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 2017- March 2018

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1. Independent Chair's report by Terry Rich

The Bedford Borough and Central Bedfordshire Safeguarding Adults Board has had a busy year which focused on a number of priority areas identified at our Business Planning Day in April last year. Later in this report details of progress against each priority area is recorded along with areas where further work is required.

Areas of strength:

i) Partnership Working:

The Board has benefited from strong and positive co-operation and partnership working across all agencies. There has been regular attendance at a senior level from all agencies and a marked willingness to bring issues of concern to the Board and to be open in discussing challenges. This has assisted us in seeking to address areas of weakness that have been identified during the course of the year.

ii) Operational effectiveness

The continued work of the Safeguarding Adults Operational Group provides the Board with regular assurance that professionals from statutory partners regularly meet to monitor performance, troubleshoot issues and identify trends. Their reports to the Board ensure that appropriate issues are escalated**.**

An example of this during the year was an identified fall in performance in one area in the completion of Deprivation of Liberty Safeguards (DoLS) assessments. The Board was able to examine the issue and seek assurance that corrective action was being taken. It is gratifying to note that performance has returned to its previous high level.

iii) Numbers of safeguarding concerns not leading to enquiries

Last year, the Board identified that there were numerous concerns being reported to the local authority safeguarding teams which did not meet the criteria for an enquiry. Many were welfare concerns or mental health concerns picked up by police or ambulance crews. The Board had been concerned that some of those referrals might a) be taking up valuable time and resources within the safeguarding teams, and b) might be delaying that referral reaching the more appropriate destination.

Bedford Police have initiated a series of workshops which aim to clarify the issues and to look to improve pathways of referral. The Board will monitor the impact of this work on figures over the coming period.

Areas of concern:

i) **Mental Health and the AMHP service:**

The Board has been concerned that several cases referred for consideration of a Serious Adults Review have related to service users with mental health needs. There have been several cases where the response of the Approved Mental Health Professionals Service (AMHPs) has been a significant factor. It is though the case that in all the cases referred, the view was that a single agency investigation was the most appropriate outcome. However, the Board will need to continue to have close oversight of the way in which people with mental health needs are safeguarded.

We have been partially reassured by the instigation of an independent review of the AMHP service commissioned by the ELFT and are keen to see evidence of improvements as a result. We are also pleased to note the establishment of the AMHP Governance Group chaired by Kate Walker, DASS (Director of Adult Social Services) in Bedford Borough Council. The Board will be keeping in touch with this group to ensure that the service is operating in a way that keeps people in mental health crisis safeguarded.

ii) **Mental Health provider organisation:**

The Board has throughout the year been concerned at the number of safeguarding concerns arising from a privately owned ("Accomplish" previously known as Tracscare) mental health facility within the Bedford Borough area – previously known as Milton Park and recently renamed Lakeside. A Safeguarding Adults Review in respect of a patient/resident of the facility who tragically died when she was hit by a vehicle on the nearby A1, was conducted over the course of 2017-18. The findings identified significant shortcomings in her care and support and the Board is closely monitoring multiagency actions plans arising from the recommendations.

Safeguarding concerns have continued to be raised regarding the facility and regular oversight is maintained by the CCG, Bedford Borough as well as the regulator, CQC. As Chair, I also visited the facility and met with senior managers to hear about how they have addressed difficulties and plan for further progress.

The SAR identified an issue in relation to residents discharged to the organisation's own residential care facility on a neighbouring site. Such residents in effect become resident in Bedford on discharge and their access to local Mental Health services appears to be ambiguous. The Board has been assured that the residential facility is now separately managed and that full discharge planning takes place when a patient moves into the residential facility. However, there remains a concern that all residents of that facility "Pathway House" should be known to and have access to the support of local mental health services if required. This issue is being monitored through the SAR Action Plan.

Emerging Issues:

i) Risk management:

The Board's business planning day this year focused on the issue of managing risk – particularly in respect of people who are either not receiving formal care and support services or who are perhaps putting themselves at risk through their lifestyle. The Board is keen to see the development of a Risk management tool which is common and shared across Bedford, Central Bedfordshire and Luton.

ii) Exploitation

The Board has been briefed by partners – and, in particular, by Bedfordshire Police regarding the growing risk of exploitation of vulnerable groups through issues like modern day slavery and "County Lines" drug gangs. Whilst there have only been a small number of cases recorded locally to date, all partner agencies recognise the importance of working together when such cases emerge. Similarly, the Board has been briefed on issues arising from the Prevent strategy, and in particular are concerned that agencies are ready to manage the potential for people with care and support needs returning from Syria.

