.

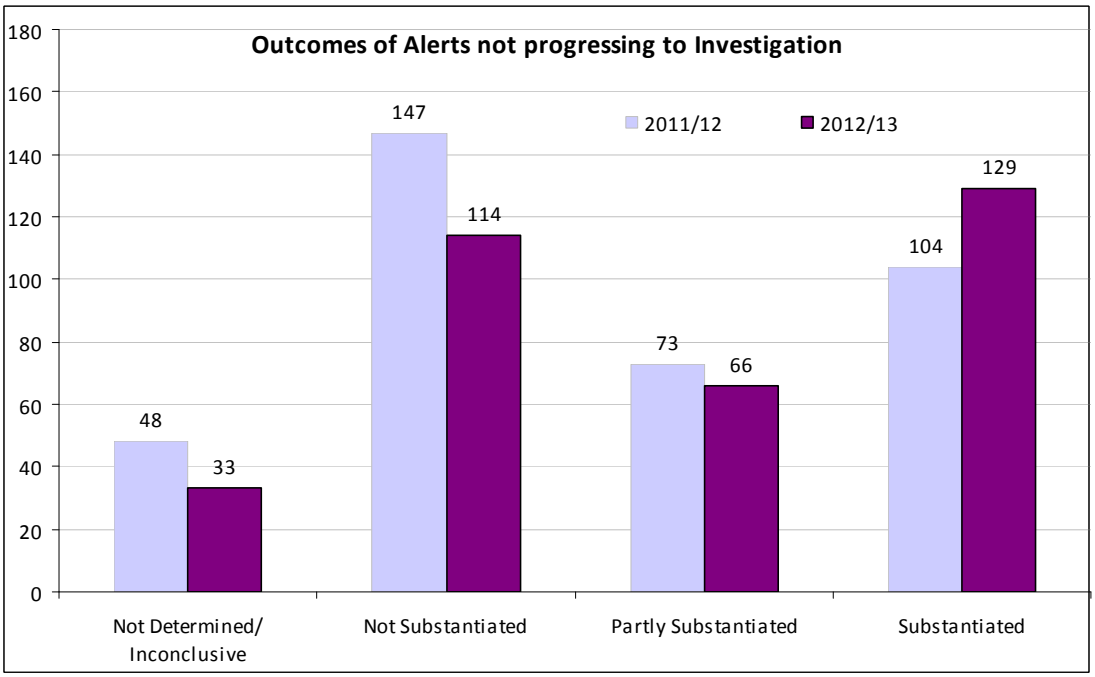
3.10.5 Central Bedfordshire's statistics are consistent with the previous year, the majority of alerts and referrals relate to older people. Proportionately, fewer of these alerts progress to referral – about 30-40% over the past two years. Many of these alerts are passed through to the assessment and care management teams as they are frequently identified as "persons at risk" through needing urgent care and support, rather than because of being at risk of harm from abuse or neglect. While there are fewer alerts in relation to people with mental health needs, it is notable that 50% of these alerts progress to referral. This may because of more appropriate reporting, or because of the higher perception of risk at the time of the alert.

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

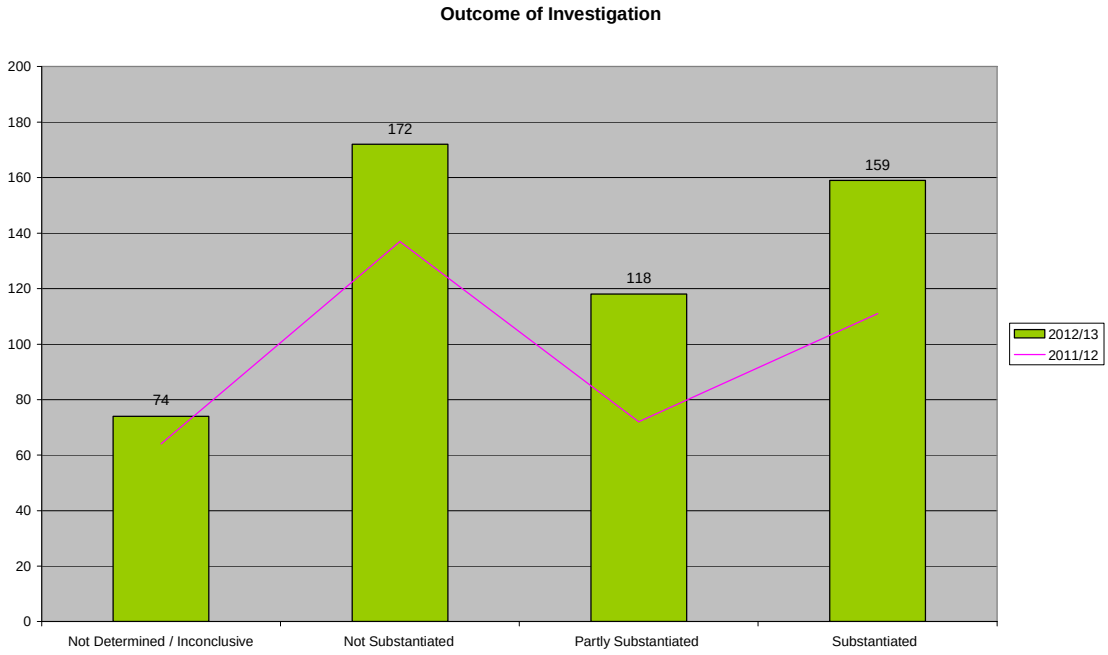
3.10.7 In Central Bedfordshire, safeguarding referrals in relation to people with a learning disability are more likely to involve physical abuse. There is also a higher incidence of reports of allegations of sexual abuse and emotional abuse in relation to people with learning disabilities. The person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

3.11 Outcomes of investigations

Bedford Borough



Central Bedfordshire



3.11.1 In this reporting year there has been an increase in the number of Bedford Borough safeguarding cases where the outcome has been substantiated from 104 to 129. This is likely to be as a result of the screening process and the decision making at the alert stage improving with a consistency in applying the thresholds. Fewer cases progressed from an alert to an investigation, the higher level of cases substantiated indicate that initial information and facts gathered at the beginning of the process and robust investigations have led to more appropriate referrals and improved outcomes.

3.11.2 All other outcomes have reduced signifying better use of resources to investigate Bedford Borough safeguarding alerts. Analysis of the Not determined / inconclusive outcomes shows that the outcomes are reached based on lack of evidence.

3.11.3 In Bedford Borough the outcomes of investigations can be broken down as follows:

	2012/13	2011/12	2010/11
Not Determined / Inconclusive	9%	12%	16%
Not Substantiated	33%	40%	38%
Partly Substantiated	20%	20%	8%
Substantiated	38%	28%	38%

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

	2012/13	2011/12	2010/11
Not Determined / Inconclusive	14%	17%	8%
Not Substantiated	33%	36%	57%
Partly Substantiated	23%	19%	11%
Substantiated	30%	29%	25%

3.11.5 In Central Bedfordshire, there has been a small increase in the number of cases substantiated and a decrease in the number not substantiated, which can be considered positive, although there has been a small increase in the numbers not determined. The majority of cases are not substantiated. As reported previously, 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, there has been a renewed focus on resolving concerns to the satisfaction of the person at risk and devising an appropriate protection plan, rather than focusing on the person causing harm. This has become increasingly common in family relationships, where models such as family group conferencing are being used.

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

4.1 Bedford Borough

Deprivation of Liberty Applications Received 2012-13

Bedford Borough	Authorisations granted	Authorisations not granted
18-64	1	4
65+	17	16
Total	18	20

Bedford Borough	Authorisations granted	Authorisations not granted
Male	3	5
Female	15	15
Total	18	20

Health / NHS	Authorisations granted	Authorisations not granted
18-64	1	4
65+	14	36
Total	15	40

NHS /Health	Authorisations granted	Authorisations not granted
Male	10	23
Female	5	17
Total	15	40

4.2 Central Bedfordshire

Deprivation of Liberty Applications Received 2012-13

	Authorisations granted	Authorisations not granted
18-64	0	2
65-74	4	0
75-84	6	7
85+	0	4
Total	10	13

	Authorisations granted	Authorisations not granted
Male	6	5
Female	4	8
Total	10	3

Mental Capacity Requirement Not Met	1
Eligibility Requirement Not Met	1
Best Interests Requirements Not Met	11

4.2.1 The department of Health fifth annual report into the IMCA service was published in February 2013. Nationally there was a 9% increase in referrals from the previous year. The numbers have more than doubled in five years; however there are still wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences. The report highlights that nationally referrals to IMCA in safeguarding cases have dropped and asks local authorities to review these. This will be taken forward as part of the 2012-13 action plan.

4.2.2 On 1 April 2013 when Primary Care Trusts (PCTs) ceased to exist, their supervisory body responsibilities under Deprivation of Liberty Safeguards relating to hospitals passed to local authorities. In the lead up to this state a series of meetings where held between Bedford

Borough Council, Central Bedfordshire Council & PCT/ Clinical Commissioning Group to ensure a smooth transfer of responsibilities. This means that as from 1st April 2013, any Deprivation of Liberty Safeguard queries for health related institutions will need to be referred to the relevant Local Authority and will be based on the Ordinary Residence criteria.

4.2.3 The Bedford Borough Mental Capacity Act Coordinator has continued to raise awareness of Mental Capacity and Deprivation of Liberty Safeguards across a range of providers to improve practice and implementation.

4.2.4 Bedford Borough Council continue to audit mental capacity assessments and the quality of best interest assessments with feedback being given to individuals completing the assessments.

4.2.5 Bedford Borough hold quarterly training and refresher sessions for all qualified Best Interest Assessors as part of their professional development.

4.2.6 In March 2013 the Mental Capacity Act Coordinator completed a review of Central Bedfordshire Council's approach in respect of its responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards. Eight themes were identified from this review which have populated the current action plan, which are:

- Reviewing and formalising the DOLS process within the safeguarding team
- Developing clear reporting processes on DOLS including for the new national data collections
- Best Interests Assessor training, learning, development and supervision
- Improving the Quality Assurance of Best Interests, specifically the scrutiny role of the supervisory body
- Developing support to managing authorities to improve their understanding on DOLS and the MCA.
- Developing support to adult social care staff to improve practice in relation to mental capacity assessments and DOLS, including audit, review and practice development
- Develop a person centred planning approach to mental capacity assessments and DOLS process
- Support for adult social care teams with applications to the Court of Protection and the High Court.

5. Learning from Safeguarding Activity

Learning Outcomes	Action To Ensure Learning
Improvement in safeguarding practice and recording required as a result of independent audit and peer review.	We will ensure safeguarding paperwork and documentation is shared with individuals, families, and relevant agencies in a timely way. We will ensure transparency and timeliness of information sharing with care providers around safeguarding concerns where staff are involved.
Activity data continues to show a high volume of alerts which do not require a formal safeguarding investigation. This is a trend over four years. An increased volume of alerts is a national trend reflected in ADASS Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services March 2013.	We will continually review the types of alerts that are being raised for quality of information and appropriateness. Feed back to alerters where necessary. We will continually review responses to alerts within the safeguarding teams to ensure prioritisation and consistency in the face of increasing volume.
Activity data continues to show a low number of alerts received from members of the public and people at risk.	We will run awareness raising campaigns and will link into existing public forums and local campaigns.
National reports and analysis of local safeguarding information has shown that people with disabilities remain vulnerable to abuse and harassment.	Work completed in the previous year on hate crime and disability related harassment has been shared with both Councils Community Safety Partnerships and we will continue to work together in this area in 2013-14.
Financial abuse is on the increase and the issues involved are increasingly complex with family dynamics, property, money management and wills involved.	We will commission and review outcomes of training on financial abuse. We will continue to provide additional support for complex cases in the form of data analysis and practice development.
Locally there continues to be low numbers of applications for authorisation of the Deprivation of Liberty Safeguards. Nationally local authorities are charged with reviewing the use of IMCA in safeguarding cases.	We will continue to develop the role of the Mental Capacity and Deprivation of Liberty Coordinators to link in with services to raise awareness and increase the profile of the IMCA service.
Ongoing quality issues with services highlighted in national media and locally	We will continue to monitor and analyse trends and patterns and continue to share information with contracts and care standards teams. Data is used to trigger a serious concerns process or individual and service reviews where patterns are noted.