Board Management:

i) Board Business Manager

Last year, I highlighted the benefits of a dedicated SAB Business Manager. I'm delighted that partners have agreed to fund the post and even more pleased to report that a Business Manager has now been appointed and will take up her post in September 2018.

In the meantime, the Board has been well supported by Viv Reynolds Bedford Borough Council Adult Social Care Department and from Leire Agirre who joined Central Bedfordshire during the year taking over from Emily White who left to join the Care Quality Commission. They have continued to be assisted by Natasha Smith our SAB Support Officer.

ii) Web site

Preparatory work has been undertaken on developing the SAB website – and it is hoped that progress will be made on this once the new Business Manager is in post.

iii) Common Data Set

This is another area where more work is required to ensure that the Board is sited with the appropriate data set which enables a good oversight of activity and performance. Currently, the Board has good comparative information from the two local authorities but is less sighted on activity and performance on safeguarding from other partners. This is an issue that the Business Manager will need to work on in the coming year – aiming for a consistent approach across Bedford Borough, Central Bedfordshire and Luton.

In summary:

The arrangements made by local authorities and strategic partners to safeguard people with care needs remain robust and effective. There is continued evidence of good multi agency working and the Board's Operational sub group which reports to the main Board is an effective forum for identifying tensions and issues.

The Board has also kept track of the numbers of safeguarding concerns and enquiries and their source. Work has been initiated to review referral pathways to ensure that concerns reach the most appropriate destination without delay.

Demand for DoLS assessments and reviews continue to be an area of pressure, but is well managed and there are no undue delays for assessments or reviews.

The Board's business plan is attached at the end of this report and will guide the work of the Board in the year to come.

Terry Rich
Independent Chair,
Bedford Borough & Central Bedfordshire Safeguarding Adults Board

2. The Safeguarding Context in Bedford Borough & Central Bedfordshire

2.1 This annual report covers the work of the Bedford and Central Bedfordshire Safeguarding Adults Board during the year April 2017 to March 2018. It aims to inform residents of the Bedford Borough and Central Bedfordshire areas, including those who use social care and health services, their families and carers, elected members of each Council and those who work in social and health care across all partner agencies, about the work of the Board and safeguarding activity across the area.

2.2 Central Bedfordshire, a predominantly rural area in the East of England, is considered to be a highly desirable place to live and work. As a consequence, the population is growing, rising from 254,400 in 2011 to approximately 280,000 in 2017. Further estimated growth of 16% will see the population rise to 325,000 by 2031.

2.3 The population is aging as well as growing. Between 2016 and 2031 the number of people aged 65 and over is projected to increase from 48,500 to 71,200, a 47% increase. The main drivers of population growth are:

- Increasing life expectancy
- A rising birth rate, which exceeds the mortality rate
- A net migration gain due to more people arriving in the area than moving away

Life expectancy at birth provides a good overall indicator of health and wellbeing. Life expectancy for men (81.5 years) and for women (84.0 years) which continues to remain significantly better than the England average.

The gap in life expectancy between the least and most deprived areas of Central Bedfordshire is 6.4 years for men and 5.4 years for women.

2.4 Bedford Borough has a vibrant and diverse population and in recent years there has been a significant increase in migration from Easter European countries. Bedford's Black, Asian and Minority Ethnic population has increased substantially in recent years from 19% in 2001 to 29% in 2011.

The population in Bedford Borough is 169,900. An estimated 62,000 people in Bedford Borough are over the age of 50, of whom 29,800 are over 65 and 4,300 are over 85. Between 2016 and 2031 the number of people aged 65 and over is projected to increase from 29,300 to 42,000, a 43% increase.

Average life expectancy in Bedford Borough is 80.1 years for men and 83.4 years for women but there are large inequalities in life expectancy depending on where people are born. The gap in life expectancy between the least and most deprived areas of Bedford Borough is 11.1 years for men and 11.0 years for women.

3. Governance & Accountability

3.1 The Care Act 2014 and it's accompanying statutory guidance provides the framework for Safeguarding. It put safeguarding adults on a legal footing and required Safeguarding Adults Boards to be set up across local authority areas to encourage partner organisations to work together and ensure local arrangements effectively help and protect adults in the local area so that everyone can live safely, free from abuse and neglect. Our Board is well established with strong support from both statutory and partner agencies.