Appendix 1

Strategic Objectives for 2013-2014

Strategic aims:

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

Members of the Board must be able to:

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

1 Prevention and Raising Awareness

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

2 Workforce Development and Accountability

- Staff should be able to recognise and manage risks in supporting and caring for adults at risk of harm or abuse.

- Staff should treat people with dignity.

- Staff should understand how to empower people and enable positive risk taking.

- There should be a focus on achieving outcomes for individuals and evidencing that these have been achieved, rather than processes.

- There should be competency based training to ensure that practice meets good quality standards and targeted training.

- Mental Capacity Assessments and Deprivation of Liberty Safeguards including the use of Independent Mental Capacity Advocates to raise awareness and improve practice within these areas

3 Partnership Working

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

- Tissue viability issues addressed through the Harm Free Care group and actions to be put arrangements and NHS bodies to monitor.

- Mental capacity and unwise decision making – put mechanisms, guidance, training in place.

- Ensuring safeguarding remains a priority and that lack of continuity does not cause risk to vulnerable person through organisational change.

- Ensure links are maintained to the Health and Wellbeing Boards, Community Safety Partnerships, Children's Safeguarding Boards and other strategic partnerships.

- Improvements to out of hours responses.

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

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

4 Quality Assurance and Protection

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

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

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

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

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

5 Involving People and Empowerment

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

- Gain feedback following incidents.

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

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

- Provide case studies to assist with developing services.

6 Outcomes and Proportionality

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

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

- Involve service users during the investigation process.

- Continue to promote communication literature to the public via information leaflets about 'what is abuse' in different format and languages.

- Build confidence in the process of investigating concerns by making people feel comfortable at the start of a safeguarding process.

Appendix 2

Partnership Contributions to Adult Safeguarding 2012/13

Name Of Organisation:	Bedfordshire Clinical Commissioning Group (BCCG)
Name(s) Of Person(s) Reporting:	Anne Murray, Director Nursing and Quality Yvette Aris, Head of Adult Safeguarding

1. Local priority: Prevention and raising awareness

BCCG appointed a Patient Safety Project Nurse to support the delivery of the Harm Free Care initiative 'no avoidable grade 3 and grade 4 pressure ulcers' the work programme includes the following activities: review of Root Cause Analysis (RCA) of pressure ulcer alerts and serious incidents, feedback lessons learnt into the Countywide Pressure Ulcer Group; delivery of 'Stop the Pressure Training' to service providers within the community particularly residential homes and care agencies. The project nurse will work closely with the CCG safeguarding team participating in unannounced visits where a concern has been identified with pressure care.

During 2012/13 the Patient Safety Project Nurse's have delivered six sessions to Central Bedfordshire providers, overall feedback from the events have been positive with care providers identifying actions to help them improve the quality of care delivered i.e. identify service users that are at risk of pressure ulcers and clear documentation; Implementation of the use of the pressure ulcer safety cross in individual care plans which identifies how many days the area is free from pressure ulcer development. Sessions for Bedford Borough providers have been organised for 2013/14.

BCCG continue to raise awareness around the safeguarding adults agenda via a number of forums, using the BCCG extranet a safeguarding page has been developed where CCG staff and members can access policies, recent documents, contact details and links for safeguarding training; the safeguarding team also works with locality leads within BCCG and attends practice meetings providing training with locality specific information.

2. Local priority: Workforce Development

Bedfordshire CCG has developed a training strategy for Adult and Children Safeguarding training, the strategy outlines CCG staff and member requirements for Safeguarding training; requirements were agreed at a multiagency meeting that included local authority, commissioning and named/designated GPs.

The CCG completed an audit with GP practices in Bedfordshire and requested that each GP practice identified a safeguarding lead for their organisation; all practices in Bedfordshire have a safeguarding adult lead. As part of the training strategy the GP leads will be required to attend a face to face training session which it is anticipated will be delivered at the end of the year.

The CCG safeguarding team have been promoting Skills for Health e-learning module for Safeguarding adults to all staff, CCG members and practice staff. The team has administration rights to this module; uptake is monitored via the Integrated Safeguarding Adult and Children Meeting.

The safeguarding team continues to participate in locality meetings and protected learning events to raise awareness and share local data with GPs, Practice Nurses and Practice staff.

3. Local priority: Partnership working

The CCG safeguarding team has been working with both acute providers to share A&E admission data for patients admitted from nursing and residential homes. This data allows the CCG to identify nursing and residential homes within the community

with high admission rates; the data is reviewed for time and reason for admission to see if the CCG can support the homes with appropriate signposting and reduce admission rates.

Membership with local authority quality assurance steering groups continues; information shared at these groups includes serious incident, pressure ulcer, infection control and acute admission data. In addition to this the safeguarding team meets regularly with safeguarding leads.

The CCG regularly share information with the CQC at meetings held with the local authority. The information is triangulated to ensure all partners are aware of concerns and work together to improve and support services.

4. Local priority: Quality assurance

In 2012/13 Bedfordshire CCG received 373 health related safeguarding alerts from Bedford Borough and Central Bedfordshire local authority.

Every month the safeguarding team completes a thematic review of the alerts received and reported to the CCG Board via the quality dashboard.

The top five themes for 2012/13 were as follows;
1) Neglect
2) Physical
3) Pressure Care
4) Poor Discharge
5) Medication

Bedfordshire CCG have seen an increase in the number of safeguarding alerts received referring to physical abuse, the majority of these alerts have involved mental health service users with drug and alcohol use issues, any alerts raised to investigation are led by SEPT and CCG are informed of outcomes. A number of physical abuse alerts also relate to dementia service users and involve other service users in residential homes during periods of agitation, where applicable the Continuing Health Care team are involved and reviews completed to ensure the care package in place continues to meet the service user's needs.

In December 2012 the CCG appointed a Patient Safety Project Nurse, this position is a job share and the nurses work together to deliver the Harm Free Care Initiative 'No avoidable Grade 3 and 4 Pressure Ulcers', this includes delivering training across Bedfordshire to residential/nursing and care agency staff around pressure ulcer prevention, working closely with the safeguarding team and patient safety coordinator reviewing incidents of pressure care and collecting information on service providers; all of the above helps to inform the nurses when an unannounced visit is required to understand issues around pressure care.

The CCG and local authority are working closely with acute providers to support improvement around the discharge of vulnerable patients A starting point was to look at the themes taken from the safeguarding trigger tool that related to poor discharge of CBC residents, this was then forwarded to the acute trust with a request to look at the cases and ensure appropriate actions are taken. This work remains under review and scrutiny.

The CCGs Care Home Lead Pharmacist is a member of the Integrated Safeguarding Adult and Children Group and feedbacks any concerns and/or work completed with residential homes in Bedfordshire. In addition, the lead pharmacist supports the safeguarding team with safeguarding investigations involving issues with medication.

5. Local priority: Involving People

The safeguarding lead is committed to ensuring that all vulnerable adults involved in the safeguarding process, have been fully informed of the process and relevant decisions and have been given the information that is required for the person to make the decisions, or offered the opportunity to have an advocate.

6. Local priority: Outcomes and Improving Experiences

During 2012/13 there were 354 Serious Incidents (SI) reported to NHS Bedfordshire and NHS Luton. There was a small decrease in numbers reported since last year, however, it should be noted that the criteria for reporting pressure ulcers has changed which may have had an impact on this.

Pressure Ulcers are the highest reported SIs, and falls resulting in fracture the second highest reported incident. The majority of patients developing a pressure ulcer are patients who have multiple co-morbidities, are elderly and may decline pressure relieving equipment until the pressure ulcer has developed. In some cases assessment of pressure areas has been incomplete; however, the "SSKIN bundle" is now being introduced by providers, which includes skin inspection risk assessment and treatment. The Clinical Commission Groups host a 'Harm Free' Care Group and County Wide Pressure Ulcer Group in which data is reviewed, both from SIs and the Safety Thermometer and recommendations and actions are shared. Representatives from all providers attend both these groups. Initiatives this year includes pressure care training to care home staff, and a review of the publicity material on pressure ulcers in order to take forward an awareness campaign. The providers also participate in the 'Pressure Alert' System in which pressure ulcers that have occurred outside the providers care are passed to the relevant provider and if necessary raised as an SI or shared with the Safeguarding Team.

Falls are also reviewed at the Harm Free Care Group through both SIs and Safety Thermometer data. There are various initiatives by the Trusts including implementation of the Royal College of Physician's 'FallSafe' care bundle, 2 hourly care rounds, the cohort of high risk patients into one area, the use of low rise beds and work on pathways for patients with dementia. This work links with the Falls Prevention Steering Group.

There have been three prison related SIs reported. All are currently being investigated and are subject to Prison Ombudsman reviews. Commissioning arrangements for offender health care has changed following restructure of the NHS and is now commissioned by the National Commissioning Board in the Anglian Hub.

Highlight report of key issues arising during 2012/13, addressing the priorities

Lessons have been learned in 2012/13 from serious concerns of a Care home, with joint working from all partners in supporting the home. Ensuring residents in care homes have equal access to healthcare and are cared for in safe environments

Working with providers to ensure Community services are able to continue to support patients in the community where appropriate and deliver care safely and effectively.

Identifying poor discharge themes, and working with acute trusts to examine causes and produce action plans.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

The Independent provider trigger tool has been implemented to monitor and identify providers that have concerns logged. This is a method for using information gained

via patient safety nurse visits and quality team. The information gathered acts as an early warning system so that prompt action can be taken.

Data sharing from acute trusts in relation to hospital admissions, to identify independent providers who may require extra support or reasons for admission that can be avoided.

Serious incident reporting has shown a decrease in hospital acquired pressure damage. Due to this reporting and monitoring, the majority of pressure damage begins in the patient's own home. The countywide pressure area group are developing a leaflet for pressure ulcer awareness and prevention to be distributed via all pharmacies and domiciliary care agencies in Bedfordshire with the aim of raising public awareness.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

Safeguarding face to face training with GP's to commence, and continue promoting safeguarding awareness at Health professionals' meetings.

BCCG to continue to monitor and act on incidence of pressure ulcer reporting, through training via the patient safety nurses

BCCG will develop a strategy to capture patient experience; the aim being to gather information by listening to our patients and public so that we really understand what it feels like to experience services. This will be an early warning indicator and support the commissioning of pathways based on patient views.

BCCG will separate the resources and governance structures from Luton CCG from September 2013. This will enable more of a focus and the strengthen the approach within Bedfordshire going forward.

Name Of Organisation:	Bedfordshire Police
Name(s) Of Person(s) Reporting:	DCI Hawkes-Detective Chief Inspector Public Protection Bedfordshire Police

Highlight report of key issues arising during 2012/13, addressing the priorities

Introduction

Bedfordshire Police continue to place the service to the most vulnerable in society as a key priority. This commitment is reflected in the fact that recent force restructures have left the Public Protection structure mainly untouched.

A major development in the past year is the introduction of the Police and Crime Commissioner who has now published his priorities with an emphasis on the victims of Hate Crime, Anti-Social Behaviour and Domestic Abuse.

Below are some of the headlines over the past year.

Workforce development

Bedfordshire Police continue to develop the services we provide to the most vulnerable in our communities, both adults and children. The Safeguarding Investigation Units (SIU's) North and South of the county are now well embedded with well-defined referral processes and multi-agency partnership working in place.

The Public Protection Unit Support Team (PPUST) remains the gateway into and out of the organisation and takes responsibility for assessing and disseminating referrals.

The force restructure implemented in 2012 with the merger of the uniformed response teams and local policing officers across the North and South of the county is currently subject of a 6 month organisational review.

In October 2012 a new unit, Domestic Abuse Repeat Offenders Unit (DARO) was formed consisting of a sergeant and three constables. This team focus on the most prolific perpetrators of domestic abuse and take an offender management approach in managing the risk to potential victims. This work dovetails with the victim focussed approach of the Multi Agency Risk Assessment Conference team (MARAC team) who manage the safety planning around the very highest risk domestic abuse victims.

Management and membership change

Over the past year the senior management personnel within the Public Protection Unit has changed with the Head of Department, Detective Superintendent Karena Thomas in post, supported by Detective Chief Inspector Will Hawkes. DS Thomas and DCI Hawkes are supported by three Detective Inspectors.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Workforce development/ Partnership working

During the past year Bedfordshire Police have formed a Safeguarding Steering Group (SSG) whose membership consists of Safeguarding managers within the police and SOVA leads from the three local authorities. This group was formed to improve communication at a management level, check the effectiveness of processes and practise, and be a forum where concerns can be raised and dealt with. The group is chaired by DCI Hawkes and the meetings so far have been lively and productive. The actions are tracked with a Safeguarding Improvement Plan.

The police response to Hate Crime is managed by Chief Inspector Gavin Hughes–Rowlands and he has coordinated improvements in the way this crime is recorded and managed. The connections with this and Anti-Social Behaviour are well understood and following a recent inspection Bedfordshire Police have been given positive feedback on the improvements made.

Raising awareness

Vulnerable adult training has been delivered to PPU staff along with Serious Case Review reflection inputs, covering both national and local incidents. This training has received positive feedback from all and ensures a raised awareness to the risks facing the vulnerable and how we can better safeguard. Continuous Professional Development Days (CPD) are now scheduled into the PPU calendar to ensure learning from internal and external audits.

Quality Assurance

As part of the SSG (Safeguarding Steering Group), the safeguarding improvement plan is reviewed at supervisory level with relevant actions raised and completed within the organisation.

Currently the Standard Operating Procedures (SOPS) for Vulnerable Adult and Child

Safeguarding are being reviewed as part of the PPU improvement Plan, with new practices being included.

Audits have become an increasingly important quality assurance tool with both internal and multi-agency audits being undertaken. Lessons learnt from these are disseminated as described above in the training section.

Outcomes / investigations

Since the Vulnerable Adults Investigation Unit (VAIU) was subsumed into the Safeguarding Investigation Units (SIU) in 2011 there has been a marked increase in criminal cases reaching a prosecution stage. This is mainly due to the improved resilience within these larger teams, improved supervision and the expertise of these complex crimes being investigated by suitably trained detectives.

The cases that the specialist units investigate fit a criteria based around the victims capacity and what support that victim requires for living, if in the community. Clearly Bedfordshire Police deal with all aspects of vulnerability and careful consideration is given to the most suitable area of the organisation for ownership of each crime.

In the last year 1834 SOVA referrals were processed in the PPU Support Team. Of these, 121 were formally investigated by the Safeguarding Investigation Units in relation to identified criminal offences, with 55 investigations for the North of the county and 66 for the South. Although this may appear to be a small proportion, the supervisors within the PPUST deal with the majority of these referrals at source, ensuring the police participate in strategy meetings where required, and providing advice and guidance on general concerns and police intervention. Should there be any disagreement on the level of police involvement there is an identified escalation procedure.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

As previously mentioned there is currently a Post Implementation Review taking place within Bedfordshire Police where structures are once again being assessed. The review will report back in the autumn. The organisations promise to fight crime and to protect the public is the key objective and as such the protection of the most vulnerable people within Bedfordshire will remain a priority.

The Safeguarding Steering Group will continue to evolve ensuring that the police and social care in particular work closely in problem solving. This group will also be able to ensure that the response to vulnerabilities around hate crime, domestic abuse and Anti–Social behaviour are joined up.

The continuous professional development (CPD) of the workforce will remain a priority with CPD days scheduled in at regular intervals.

There is work taking place with Bedfordshire Police and Bedford Borough around the formation of a Multi-Agency Safeguarding Hub (MASH) during 2013/14. Whilst primarily aimed initially at child protection it is envisaged that as it matures there will be a place for SOVA referrals and enhanced joint working.

Name Of Organisation:	Bedford Hospital NHS Trust
Name(s) Of Person(s) Reporting:	Nina Fraser/Tracey Brigstock/Anna Taylor/Susan Albon
Highlight Report Of Key Issues Arising During 2012/13	
The following report relates to the safeguarding vulnerable adult's agenda and activity	

for 2012/13, improvements made in year and improvements planned 2013/14.

1.0 Alerts upheld in 2012/13

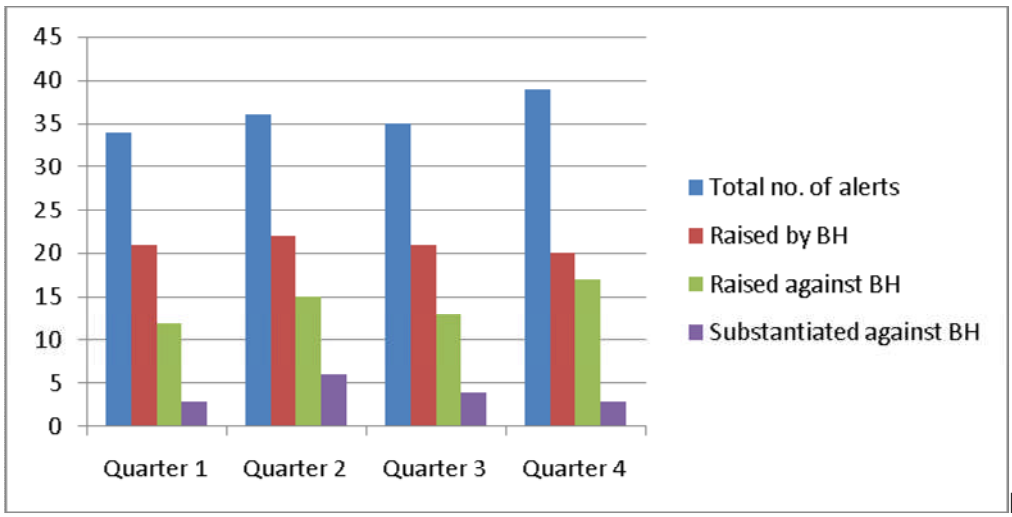


Fig 1

As indicated in the table above, 144 alerts were raised in 2012/13, a decrease of 17% from the previous year.
There were 26 alerts substantiated (hospital and community) in 2012/13 of which 16 were against the trust.

2.2 Themes

All safeguarding themes, of the 26 substantiated, are reflected in the table below (Fig 2)

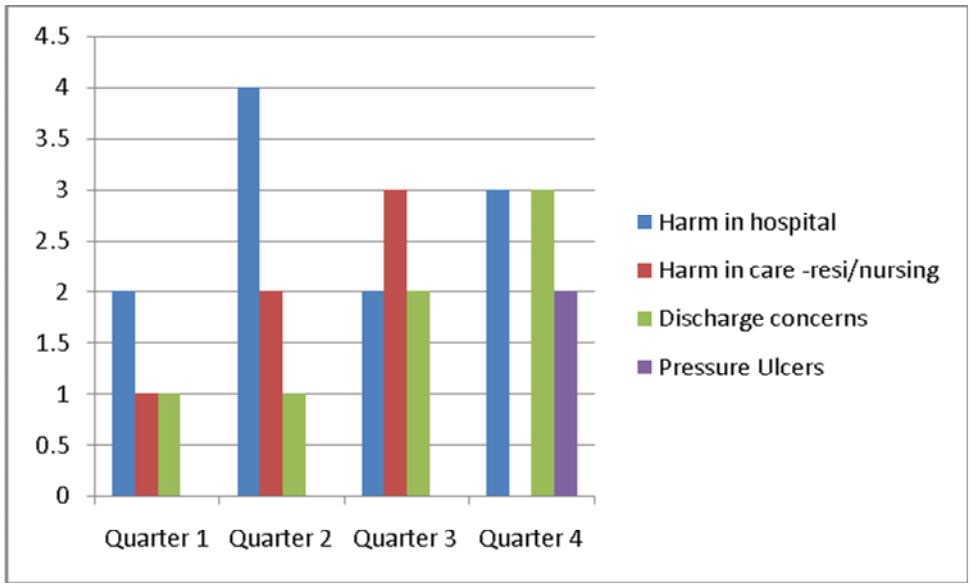


Fig 2

Examples of 'harm in hospital' include missed medications, basic hygiene needs not being carried out promptly, injury sustained and inconsistent documentation.

Within the hospital, Incidents of harm are monitored through the Datix reporting system, with appropriate action plans developed and monitored through quality governance frameworks.

Improvements Made In Adult Safeguarding During 2012/13

Following a 3 day inspection by the Care Quality Commission in Quarter 2 (July 2012), the Trust was deemed 'compliant' in Outcome 7 'People should be protected from abuse and staff should respect their human rights'.

The Trust has undertaken a Nursing Establishment Review concluding March 2013. A financial investment has been agreed which will increase nursing establishment on each general ward and support Senior Ward Sisters to become more supervisory in their role moving forward into 2013, strengthening leadership and improving patient safety and experience

The hospital introduced a ward Quality Dashboard in February 2013, whereby each ward audits the processes that underpin patient observation, falls, pressure ulcers, nutrition and hydration and documentation, on a monthly basis across all adult inpatient wards. Results are published and presented to Quality Board for monitoring and assurance.

A thematic review of patient falls has been undertaken which has demonstrated that the falls rate has been steadily increasing over the last three years, partly explained by the numbers of increasing elderly vulnerable patients entering acute care with complex health needs. Recommendations from the report include creating a Falls Lead post and the introduction of 'fallsafe' care plans that include medication reviews for all high risk patients.

The service user/Hospital Learning Disability Forum continues to meet quarterly. Highlights of the agenda for the year include the completion and launch of the Bedford Hospital DVD; this involved people who have a Learning Disability and hospital staff showing the experience you would expect as an inpatient, having a blood test, chest x-ray and ultrasound. We are also now discussing completing a poster campaign which will be entitled 'See Me not my Disability' to raise the profile for learning Disabilities within the hospital and a Learning Disability Awareness training DVD for staff to complete.

A briefing paper was written for in response to Winterbourne View and an action plan is in place, including a 'flagging' system for notification of repeat admissions to the LD Liaison Nurse.
Work continues on the LD 'Self Assessment' Action Plan- aiming for completion in March 2014.
In January 2013, the LD service supported 50 service users including inpatients and outpatients, which proved to be the busiest month for LD Support Services since August 2010 and the commencement of recording this data.

In response to National directives and initiatives arising from the Francis report, Winterbourne View enquiry and the Jimmy Savile investigation the Trust has responded by reviewing the findings all reports and developing action plans relevant to people being cared for within the Trust, as well as revising appropriate Trust policies.

Staff Training

SOVA Training compliance

Training Data for SOVA – 3 years rolling YTD – March - 2013

(Note :The highlighted staff groups are those receiving annual training as part of Clinical Update, the other staff groups receive training on a three yearly basis.)