3.2 The Care Act 2014 also required all agencies to promote individual wellbeing with a multi-agency approach to achieving a focus on positive outcomes for people who use services and on person centred practice. Making Safeguarding Personal required a change in practice and organisational culture to allow the person who may be at risk to be put in charge of their own life and to be able to state their wishes.

3.3 The Care Act 2014 requires all local authorities to report and safeguard adults suspected to be at risk of, or experiencing exploitation and abuse. As well as promoting and safeguarding the mental and emotional wellbeing of adults and protecting adults from abuse and neglect.

3.4 Safeguarding is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, having regard to their views, wishes, feelings and beliefs in deciding on the course of action to take. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Safeguarding is concerned with;

- achieving the desired outcomes for people subject to abuse within communities whether they are in their own home or in a health or care service setting,
- ensuring appropriate advocacy is available for people who may need safeguarding,
- effective multiagency interventions are planned and delivered for vulnerable people whose life-style may place them at risk of significant and foreseeable harm (for example self-neglect or hoarding)
- monitoring the quality of local care and support services and their awareness of safeguarding
- supporting more provider organisations to be able to undertake Safeguarding Enquires (S42 enquiries)
- making connections between adult safeguarding and domestic abuse and adult exploitation and focusing on those with care and support needs.

3.5 The Safeguarding Adults Board (SAB)

The Safeguarding Adults Board leads adult safeguarding arrangements across its locality and it is it's role to oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies.

The SAB duties are as follows;

- identify the role, responsibility, authority and accountability with regards to the action of each agency and professional group should take to ensure the protection of adults.
- establish a way of analysing data that increase the board's understanding of abuse and neglect locally.
- establish how it will hold partners to account and gain assurance of the effectiveness of it's arrangements.
- determine it's arrangements for peer review and self-audit.

The SAB does this by;

- establishing a framework of subgroups in place to assure ourselves that local safeguarding arrangements are in place as defined by the Care Act 2014 and it's statutory guidance.

- prioritising Making Safeguarding Personal (MSP) in the Business Plan as well as within the multiagency audits and in the in depth individual Agency Self-assessment to assure itself that safeguarding practice is person centred and outcome focused.
- working collaboratively to prevent abuse and neglect, strengthening our escalation policy to ensure strong multiagency response where required.
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in it's area, aligning strategic objectives to training and undertaking multiagency themed audits.

As part of the SABs core statutory duties, we have:

- developed a two-year Business plan which sets out the boards objectives and how they will meet their objectives including collaborative work with partners.
- published an annual report detailing how effective our work has been.
- commissioned one Safeguarding Adults Review (SAR) and we have a SAR subgroup in place to consider any cases which meet the criteria.

4. Finance & Resources

4.1 There is no national formula for Safeguarding Adults Board funding, therefore levels of contribution are agreed locally. This year, the Board agreed to increase the level of contributions to facilitate the appointment of a dedicated part time board manager. The positions of the Independent Chair and the Business Support Officer (three days per week) are funded as follows: one third Central Bedfordshire Council; one third Bedford Borough Council and shared third Bedfordshire Clinical Commissioning Group and Bedfordshire Police.

4.2 There is no budget provision within the SAB Budget for the cost of undertaking a Safeguarding Adult Review and therefore each Local Authority has funded any SAR related to an individual within their locality. The costs of this year's commissioned Safeguarding Adults Review has been met by Bedford Borough Council.

5. Safeguarding Activity 2017 - 2018

5.1 For Central Bedfordshire Council, safeguarding reporting received 2178 contacts, a similar amount to the previous year. The reporting does not include phone calls where advice and information is provided. Out of the 2178, 425 cases or 19% were treated as a S42 enquiry. This signifies an increase of 24% in S42 enquiries when compared to the previous year. Concerns reported by the police have seen the biggest increase from the previous year from 506 in 16-17 to 662 in 17-18 or a 30% increase in numbers received from the Police. Out of the 662 concerns received, 27 resulted in a S42 enquiries being undertaken. Bedfordshire Police has been working closely with the safeguarding team to understand the rise and nature of the referrals and we have initiated a piece of work across Bedfordshire to agree referral pathways.