Staff Group	Target No	Actual number of staff trained over 3 year period	% against target
Add Prof Scientific and Technic	100	97	97%
Additional Clinical Services	319	285	89%
Administrative and Clerical	382	256	67%
Allied Health Professionals	171	122	71%
Estates and Ancillary	200	122	61%
Health Care Scientists	7	5	71%
Medical and Dental	270	142	53%
Nursing and Midwifery Registered	780	738	95%
	2229	1767	79%

The Trust Education and Development department commissioned a one day Safeguarding (level 2) course with the University of Bedfordshire. This includes half the day covering the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. 68 Nursing and midwifery staff attended in 2012/13. Staff reported that they felt more confident to follow the process for raising concerns following attending this training event. So far, in response to applications made within the Trust a further 26 places have been commissioned for 2013/14.

Externally sourced Level 3 Safeguarding and Mental Capacity Act training specifically for Senior Clinicians and Nurses have been carried out in Quarters 2 and 3. In addition, the Mental Capacity Act Co-ordinator employed by Beds Borough Council gave a presentation to the Trust's Nursing and Midwifery Professional Forum in year. MCA training compliance is currently 62%.

Partnership Working

Bi-monthly safeguarding meetings have continued between Bedford Borough Council (BBC) and Trust representatives (Deputy Director of Nursing and Trust Safeguarding Lead) to communicate relevant developments within organisations potentially impacting on service delivery, for example, workforce changes.

The Safeguarding Adults Lead and the interim Operational Lead have been attending the PAN Bedfordshire safeguarding meetings and Operational Group and Quarterly meetings have been scheduled with the Bedford Clinical Commissioning Group (formerly PCT) Safeguarding Adults Lead and SEPT Safeguarding Adults Practitioner to continue partnership working.

The internal SOVA Operational Group meets monthly – with interdisciplinary representation, to review SOVA cases and to determine actions / feedback for learning. A sub group has been formed to implement the Hydration Care Bundle (charts and care plan) pilot – with rollout planned 2013/14.

The Dementia Steering Group, established in January 2013 includes a carer representative, SEPT and CCG Dementia Care Leads and to date outputs include the adoption of the Butterfly scheme, development of a Carers Audit and links to the inpatient pathway work stream within the hospital Transforming for Excellence programme.

A joint bid with Bedford Borough Council has been put forward to DH (Jan 2013) to promote the patient environment in both settings for people with dementia. This includes the consistent use of colours, furnishings and signage from one care setting

to another. In Q4, the Trust has been informed that the bid has successfully reached the second stage of approval with notification of the outcome anticipated by 30th June 2013.

Four patient council sub groups have been developed for Nutrition and the Care Environment, Patient Information, Dignity and Compassion and Discharge and Aftercare – where work programmes are being developed 2013/14 aligned to Trust objectives and Quality Account priorities.

Improvements Planned In Adult Safeguarding During 2013/14

Following the final publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry (5 Feb 2013) the Director of Nursing reviewed the 290 recommendations and undertook a gap analysis on those relevant to acute settings. An organisational Action Plan has been developed and shaped through a series of listening events with key staff and patient groups, with a Trust Action Plan in progress.

In year 2 of the Equality Delivery System (4 year National Strategy) the Trust was pleased to report a number of improvements taking several indicators from 'amber' to 'green' in areas such as providing interpreters and access to services. Trust self-assessment and recommendations were supported by community interest groups attending the event held in March 2013, with the final outcome awaited.

Following problems with delayed discharges related to patient transport services, the hospital met with our current provider and it has been agreed that a monthly report will be generated by Medical Services detailing both day time and out of hours discharges (including weekends) and time delays in the system – for action.

The Patient Council subgroups will meet bi-monthly, to deliver work programmes aligned to the National Inpatient Survey results and corporate objectives (patient safety, effectiveness and experience)

The Trust continues to drive towards a 'zero' ambition of all avoidable pressure ulcers with focussed work including staff education and training, patient information and introduction of the hydration care bundle. This is currently being piloted on two wards for rollout 2013/14

A review of nursing documentation has been commissioned by the University of Bedford to inform the future model 2013/14 and to promote standards of record keeping. This will be developed in year.

A hydration care bundle has been implemented on one medical ward and one surgical ward, with a planned rollout 2013/14, led by the hospital Resuscitation Team.

An improvement plan has been put in place reflecting the recommendations of the report entitled '*Improving Acute Hospital Care for Adults with a Learning Disability and Adults with Autism in the East of England. A Review of the Acute Hospital Self Assessments and Improvement Plans' (September 2012) and forms part of the LD work plan this year,* with a completion date of March 2014.

In Summary

The SOVA Operational Group will continue to monitor and review key publications and national / local directives throughout the year, taking action where appropriate and reporting these through to the Quality Committee for assurance purposes.

A comprehensive 'Self Assessment and Assurance Framework' document was completed in Quarter 3 and this will form the basis for the 2013/14 work programme

for safeguarding vulnerable adults.

Key priorities for 2013 / 14 include strengthening partnership working, strengthening clinical leadership and developing the quality of staff education and training for improved patient and carer experience, while continuing to strengthen patient pathways from one care setting to another.

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

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

This is done via Provider forums in both Local Authorities and by meetings held with members of the Bedfordshire Care Group, highlighting relevant issues/concerns; smaller meetings are also been held where providers and the safeguarding leads have shared case scenarios highlighting lessons to learn from.

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

As well as all providers being required to deliver safeguarding training, the SOVA competencies continue to be required to be completed and providers are aware safeguarding is given high priority in any inspections carried out.

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

Homes should provide information to family and friends visiting with respect to safeguarding and publicise how concerns can be raised via posters in the home etc, discuss this in staff, relatives and service user meetings.

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

Each provider has their own quality assurance systems and Local Authority Quality Monitoring Teams and CQC feed into this process. Advocacy services also provide support alongside professionals to represent those in need.

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

Service users are always consulted wherever possible to seek consent with respect to any action taken.

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

Providers continue to feedback where there are concerns relating to people's experiences to the relevant SOVA leads with a view to learning from lessons.

Highlight report of key issues arising during 2012/13, addressing the priorities
Ongoing issue of minute takers at Strategy Meetings held by SEPT, and lack of accurate and timely minutes
Improvements made in adult safeguarding during 2012/13, addressing the priorities
Provider meetings relating to safeguarding where anonymous case scenarios and lessons to learn were shared. Sharing of best practice at these meetings. Sharing of information from the Eastern Region Safeguarding Conference.
Improvements planned in adult safeguarding during 2013/14, addressing the priorities
Introduction of the Sector Compact by the Department of Health in November 2013. Ongoing Partnership Working

Name Of Organisation:	Bedfordshire Fire and Rescue Service
Name(s) Of Person(s) Reporting:	AC Simon Barker

Highlight report of key issues arising during 2012/13, addressing the priorities
Bedfordshire Fire and Rescue Service is a referring agency only and does not undertake specific case work therefore no known key issues arose during 2012/13. BFRS continues to attend partnership board meetings and when necessary operational meetings relating to Safeguarding of Vulnerable Adults.
Improvements made in adult safeguarding during 2012/13, addressing the priorities
Prevention and raising awareness During 2012-13 Bedfordshire Fire and Rescue Service rolled out Safeguarding of Vulnerable Adults training to all frontline staff to raise awareness of adult safeguarding. The objective of the training was to allow frontline staff to identify possible safeguarding issues and how to raise a referral if they were to come across any. **Workforce Development** The Service has its own safeguarding policy which all staff are familiar with and is reviewed and updated if necessary annually. **Partnership working** The Service had worked in partnership with Adult Safeguarding Services to make sure our policy and processes were current and in line with current legislation. **Quality assurance** BFRS continues to monitor the number of referrals the service receives to make sure the information provided is correct and all the correct processes have been followed. No known feedback was received.
Improvements planned in adult safeguarding during 2013/14, addressing the

priorities
Bedfordshire Fire and Rescue Service will continue to review our policies and processes to ensure they are relevant and up to date to promote 'best practice'. BFRS accepts feedback and will be willing to make any improvements if required. The Service is a key participant in raising awareness of adult safeguarding and providing training to all necessary staff when deemed necessary. Overall BFRS referred 18 cases that were believed at the time to be a safeguarding concern; however many of these were a need for further assistance and not necessarily safeguarding. The Service intends to work with frontline staff and Adult Social Care to continue to raise awareness of adult safeguarding and to ensure the correct type of referrals are made; minor changes will be made to the Services Safeguarding Policy.

Name Of Organisation:	Bedfordshire Probation Trust
Name(s) Of Person(s) Reporting:	Emma Osborne, Assistant Chief Officer
Highlight report of key issues arising during 2012/13, addressing the priorities	
Over the last few years the Ministry of Justice published 'Breaking the Cycle', and 'Punishment and reform; effective Probation services'. Both consultation documents looking at the future delivery of community Probation services or community criminal justice. These consultation documents used in conjunction with the 'Transforming Rehabilitation' programme agenda laid out plans on how the Government aims to rehabilitate offenders in the future. The new ways of working included a 12 month statutory community supervision or licence for all offenders serving a period of 12 months or less in custody (not currently delivered by the Probation Trusts). The new ways or working also included a through the gate resettlement programme, opening up the majority of community Probation services to competition in the private sector and introducing payment by results incentives to new providers for reducing reoffending rates. Since March, timeframe dates for completion of the competitive process and the implementation of new programmes of work have been set to start in the summer 2013 and completing with new contracts up and running by January 2015. The Probation Trust will be delivering 'business as usual' services to both offenders and partnerships until further notice. Changes to service delivery that may impact on partnership working will be communicated as the new processes are rolled out. **Prevention** 2012/13 saw the Probation Trust set objectives around early intervention work with perpetrators of domestic abuse and enter into a contract with Bedford Borough local authority to deliver the IDAP (Integrated Domestic Abuse Programme) to men who were not statutory offenders. Since October 2012 BPT has received 24 referrals from a number of sources to include, children's social care, Strengthening Families teams, GP's, private law firms, Cafcass and self referrals. The project has a Women Safety Officer support for the partners of the men attending the programme, these women are often vulnerable and require safety planning work, advice, signposting to community agencies that specialise in mental health support, drug and alcohol treatment and therapeutic services. To-date 7 men have completed the programme and a further 10 are attending regularly. Project	

effectiveness is being guided by Police call out numbers and pre and post psychometric testing measuring attitude and behaviour change.

BPT has continued to focus energies and financial resource in the PREVENT and counter terrorism agenda, all staff have attended training to recognise and identify extremist behaviour and how offenders identified as having vulnerabilities maybe more susceptible to radicalisation. Close working relationships with the Police and Prison has greatly supported our work in this area.

2012/13 priorities were also set around working with offenders who evidenced both mental health issues and those identified as having personality disordered type behaviours.

Bedfordshire Probation Trust (BPT) was successful in tendering for money from the Ministry of Justice to employ Psychologists, to support operational staff to improve the psychological health and wellbeing of offenders currently assessed as being high risk. The specific focus of the project has concentrated on reducing the number of incidents of suicide attempts, threats of self harm of those offenders accommodated in our Approved Premises, reducing the number of recalls back to custody due to mental health related offending, support staff skills' development and retention of staff.

This project is currently being rolled out and has gained wide support from operational staff in identification of skills development in working with this difficult cohort, as well as knowledge regarding access to community services, professional mental health screening and support in the diagnosis of borderline personality disorder cases.

BPT have also this year employed two mental health nurses that have supported both the Integrated Offender Management team (prolific offender cohort) and also the provision of services to women offenders in order to divert those with children from custody when appropriate.