5.2 In the previous year, physical, psychological abuse and neglect and acts of omission, were the most common types of abuse resulting in enquiries reported. This year, neglect and acts of omission has been the most common, followed by physical abuse, financial, emotional. In the previous year, there had been a rise in enquiries related to domestic abuse of people with care and support needs with 9 cases in 15/16, rising to 59 in 16/17. Whilst partner agencies have continued to report an increase of Domestic abuse, the number of incidents for people with care and support needs resulting in S42 have remained almost the same than the previous year with 56 S42 enquiries in 17-18.

5.3 There has been a noticeable increase of 50% more cases featuring self-neglect. In response to this increase, CBC is offering additional training in this area and a multiagency task and finish group working under the Operational Subgroup of the board has initiated the undertaking of a Pan Bedfordshire Self Neglect and Hoarding Protocol.

5.4 The trend in terms of location of abuse continues to be a person's own home as the primary location and care homes accounting for the second highest. There has been an increase in the numbers of cases taking place in a person's own home and a rise in incidents taking place in public spaces. There has been a decrease in the number of cases of organisational abuse as well as a decrease in professionals causing harm, but an increase in harm being caused by other people either known or unknown to the person. Known people would be family members which is consistent with the primary location of abuse being the person's own home. Although in the previous year there had been an increase in the numbers of enquiries related to a person with a learning disability, from 40 in 15/16 to 62 to 16/17, the number has reduced to 48 this year.

5.5 In terms of outcomes, 39% of people did not express a desired outcome at the outset of the safeguarding enquiry. However, for those who did express a desired outcome, 83% reported that this had been wholly or partially met.

5.6 Bedford Borough has received 2702 safeguarding contacts to the team for this reporting year, this is an increase 35% from the 1997 contacts the team received the previous year. This does not include phone calls where advice and information is provided. The number of Section 42's resulting from those concerns were 212 cases or 8 % which is an increase of 54% from the previous year. This is likely to be a result of increased numbers of referrals to the team and a greater awareness of partners to report concerns.

5.7 Bedford Borough has seen a significant increase in contacts to the team that do not result in being managed under safeguarding. The majority of these contacts are received from the police and ambulance service where a risk or concern has been identified but is not of a safeguarding nature.

5.8 Police contacts to the team have increased from 298 in 16/17 to 771 for 17/18, of which 39 progressed to a S42 Enquiry. A large proportion of the police contacts relate to persons deemed to have mental health needs and ongoing work is in place to look at referral pathways.

5.9 Own home remains the location where abuse is most likely to take place. This year has seen an increase in the level of cases that have progressed to a S42 Enquiry. The majority of the enquires are related to financial abuse where the person causing harm is most likely to be a family member, friend or partner.

5.10 Second most prevalent place is care homes, Bedford Borough has 73 residential and nursing homes within it's locality and this is reflected in the continuing high number of safeguarding concerns received from this source. Only a small proportion of the concerns result in a S42 Enquiry 8.8%, with the majority of the concerns being managed through providers reviewing their care plans and risk assessments or a review of the individuals care package.

5.11 Safeguarding reporting patterns remain similar to previous years, but there has been an increase in the reporting of domestic abuse, with 26 S42 Enquires carried out compared to 5 in the previous year. Increased awareness to both the public and professionals through the media and training on this topic is likely to have resulted in this increase. Ongoing awareness raising means it is probable that domestic abuse concerns to the team will increase in the next reporting year. Across both localities, other partners including mental health services have throughout the quarterly reporter a higher incidence of domestic abuse for people with mental health needs and a result have increased the training to staff in this area.

5.12 This year, Bedford has seen an increase in numbers of alleged exploitation by others often where drugs are involved. Cases of alleged exploitation by others has risen from 4 in 16/17, to 23 cases in 17/18 of which 10 cases progressed to a S42 enquiry.

5.13 Across two local authority areas, there has been increased understanding of the issues and awareness raising about exploitation and the risk of cuckooing requiring multi-agency approach and forum involving police, housing, mental health services and the council to share information, identify vulnerable adults and agree safeguarding measures.

5.14 Where individuals expressed an outcome for the S42 Enquiry relating to them, 40.4 % felt their outcomes were fully achieved, with 26.2% feeling their outcomes were partially achieved and 9% feeling outcomes were not achieved.

5.15 Serious Incidents(SI's) seek to improve the way services are provided and to minimise the risk that incidents of concern will reoccur through lessons learnt. As part of the initial review of a Serious Incident and integral to the process, each health provider is required to consider if there are any associated safeguarding concerns. This information is routinely shared with Bedfordshire Clinical Commissioning Group (BCCG) and where required, BCCG will challenge/ seek further assurance that safeguarding has been considered. In total, 11 serious incidents reported to BCCG were raised as safeguarding alerts and 7 were progressed through to a S42 enquiry, no themes have been identified.