Quality Assurance

April 2013 saw the first HMIP inspection into adult offending, the content of the inspection had a focus on violence and covered the Trusts ability to minimise risk, the effectiveness of our work with victims and reoffending rates. The final report is yet to be published but initial verbal feedback was positive and specifically referenced our work with the courts and our work with partnerships as strengths.

BPT continues to be involved in internal audits of services and have particularly focused our efforts on the Multi Agency Audit of high-risk offenders, Multi Agency Public Protection cases or MAPPA and those high-risk cases who have and are in contact with their children.

BPT has also focused on the quality assurance process linked with OASys (our risk of reoffending and risk of harm assessment tool) in order to support staff development and assure ourselves that we are managing the risk and supervision of offenders appropriately.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Involving people.

2012 saw the commencement of BPT's offender engagement and service user feedback project. Over the last 8 months staff across the organisation have been involving victims and offenders in the planning, development and improvement of

services delivered, it is now widely accepted that service users are experts through their own life experiences at knowing where problems exist in the criminal justice process and how in their opinion, measures can be put in place to improve service delivery.

Results from this project have fed into Trust planning supported by service users who were actively and genuinely involved in defining issues and giving their time free to achieve change and improvements.

Staff have also welcomed this project and are keen to extend the project to focus on how to improve the interventions we deliver and the experiences of offenders who are being accommodated in our approved premises.

BPT continues to deliver a victim satisfaction questionnaire, and score in excess of 95% satisfaction for services delivered to victims of crime. We have increased our resource in our Victims Liaison Unit recently in order to support increasing workloads and maintain quality of service.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

Workforce Development

BPT has also looked at issues of disability hate crime in our offender population, and although very low numbers of this type of offending were identified, policies and procedures have been developed to support timely referrals into adult social care. Additional guidance has also been developed for victim liaison officers to support cases in a meaningful way when identified.

Our experience in BPT is that very few of the offenders or victims under our supervision meet the adult social care threshold for vulnerability, this year we are focusing on getting a clearer definition of vulnerability for the people we work with and how we can improve how we safeguard and meet our responsibilities, especially the identification of where victims of offences may meet the vulnerable adult definitions.

Priorities include getting better definitions of vulnerability, getting better and more timely information from Police, in order for staff to be able to make reference to victim vulnerabilities in their reports to court.

This could mean more appropriate interventions and sentence recommendations identified to manage risk and needs and making sure there is community criminal justice focus at SOVA Board level.

Name Of Organisation:	Community and Voluntary Service
Name(s) Of Person(s) Reporting:	Martin Trinder – Chief Officer

Highlight report of key issues arising during 2012/13, addressing the priorities

1. Prevention / raising awareness

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

Community & Voluntary Service continued to deliver workshops on safeguarding issues to local voluntary and community organisations. These courses are aimed at organisations working with children and adults. During the period of this report, we delivered five courses and trained 23 people from 17 organisations.

The course content has been adapted to reflect recent changes to guidance and updated toolkits and resources available to Voluntary and Community Sector organisations. The courses were free for Voluntary and Community Sector organisations to attend.

In addition we enabled a further 101 individuals from 39 organisation to access safeguarding e-learning; many of these organisation also received one-to-one advice on safeguarding issues. Our funding and development service provided one-to-one advice to hundreds of organisations, providing an opportunity to discuss safeguarding arrangements and offer support to frontline organisations as required.

We have also promoted safeguarding in our regular mailing Beds-Spread, on our website and in our development work with frontline organisations. In particular, new requirements relating to Disclosure and Barring Service checks have been featured.

2. Workforce development

See information under 1 above – during this period a total of 124 people from 56 organisations received safeguarding training.

3. Partnership working

We held a Safeguarding Community Lunch on 24th January working with Bedford Borough Council's Safeguarding Adults Team and Local Authority Designated Officer (LADO). The event was designed to provide Voluntary and Community Sector organisations working in Bedford Borough with an opportunity to meet the key safeguarding contacts and find out more about their roles. Presentations covered:
- how to make a referral and what happens when you do
- what to do when an allegation or concern is raised about a volunteer or staff member

29 people attended from 23 organisations.

Community & Voluntary Service Volunteer Centre staff worked in partnership with Bedfordshire Rural Communities Charity to provide three drop-in sessions during March giving advice on the new Disclosure and Barring Service and the revised procedure for getting checks done.

Community & Voluntary Service also met with Vivien Matthews from Bedford Borough Council to discuss how to improve safeguarding referral pathways for voluntary and community groups. It was agreed that any opportunities for the Bedford Borough SOVA Team to provide an awareness presentation or outreach to community groups would be arranged with the team – to include the forthcoming Information Fair linked with the Bedford Borough Partnership. Training provision and safer commissioning were also discussed and we will meet again to review progress and plan future work.

4. Quality Assurance

No relevant activity

5. Involving people in development of safeguarding services

See information under 3 above.

6. Outcomes and improving people's experience

No relevant activity

Improvements made in adult safeguarding during 2012/13, addressing the priorities

1. Prevention / raising awareness

A larger number of individuals from voluntary & community organisations have accessed our safeguarding training than in previous years. Requests for one-to-one advice have increased and feedback from groups shows that they are better able to put adequate safeguarding measures in place in their organisation.

The safeguarding course content has been adapted to reflect recent changes to guidance and updated toolkits and resources available to Voluntary and Community Sector organisations.

2. Workforce development

See information under 1 above

3. Partnership working

We are working more closely with Bedford Borough Council's Safeguarding Adults Team and Local Authority Designated Officer (LADO). We are also working in partnership with other local support and development organisations to provide better signposting and more support with safeguarding issues, in particular through joint work with Bedfordshire Rural Communities Charity and local funders.

4. Quality Assurance

No relevant activity

5. Involving people in development of safeguarding services

See information under 3 above.

6. Outcomes and improving people's experience

No relevant activity

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

1. Prevention / raising awareness

A new website is currently being developed which will include information on Safeguarding for voluntary and community organisations. The new website is due to launch by September and will improve access to and content of the information available to groups.

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

To continue to update safeguarding course content to reflect changes to guidance and updated toolkits and resources available to Voluntary and Community Sector organisations.

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

2. Workforce development

See information under 1 above.

3. Partnership working

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

4. Quality Assurance

No relevant activity

5. Involving people in development of safeguarding services

See information under 3 above.

6. Outcomes and improving people's experience

No relevant activity-

Name Of Organisation:	East of England Ambulance Service NHS Trust
Name Of Person Reporting:	Anneliese Hillyer-Thake

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

The Trust has processes in place to inform all new members of the Trust workforce to their responsibilities regarding safeguarding members of the public who use our services.
Training is mandatory of all operational and non-operational staff and is integral in professional updates annually as well as all basic training programmes.
The Trust has a low threshold for referral and operational staff are informed to relay any concern through to the local authority and GP as the issues arise.
It is often difficult for Trust staff to gain a full insight into the patient/person's lived experience and as such the Trust believes a low threshold for referral is the safest measure the Trust can have in place.
The Trust has a training strategy that defines the levels of each member of staff as per the ADASS standards. The Training strategy guides staff as to the professional responsibilities and supports them in their expectations of training.
Often the Trust does not have knowledge of the patient/person prior to the 999 contact and as such it is often difficult for the Trust to take action prior to harm occurring. However where possible, when Trust staff do accessed a patient/person and concern for their safety or lived experience has been highlighted. Trust staff are told they must share the information known.
The Trust has process in place to identify frequent callers; this process identifies monthly, people using the 999 service. The Trust has a process of evaluating the frequency via a stipulated process set out in the Trust policy (this is also part of a National evaluation process within Ambulance Trusts). Once a person is identified then their information is checked with the Trust safeguarding team, where the

safeguarding team are aware of the person, the safeguarding team will check with the person's GP and the local authority to see what actions have been taken from the information previous shared via a referral.

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

Safeguarding is integral to appropriate work streams, the Trust safeguarding team works closely with areas of the Trust such as PALs and Complaints, HR and operations to ensure that effective communication is initiated at the time any incidents become apparent or where concerns may be notified by an external agency.
The Trust has robust policy and procedure inclusive of Safeguarding adults, children and consent and capacity.
The Trust reports quarterly to the board to inform of any issues or concerns in service delivery.
Clear lines of accountability are identified within the Trust structure.
The Trust was visited by the CQC in January 2013. The CQC was focused on safeguarding specifically as part of their evaluation of the Trust.

The CQC found:

- Safeguarding team within the trust who offer expert advice and guidance on all safeguarding matters
- Complete safeguarding quality audits across the trust and ensure the trust's policies and procedures were robust
- Named professional whom recently completed a Master's degree in safeguarding
- National Ambulance Service Safeguarding Forum and was about to embark in a peer review exercise where safeguarding leads in different trusts would audit each other's procedures and protocols to ensure best practice was achieved
- Safeguarding area general managers within the Trust who offer more local support to staff
- A member of the Trust board with specific responsibility for championing safeguarding matters at a high level within the Trust
- Evidence of monthly, quarterly and annual audits that had taken place covering all aspects of the Trust's safeguarding referral process including types of incidents reported and the quality of information recorded by staff about them in patient care records
- Trust safeguarding team had been working hard to gather feedback about the outcome of the safeguarding referrals its staff had made and had seen a steady rise in it as a result
- The Trust had excellent information on its public website about its safeguarding procedures as well as the results of local audits, its annual safeguarding report and national guidance, making it easily available to both staff and the people who used the service
- Evidence within editions of 'Clinical Quality Matters' (the Trust's in-house monthly newsletter for staff) of safeguarding with a particular focus on safeguarding challenges that staff might find in care homes that they visit. This meant that the trust communicated information about safeguarding issues to its staff and the public
- Safeguarding training for staff was provided as part of their yearly mandatory training and a number of managers had completed the level 2 Local Safeguarding Children's Board training
- Staff spoken to confirmed that they had received both adult and children's safeguarding training
- They told us that if they had any safeguarding concerns about people they shared this information with the hospital and also contacted the Trust's single point of contact centre (SPOC) who would make a referral to the appropriate safeguarding agency on their behalf. Staff told us this system worked well. Staff were very clear

about their responsibility to report any concerns and gave us many good examples of the type of referrals they regularly made

The Trust continue to participate in the audits specified within the 11 LSABs within the Eastern region, seeking feedback and assurance as part of the evaluation, and where appropriate ensure changes to practice .

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

The Trust continue to work in partnership with Local Safeguarding Children Board (LSCB) and the local safeguarding adult boards (LSAB) around the Eastern Region. The assistant general managers with safeguarding responsibilities have started to attend these meetings supported by the Named Professional and the SAGMs in order to strengthen local area networks.

The Trust has undertaken an audit of engagement at the beginning of 2012 to ensure that all the Local Safeguarding Boards for both Adults and Children for the eleven Local Authorities (Las) of the Eastern region are satisfied with the Trust engagement and level of participation. The audit included analysis of whether boards have made contact with and begun to engage with the Safeguarding Assistant General Managers (SAGM), this has been a good process of updating LSCB and LSAB details and to give all the boards an opportunity to express any feedback in relation to involvement and participation.

The Trust continues to be an integral member of the National Ambulance Service Forum; the Trust Named Professional has attended the DH in representation of the National Group to support the DH in NHS developments and Safeguarding reforms. The Trust Named Professional is vice chair of the National Group and will become chair within this coming year.

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

The Trust seeks assurance for practice in many different ways, this will be through internal audit of practice undertaken monthly, quarterly and annually.
Learning from these audits has been incorporated into the Safeguarding Teams Action plan and wider Trust agenda. Audits are undertaken to achieve the following outcomes focuses:

- 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
- The quality of the information supplied by the Trust member of staff making the referral
- 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. This process is to check what actions have been undertaken once the referral is made. Included in this is an assurance process of the Local Authority or GP having received and processed the information
- 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 Trust has very closely monitored the referral pathway for vulnerable patients; this information is sent through to the patients GP the following working day
- The safeguarding team will check these referrals within three working days to ensure that the GP was the correct option and that there are no concerns that may require action from the LA
- A sample of Patient Care Record's relating to referrals are also audited

This information is shared with external agencies on request and to the Trust Board for assurance.
Where issues are identified the actions required will be logged on the Safeguarding action plan and monitored by the Trust safeguarding forum.

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

The Trust has a regular PPI engagement and the Head of safeguarding has accessed that forum to gauge some support around having feedback from service users.
The Trust has a Consent and Capacity policy and a process of evidencing assessment of capacity and acting in the patient's best interest. This policy has just been reviewed and is due to be signed off by the Trust Board. The Trust audits monthly the completion of Capacity forms from both Emergency and Non-Emergency partitions. This monthly audits focus on outcomes for patients, compliance to policy, use of and documentation of restraint. The safeguarding team triangulate this to the number of referrals made for safeguarding of adults at risk. The audits results are provided to the Trust Board and the final agreed audit document is published on the Trust web page.

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

The Trust continues to seek the views of service users via service user feedback surveys and has seen a drop in PALs and Complains issues within the Trust.

Highlight report of key issues arising during 2012/13, addressing the priorities

The Trust identifies:
Problems in gaining feedback to staff as this is difficult to get back from LA's and GP's

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Significant progress was made in 2012/13;

The last year has seen regular involvement of the safeguarding team in supporting Trust staff to focus on the differences between vulnerability (where information is sent to the patient's GP) and safeguarding concerns (where information is sent to the Local Authority).

Monitoring of the safeguarding referral line has remained consistent over the last year; this work ensures the quality of data leaving the Trust and the pathway choices are evaluated no more than 3 days after the referral is made. If vulnerability has been highlighted, but issues around safeguarding are present the Safeguarding Team will redirect to the LAs as appropriate.

Further training has been undertaken to support all Trust staff in using the Consent and Capacity Policy and paperwork. The Trust issued further guidance regarding restraint and how to use restraint, how to document the use of such procedures and what the Trust expects of Trust staff. Further work will continue over the next year.

The Trust has also updated its public and intranet website in relation to Safeguarding, both sites, containing the Trust's declaration of compliance (updated this year). There is a wealth of useful information for staff and members of the public including; Trust policies and procedures, staff bulletins, learning outcomes (internal and national), Department of Health and other National and Trust publications. These are updated and monitored regularly by the safeguarding team. The CQC praised the web page during the most recent routine inspection.

Work has been undertaken to support private and voluntary ambulance services and Community First Responders (CFR) working with the Trust and ensuring that all Safeguarding procedures are followed. This work is undertaken by the Named professional working closely with governance, procurement and the senior managers of the Trust's non-emergency services. The quality of support agencies to the Trust is monitored through audit, assurance visits and contracting, the Named Professional offers support in all these areas.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

The Trust will be focused on the following issues of the next year, these issues have been highlighted from Government initiatives and new legislation, SCR outcomes and ongoing monitoring of Trust systems to ensure the Trust keeps up to date on all changes as the NHS and Safeguarding restructures take place nationally.

- Sexual exploitation – the Trust has already developed this as a type of abuse within the Trust and has integrated this into Trust staff mandatory training. Further work in informing all Trust staff on this focus will be undertaken via fact sheets for the Safeguarding Team
- Safeguarding policy review by the Government – the Safeguarding team for the Trust is focused on monitoring changes and ensuring compliance to statute set out in Working Together 2013
- Robust training - the Trust intends to further support operational staff with Safeguarding by ensuring that all senior managers and clinical managers round the Eastern Region have attended Bedfordshire LSCB level 2 multiagency training. This will ensure that senior staff have a full understanding of the statutory and volunteer agencies engagement within the Safeguarding children and young people agenda, this will assist senior managers to support and supervise staff more effectively
- Development of Adult safeguarding – the government is likely to increase statute for safeguarding adults once the Health and Social Care Bill has been passed in parliament. The Trust Named Professional will monitor requirements to ensure compliance to legislation as appropriate
- Trust move to sector led areas – the Safeguarding team will support the move to sector leads and look to improve safeguarding support within the local areas. It is currently unclear as to how this will look, however proposals have been developed

Name Of Organisation:	Healthwatch Bedford Borough
Name(s) Of Person(s) Reporting:	Anne Bustin
Highlight report of key issues arising during 2012/13, addressing the priorities	
Local Priority 3 - A major consideration is the fact that on the 1 April 2013 Bedford	

LINk will transform into Healthwatch Bedford Borough (HBB). It will be the new local consumer champion for publicly funded health and social care. It is to deliver services which can be summarised as:
• **Influencing** – helping shape the planning of health and social care services
• **Signposting** – helping people access and make choices about care
• **Information, advice and guidance** – including independent advocacy for individuals making complaints about healthcare

Whilst Bedford LINk does not have a formal Safeguarding Policy, it is the intention to introduce one for HBB, because the new organisation will have a far wider remit than the LINk.

A Community Interest Company (CIC) will be the delivery vehicle for contractual purposes. It will therefore be important and mandatory, that all those people, volunteers and paid staff who will be engaged in the management of the CIC have received appropriate development in Safeguarding issues.
It is likely that this will be based on an introductory half day highly participative session, followed by regular updating.
Quite clearly the role which has been identified for HBB will in some respects mirror services already being successfully delivered by many voluntary, community and other organisations.

Indeed in a recent report prepared by the local voluntary and community sector it identified that there is in excess of 90 organisations that either provide a full range or a proportion of the services identified above.
It is hoped that in partnership with many individuals, colleagues and organisations HBB will be able to provide direct support to the future work of the Safeguarding Board

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Local Priority 2 - Training for five volunteers who are going to undertake Enter and View visits was provided. This included a mandatory session on Safeguarding issues.

The Management Group met with an Inspector from Ofsted – this provided an excellent insight into the work of this organisation. It was very useful to the Management Group as plans are made for the necessary future Healthwatch activity in working with children and young people.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

Training/development for the Healthwatch Bedford Borough Management Group in Safeguarding Issues is to be arranged.

Name Of Organisation:	Luton & Dunstable University Hospitals Foundation Trust
Name(s) Of Person(s) Reporting:	Patricia Reid, Chief Nurse

1. Prevention and raising awareness
Safeguarding continues to have a high profile within the Trust, and there is ongoing work to develop staff awareness as detailed below.

The Trust intranet-safeguarding site, that was launched in August 2011 and has been continually updated since, was designed to support staff by providing access to information, procedures, policies and referral forms. The information has also been available in a Safeguarding Folder in all clinical areas since October 2012. This has

been a highly successful project with excellent feedback from staff, especially when trying to find forms and other documentation for referral and clarification of procedures.

The Trust has also raised awareness through presentation of a safeguarding case at an Schwarz round. The Schwarz round provides the multi professional health care team staff with an opportunity to reflect on and share their experiences of caring and providing care to patients that may have presented challenges and/or situations that were unusual and unfamiliar for some or all of the team.

A Dementia Awareness event, hosted by University of Bedfordshire Social Care Team in March 2013, provided the Safeguarding Lead Nurse an opportunity to display information on work within the hospital; the event was attended by paid and unpaid carers of people with Dementia from primary care, secondary care and third sector organisations.

As an acute teaching and training hospital pre registration students care for our patients. The Trust Safeguarding Lead has agreed to provide MCA and Consent training to the nursing students at the start of their training programme; the training is currently scheduled at the end of the 3rd year and is felt to be a missed opportunity to raise awareness and understanding of safeguarding practice before students have contact with patients.

PREVENT is 1 of the 4 elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. The Trust has identified a lead and training has been provided to raise awareness of the contribution healthcare professionals can make to stop people becoming terrorists or supporting terrorism. The PREVENT lead is now cascading this training to Trust staff.

The Trust established a Safeguarding Adult Board chaired by the Deputy Chief Nurse in November 2012; a core action plan based on strategic safeguarding aims for the Trust is in the process of being developed. The inaugural meeting was held in November 2012 and quarterly meetings were held in January & April 2013. Membership of the group includes voluntary organisations and partner agencies (Luton & Bedfordshire CCG, SEPT, Adult Social Care and POhWER).

The Trust has received a donation of textbooks and funds to purchase copies of national reports relevant to safeguarding. These resources will be available to Trust staff and university students from all disciplines in a designated Safeguarding area of the Medical Education Centre Library.

2. Workforce Development

A named Consultant and Executive Director support the Safeguarding Adult Lead Nurse to develop a competent and capable workforce that can safeguard adults in our care. In addition an Honorary contract has been negotiated for a volunteer with extensive DOLS and Mental Capacity Act Coordinator experience to provide regular training to staff in conjunction with the Safeguarding Lead Nurse. The Learning Disability Liaison Nurses are employed by SEPT but contracted to the Trust to provide a liaison service for learning disability patients and hospital staff responsible for providing ongoing care. The recently appointed Dementia Nurse Specialist further complements this team; this is a new role developed in recognition of the increasing need to provide dementia friendly services.

Safeguarding adults is incorporated in the Trust corporate induction programme, annual mandatory update and medical staff education programmes.

A six-month Safeguarding Champions Course was commissioned in September

2012 in collaboration with University of Bedfordshire for 25 senior healthcare professionals to enhance their level of safeguarding knowledge and skills and enable them to share their learning and act as an expert resource for staff working in the clinical areas. A second course was commissioned in March 2013 to start in June with ancillary staff and administrative staff involved in discharge planning enrolled on the course.

An updated Mental Capacity Act training day, incorporating accountability and consent, has been developed that is available for staff who require more than the hour long MCA training sessions that are held weekly. With support from key professionals within the organisation we are continuing to ensure this legislation is embedded as part of everyday practice and assessments are undertaken when capacity to make decisions is questioned.

3. Partnership working

Partnership working with other health and social care colleagues is essential if we are to provide a robust and seamless service and develop effective practices that avoid duplication.

The Trust is actively engaged with the key local authorities, Luton, Central Bedfordshire & Bedford Borough with the Chief Nurse, Deputy Chief Nurse and Safeguarding Lead Nurse representing the Trust at the quarterly Safeguarding Boards, quarterly Operational Boards and six weekly Safeguarding leads meetings respectively. In addition the Safeguarding Lead Nurse meets with the CCG & LBC, the Trust's lead authority for Safeguarding, to review and discuss open cases and alerts. The Deputy Chief Nurse and/or Safeguarding Adults Lead Nurse represent the Trust at the Safeguarding Operational Group, Pan Bedfordshire Safeguarding Group and Bedfordshire Dementia Commissioning Strategy Group and the Health Sub Group for Learning Disabilities chaired by NHS Luton Commissioners.

The Deputy Chief Nurse and Operations Director attended an Overview & Scrutiny Committee Task & Finish Group: Hospital Discharge Review meeting with Luton Borough Council following concerns regarding discharges from the hospital. In response to this the group visited the hospital to understand the patient pathway and process from admission to discharge. The work is ongoing and now includes the Integrated Operations Manager for the Trust.

The Learning Disability Nurses represent the needs of LD patients at the Trust's Equality & Diversity Committee, Patient Information Group, Safeguarding Adults Board & Patient Experience Group. A Learning Disability Task Group, chaired by a Parent and supported by the Trust Chairman was established and met quarterly until early 2013; there are ongoing discussions regarding the future of the group and a proposal to encompass the group into the Trust Safeguarding Adult Board that was established in November 2012.

4. Quality assurance

There were in excess of 300 alerts raised during 2012/13, 56 of which were raised against the Trust. The emerging themes from the alerts raised against the Trust were discharge, communication and documentation. Actions to address these issues have been taken in conjunction with our commissioner and local authority partners.

An unannounced CQC inspection took place on 15-18 June 2012, with a focus on learning disabilities among other aspects of clinical care. The formal report has been issued with a positive outcome for outcome 7 and not actions or improvements required.

A standard safeguarding alert referral form for hospital staff has been agreed with

Luton and Bedfordshire Councils. The new referral form was launched in the Trust in January 2013 and meets the ADASS Protocol for inter authorities' investigation of vulnerable adult abuse. A Standard Operating Procedure has been developed to guide staff with completion of the form.

The Domestic Abuse Committee inaugural meeting was held on 27 March 2013. The membership of this newly established committee includes representation from Safeguarding, Maternity, Occupational Health and Human Resources.

The Learning Disability Action Plan, incorporating East of England NHS Learning Disability QIPP: 'Improving Acute Hospital Patient Pathways for Adults with a Learning Disability and Adults with Autism has been progressed through the LD Task Group.

All patients aged 75 and over are routinely screened for cognitive impairments that may indicate the early onset of Dementia and a questionnaire has been developed for carers of people with Dementia to understand if they feel supported in their caring role, as part of the CQUIN for Dementia.

5. Involving People

The LD Nurses have developed guidance for Carers of Patients who have a Learning Disability and a protocol for inclusion of stakeholders, patients and carers, in relation to adults with a learning disability. A number of easy read leaflets and information has also been developed for complaints, discharge and patient feedback. This work is complimented by the LD Patient Experience coffee mornings that are held quarterly, facilitated by the LD Nurses and attended by the Chief Nurse, Deputy Chief Nurse and Safeguarding Lead Nurse. The coffee morning is an opportunity for LD patients to share their experiences and feed into the Trust Patient Experience Group in a non threatening, supportive environment and representatives of POWhER and MENCAP to share the experiences of their service users and clients who are unable to communicate their experiences personally.

The Trust has established a Patient Experience Group with service users and Trust Governors included in the membership to ensure views and experiences of patients are appropriately represented and shared. Information from the Patient Experience Call centre, that calls all patients who have had an in patient stay 24 hours after discharge, is discussed at the meeting and any areas of concern addressed.

6. Outcomes and Improving Experiences

The Ward 17 report was published in January 2013 and acknowledged the improvements that had been made in Safeguarding at the L&D.

The Safeguarding Adults Named Nurse has worked with A&E staff to develop an electronic alert system for flagging patients with known dementia/cognitive impairment. This system is designed to improve the patient experience through early identification on repeat admissions.

A substantive Integrated Operations Manager commenced employment in March 2013 and joined the existing liaison meeting with the local authorities, facilitated by the CCG, to support progress of the discharge from hospital work stream.

The Integrated Operations Manager and Safeguarding Lead Nurse have established a process for reviewing all patients reported to have experienced an issue on discharge, as identified by the CCG, with a full case note review. This approach has been beneficial in identifying key themes and issues that the Trust is now focusing on to improve the patient experience. This process will be continued on a regular basis

until assurance can be given that improved practice is embedded.

Preliminary work to link the Trust electronically with System One commenced in 2013. Access to this system will allow the Safeguarding Team to gain information on patients stored on the community based system that is pertinent to their care and any existing safeguarding concerns that may be of importance to the patient's current episode of illness requiring acute care intervention.

A Dementia Nurse Specialist and commenced in post in May 2013 and will take forward key issues and work closely with the clinical consultant lead in DME. These include supporting staff and patients, providing education and development programmes, identifying dementia champions at ward and department level, working with the local community towards best practice and to deliver the Dementia CQUIN targets.

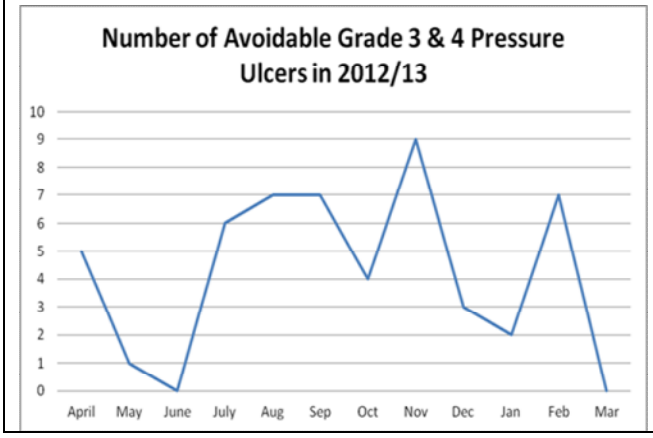
The Voluntary Services Manager has secured a volunteer from the Alzheimer's Society to set up a Dementia Support Service, based in Elderly Care Unit on a bi weekly basis commencing May 2013 as part of Dementia Awareness Week. We have continued to improve care for this client group in line with the National Dementia Strategy and Mental Health commissioners.

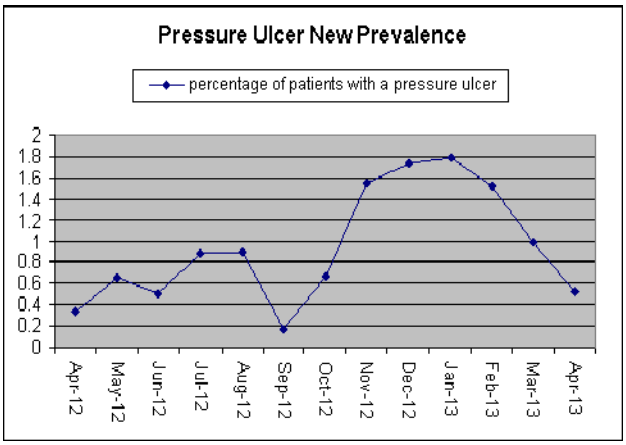
Improvements in care of LD patients include a daily email alert from the Trust's patient information system i.PM to Matrons, LD Nurses and Corporate Nursing Team with details of all registered LD patient admission/discharges over the previous 7 days. Matrons then visit all learning disability patients within 24hours of admission with ongoing daily feedback from ward managers to allow any reasonable adjustments to be made as necessary. Ward staff can also refer LD patients to the LD Nurses via Extramed, an electronic data management system used in the Trust.

A weekly email alert from i.PM is also sent to the LD Nurses informing them of all planned outpatient activity for LD registered patients in the forthcoming 2 weeks. This allows the LD nurses to contact any patients who are not already being supported in advance of their appointments to offer them support.

A number of LD Patient Pathways, as per the LD East of England QIPP recommendations, are in place in Pre-Assessment, Accident & Emergency, X-Ray/Imaging, Outpatients, and Medicine & GUM to guide and support staff in providing the best care for patients with an LD.

Preventing pressure ulcers has been a high priority for the Trust with an overall aim to eliminate all avoidable grade 2, 3 and 4 pressure ulcers. Key actions have been incorporated into a Trust pressure ulcer prevention action plan that has been driven by the Chief Nurse. Significant improvements have been achieved and progress continues.





Highlight report of key issues arising during 2012/13, addressing the priorities

There are nationally identified risks in relation to safeguarding and the transition period to Clinical Commissioning Groups (CCG) therefore it is essential that safeguarding processes and procedures across the Trust continue to be robust and effective.

The geographical position of the Trust has created some challenges when raising alerts with the local authorities; this issue was highlighted in the Ward 17 Serious Case Review published in January 2013. The publication of the revised ADASS protocols in January 2013 clarified the requirements that the location of the abuse determines which local authority the alert should be escalated to but there is still a need for partner agencies to agree the process and embed the change in practice as the lead authority for the Trust is not always the same as the authority where the abuse occurred.

A change in the referral process for Trust staff raising an alert; the local authorities did not have a standard alert form which caused confusion for staff and a potential delay in referrals being accepted when information was not provided in the required format.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

1. **Prevention and raising awareness**

The establishment of a Trust Safeguarding Board has provided a platform from which the successes and achievements to date within safeguarding can be progressed and developed further. The Board will be accountable for ensuring that the safeguarding priorities remain a focus of the Trust's wider agenda.

2. **Workforce Development**

Training and developing 25 registered nurses and allied health professionals for 6 months to take on the role of Safeguarding Champion has proved to be a success. The participants report a greater understanding of safeguarding and increased confidence in raising alerts and acting as an expert resource for colleagues. The Safeguarding Lead Nurse reports an increase in the number of staff contacting her for advice and to discuss a potential alert, further evidence of the value of the course.

3. **Partnership working**

The 6 weekly review meetings with LA's & the CCG has improved the working relationships between health and social care partners and provided an opportunity for more support and challenge in managing cases.

The establishment of a Dementia Support Service in the Trust in partnership with the Alzheimer's Society is a further example of effective partnership working.

4. Quality assurance

The results of the CQC unannounced inspection in July 2012 demonstrated significant improvements in safeguarding systems and outcomes for patients cared for within the Trust and for those accessing our services as out patients.

The dementia CQUIN will increase the number of people diagnosed with dementia and identify people at an earlier stage leading to earlier intervention and the potential to improve their quality of life for longer.

5. Involving People

The LD Patient Experience coffee mornings is an excellent example of the Trust working to involve people in the development of services and listening to patients.

6. **Outcomes and Improving Experiences**

The number and quality of referrals, both formal and informal, has increased and improved which is evidence that the ongoing education and training of staff has raised awareness and confidence of staff to raise concerns.

The appointment of a Dementia Nurse Specialist will improve the experience of patients with dementia and their carers.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

1. Prevention and raising awareness

The PREVENT agenda is particularly important for the L&D given the demographic and cultural mix of the local population; the area has been identified as one of the top 3 high risk areas nationally. Trust staff need to be aware of the early warning signs that someone may be at risk of being coerced or in the process of planning terrorist activities and how to escalate this concern to the appropriate authorities.

Dementia has been identified as an area that requires significant investment both in terms of better and early diagnosis and the care and treatment of people with the condition. The Trust is planning to roll out the 'This is Me' booklet Trust wide for all in patients. 'This is Me' provides staff with important information about the patient that can be used to provide more personalised care that will safeguard the patient more effectively and reduce their risk of harm and the potential for harm to others.

2. Workforce Development

We currently provided basic awareness training for all staff but National competencies have been developed outlining 4 levels depending on the amount of engagement staff have in the Safeguarding process (National Safeguarding Adult Competency Framework). It has been proposed that all clinical staff should receive education at level 2 so a review of Safeguarding Education and development of a standard Level 2 programme for relevant clinical staff will be progressed in 2013/14.

The second Safeguarding Champions course will be progressed and consideration given to the need for a third cohort during 2013.

The focus on increasing staff knowledge and practice in completing MCA and DOLS will be maintained with the aim of all necessary staff being trained by the end of 2013.

3. Partnership working

The Safeguarding Lead Nurse and Executive Director for Safeguarding will continue

to work in Partnership with LBC and seek to resolve current issues with LBC, working to improve on communication, responsiveness to alerts and agreeing what is an appropriate level of response to an alert.

4. Quality assurance

The case note review of health records for alerts relating to discharge will be continued and improvements in practice made to improve the patient experience on discharge form the hospital.

5. Involving People

A focus on establishing support for carers of people with dementia will be a priority for 2013/14 and maintaining the achievements in caring for people with a learning disability.

6. Outcomes and Improving Experiences

The Trust aims to achieve the Dementia CQUIN target set for 2013/14 and to improve on the 2012/13 self-assessments for adult safeguarding and learning disabilities that were initiated by the Midlands & East Strategic Health Authority.

Name Of Organisation:	POhWER and Advocacy for Older People (AOP)
Name(s) Of Person(s) Reporting:	Glenda Tizard, Community Manager, POhWER Simon Daize , Safeguarding Manager, AOP

Highlight report of key issues arising during 2012/13, addressing the priorities

The IMCA service responded to 117 issues referred to POhWER during 2012/13 (81 from Bedford Borough, 36 from Central Bedfordshire). Of the 117 referrals, 39 were referrals in respect of safeguarding. **(Priority 4 and 6)**

There have been some instances where inappropriate IMCA referrals have been made – these have been referrals which, on investigation have not met the criteria for the service. Those not meeting the criteria include:
Bedford Borough Council Social Work team – 2
Central Bedfordshire Social Work team – 2
SEPT Care Coordinator – 1
Bedford Hospital Medical staff – 1

In all cases a Community advocate has been provided.

The Community Advocacy service also receives referrals to support individuals who have been subject to a safeguarding alert. Advocates additionally raise alerts where disclosures have been made to them. During 2012/13 community advocates supported people with 27 safeguarding issues in Bedford Borough and 31 issues in Central Bedfordshire**. (Priority 4 and 6)**

<u>Advocacy for Older People (AOP)</u>
All AOP safeguarding work has been overseen by the independently funded part-time Safeguarding Manager post.

There have been 16 new safeguarding cases received specifically by AOP throughout the year. 10 of those cases related to clients living in the Bedford Borough area and the other 6 cases related to those living in Central Bedfordshire.

The abuse that was being reported and dealt with by the volunteer Advocates can be categorised as follows:-

Financial abuse - 7 cases
Physical abuse - 4 cases
Psychological and verbal abuse - 3 cases
Neglect - 2 cases

Of those 16 safeguarding cases resulting in partnerships with AOP advocates 10 have now been closed and the other 6 remain on-going. The duration of those closed partnerships ranges from the shortest being five days to the longest, spanning 8 months.
Some of the existing live cases referred last year have remained open beyond 12 months as a result of the complex nature of issues being addressed.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

The POhWER Community Manager has met regularly with the Safeguarding Leads from Bedford Borough Council and Central Bedfordshire Council to review activities and consider improvements. In particular the Community Development Workers have been considering how to engage their service users in the work of the Safeguarding Boards. Preventative work has been done in the Voice groups for people with learning disabilities, to raise awareness and understanding of safeguarding issues. **(Priority 1)**

A modular training programme has been developed by Community advocates. The voluntary training under the generic title "Keep Safe" has been delivered to individuals who have been subject to safeguarding alerts and whom it was thought would benefit. 28 individuals have benefitted from one or more of the following modules:

- Assertiveness and confidence
- Communications
- Relationships

Regular reviews with service users are held to confirm what they have learned from the experience. **(Priority 3, 4, 6)**

Regular training updates have taken place during the year, both POhWER-wide and within the local teams, to refresh knowledge on safeguarding issues and on the role of the IMCA service. The Safeguarding lead for Bedford Borough has attended a Bedfordshire POhWER meeting to explain the Local Authority perspective on safeguarding**. (Priority 2)**

<u>Advocacy for Older People (AOP)</u>
All AOP Advocates and staff have received safeguarding awareness training and continue to receive various inputs throughout the year. As part of the mandatory induction training all new volunteer Advocates and staff received training on SOVA awareness/Pressure Sore Awareness/Accurate Record Keeping and Report Writing.

Through routine work, delivery of bespoke training and its Presentations programme, AOP staff have provided training, awareness raising, information and support to a range of external organisations and groups. These included: service users, service users' family, friends and relatives, staff and service user groups in nursing homes and day centres, the Alzheimer's Society, Goldington Day Centre and Potton House.

11 x AOP volunteer Advocates have been helping clients within safeguarding cases through the year, managed and overseen by the Safeguarding Manager.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

- Monitoring of inappropriate IMCA referrals and regular reporting to Safeguarding Leads
- Further development of "Keep Safe" training modules **(Priority 3 and 4)**
- Further training updates at team meetings **(Priority 2)**
- POhWER advocates to obtain feedback, where possible, from clients on their experiences of the safeguarding process **(Priority 4 and 5)**

- Advocacy for Older People (AOP)
  AOP is seeking to continue and expand its Safeguarding provision. Work is on-going to secure independent funding for existing capacity; additional applications are being processed to resource expanded full-time cover incorporating the SOVA Manager post, increased volunteer Advocate capacity and a new part-time SOVA Co-ordinator post.

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

Highlight report of key issues arising during 2012/13, addressing the priorities

Prevention / raising awareness
A series of preventative and awareness raising initiatives have been implemented this year within the Trust 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 and CHS staff have joined the Safeguarding Leads/Champions Group. Awareness sessions have been delivered on assessing pressure ulcers and the links to safeguarding issues. Analysis of all SEPT safeguarding cases are analysed for any trends and reported to the Trust Safeguarding Group

Workforce development
Safeguarding policies were updated in September 2012. The Training strategy has been updated and all Trust staff have been mapped against the level of training required dependant on their role.

Quality Assurance
A weekly report to the Trust Executive Team to give assurance of Safeguarding activity and compliance to timescales. The Trust Safeguarding Group monitors the Safeguarding action plan for assurance. The Trust have presented monthly reports to the Partnership Management Group and quarterly reports to each Joint Beds/Central Beds Local Safeguarding Adult Board. The Trust has been involved in four audits commissioned by BBC and CBC in the past year. The outcome of all independent audits gives assurance that SEPT is consistently effective in safeguarding service users.

Involving people in development of safeguarding services
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. Two 'Lets Talk' Service User and public events have been held in Bedfordshire this year. These are joint sessions where the safeguarding service is explained and discussed and participants have given feedback on the development of posters and leaflets etc. As a result new

Safeguarding Leaflets have been developed and distributed to all Trust areas.

Outcomes and improving people's experience
The outcomes of Independent Audits and Service User Questionnaires demonstrate an improved service has been delivered and experienced by Service users. The feedback from service user questionnaire state that people feel respected, treated with dignity and involved in investigation process

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Prevention / raising awareness
The numbers of referrals this year continues to rise 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.

Workforce development
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 DoLs
- Safeguarding introduction

The Safeguarding Competency Framework has been delivered to all mental health managers and
continues to be implemented within all teams.

Partnership working
The Trust continues to be active members of the Bedfordshire Safeguarding Board, Operational Group and other sub groups. Trust staff are involved in quarterly Safeguarding Peer Group Forums with BBC staff and quarterly peer audits with CBC staff

Quality Assurance
The Trust has reported consistent improvements in the safeguarding process and outcomes of BBC and CBC audits.

Involving people in development of safeguarding services
The Trust Service user Group has been involved in the development of Safeguarding service.

Outcomes and improving people's experience
The process for investigating cases has continued to improve. 95% 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.

Savile Inquiry

As a result of the Savile Inquiry in 2012, the Trust reviewed its policies regarding visitors and celebrities. A report was presented to Trust Board providing substantial assurance that measures are in place monitor and supervise visitors and celebrities

at all times. The Trust has a visiting policy in place.

Francis Inquiry

As a result of the Francis Inquiry, all staff received a presentation on the main findings and the response planned by the Trust. A task and finish group has been formed as a subset of the Trust Executive Team and is led by Executive Directors. Key themes for the groups include

- Culture of compassionate care and zero tolerance for harm
- Detecting problems quickly
- Accountability
- Leadership

In addition to the above, a series of listening exercises for service users and staff have taken place. The outcomes will be used to influence services strategies.

An electronic and anonymous reporting system has been developed in order that staff can raise concerns either through the whistleblowing policy or anonymously through this new initiative.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities

Prevention / raising awareness
Continue to develop training programmes for CHS and mental health staff and raise mandatory training compliance to 95%

Workforce development
Continue to introduce the Competency Framework throughout the Trust workforce where relevant.

Partnership working
Continue working closely with BBC and CBC Safeguarding Teams and with Peer Review Forums and audit programmes

Quality Assurance

Involving people in development of safeguarding services
Continue to arrange service user group sessions.

Outcomes and improving people's experience

Explore alternative methods in obtaining feedback from Service users subject to a safeguarding investigation

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

Highlight report of key issues arising during 2012/13, addressing the priorities

Prevention and raising awareness
We have consistently highlighted to the Adult Safeguarding Board the need to raise awareness of safeguarding issues with voluntary organisations and community groups and for organisations/ groups to have in place adequate Safeguarding Policies so as to improve practice within the sector, particularly in smaller groups that are run by/use volunteers. At the end of the year, Central Bedfordshire Council commissioned Voluntary and Community Action to deliver a programme of 25 half-day safeguarding awareness sessions to smaller voluntary and community

organisations throughout 2013/14.

Under the regulations for the new Disclosure and Barring Service, many voluntary and community sector organisations are no longer eligible to request disclosures for staff and volunteers who may come into contact with adults who may be considered vulnerable as they do not directly provide healthcare, personal care or social work; or assistance with cash, bills, shopping, financial and personal affairs or with transport. While DBS Disclosures are only part of an organisation's safeguarding procedures, their ineligibility to request a disclosure is likely to have a mixed impact: less bureaucracy and cost versus increased risk??

Workforce development
We attended and contributed to discussions at the Bedfordshire Training and Development Sub Group to consider arrangements for the endorsement of Safeguarding Training.

Partnership working
We highlighted the need to give greater prominence to safeguarding in the prospectus for a Police and Crime Commissioner and raised the issue of how safeguarding data relating to Central Bedfordshire (rather than Bedfordshire wide) was presented by partners.

Improvements made in adult safeguarding during 2012/13, addressing the priorities

Prevention and raising awareness
We provided information, advice and guidance on safeguarding or developing safeguarding policies to one voluntary and community organisation. Information on the new Disclosure and Barring Service was prepared and circulated to the voluntary and community sector.

Workforce development
Three staff (from Voluntary and Community Action) undertook Bedfordshire Adult Skills and Community Learning mandatory training, which includes safeguarding.

An Introduction to Safeguarding workshop was held in December 2012, attended by 12 participants from six organisations. One bespoke Safeguarding workshop was delivered in January 2013 to an organisation delivering services across Bedfordshire.

Partnership working
We attended and contributed to all Adult Safeguarding Board meetings held during 2012/13.

We made a strong contribution to the development of Healthwatch Central Bedfordshire, including the preparation of a draft Safeguarding Policy.

Quality Assurance
Our Safeguarding and Recruitment Policies have been updated to include the new Disclosure and Barring Service and the new Safeguarding Alert Form (agreed at the November 2012 Safeguarding Board).

Voluntary and Community Action was awarded the Matrix standard, a national quality mark for all organisations delivering information, advice and guidance services to support people in their choice of career, learning, work and life goals, including volunteering. Safeguarding was a feature of the assessment for this standard.

Improvements planned in adult safeguarding during 2013/14, addressing the priorities
Prevention and raising awareness We will deliver a programme of 25 half-day safeguarding awareness sessions to smaller voluntary and community organisations throughout 2013/14, in partnership with Community and Voluntary Service. The programme is expected to reach 250-375 delegates across Central Bedfordshire. We will continue to prepare and circulate information to the voluntary and community sector on changes to the new Disclosure and Barring Service. We need to review and update our Better Care resource pack to ensure that it is consistent with current practice. **Workforce development** All newly appointed staff will undertake Safeguarding Training. Once arrangements for the endorsement of Safeguarding Training are agreed/in place we will submit our Safeguarding Vulnerable Adults training workshop for endorsement. **Partnership working** We will continue to attend and contribute to all Adult Safeguarding Board meetings during the year.

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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