Case scenarios

A case of Financial and Emotional Abuse by unpaid carers who took over the informal support of a person with a mild learning disability when his mother passed away. Despite working full time, the individual had no access to his own money, there were numerous bills on his account for the unpaid carers and their relatives, he was not allowed access to his finances if he wanted to go out, and if he needed something new, the unpaid carers would buy themselves the new item and give him their old one. All aspects of his life were controlled by the carers including shopping tasks.

As part of the safeguarding process the police were alerted due to the level of theft from the individual's account which has resulted in a criminal prosecution. The individual was supported to have his bank account stopped and with his agreement it is now managed by Bedford Borough Council, enabling the person to have access to his finances including wages, and to be able to go out and do what he chooses. With support the person changed his phone number and moved to a Supported Living tenancy nearer his work and where the unpaid carers did not know where he had moved to.

The individual is undergoing counselling for his bereavement and also to support with what has happened. He is happy and settled in his new home and has made friends who he regularly spends time with. He is able to buy what he wants for his home or himself, go out with his friends, and has accrued savings which he used to go on holiday with. He has some support from care staff but is mainly independent now. He has developed in confidence and is able to ask people for help when he needs it, as previously he was too scared to speak for himself for fear of repercussions.

A 63 year old gentleman living alone in a privately rented two-bedroom bungalow. He had a right below knee amputation, he was diabetic and had a prosthetic limb. When able to wear the prosthesis, his poor balance prevented him from walking more than one or two steps. He relied on a manually propelled wheelchair to mobilise. The Safeguarding team receiving information from a neighbour that he had alerted her by banging on the window from the inside of his home requesting support to purchase food because he had not eaten for 3-4 days, he had no access to money. Neighbours reported that his main carer, his son, had not been seen for several weeks. Workers took time to build rapport as he did not want an intervention and only expressed a need for food. He presented as dishevelled and unkempt, his clothes were dirty. Reluctantly, he allowed the worker access to the property which was infested with flies, there was an overwhelming smell of urine and cat faeces covered the hallway. There were piles of rubbish on every surface and on all the floors. The kitchen appeared not to have been used for some time, the bathroom appeared not fit for purpose with bags of faeces and bottles of urine in the bathroom and under his bed. Mobility around the bungalow was restricted due to the clutter, and he crawled on the floor due to the lack of space to manoeuvre the wheelchair. The worker was able to start to build a rapport, purchasing essential shopping for him and arranging a hot meal and packed tea the worker explained we were there to help and to support to make changes at his pace.

He disclosed his son and main carer "got sick of things" and left. He had a mobility car which his son used and they shared a joint Post Office account which he no longer had access to. He agreed that his current accommodation was no longer suitable for his needs and the landlord had been trying to evict him for over a year. Rapport was built up to gain his trust and engagement. The initial need was to provide meals on a daily basis and to co-ordinate support with him ensuring he had control over the decisions made. Contact made with private Housing sector for advice and they allocated a worker, joint visits were carried out to introduce this worker who was able to build a rapport with him and plan an intervention. The Housing worker visited and arranged for the work to be managed sensitively with cleaning contractors, he was involved in the plans and was adamant he wanted to co-ordinate the packing of his items. Referral made to Independent Living Prevention Team to support with re-establishing benefits and to assist with the housing application. The worker supported a move back to Scotland to be near family who were aware and supportive and instrumental in this move. Referral made to Occupational Therapy for support with equipment, replacement wheelchair, profile bed whilst at respite and a full report to support accommodation needs. Referral made to Safeguarding regarding concerns about son, access to his vehicle and post office account. He had disclosed his son had anger issues and it was felt appropriate to undertake further work once he was moved into a safer environment. He did not want any action taken against his son. He had agreed we could disclose where he now lived to his son and wanted him to know that he was safe and well. Referral was made to a community service which provided food parcels, bedding, new clothes and toiletries to go into respite care. A referral was made to the Limb fitting service for assessments for a new prosthetic limb. Allocated worker established that the individual had full capacity and he was fully involved in all decision making and took an active role in all plans. As a result outcomes were;

-Reduced health risks due to living in squalid housing conditions.

-Re-establishing contact with GP and other health professionals improving health and well-being.

-Improved confidence being out in the community. Improved Mental Health and well-being. He has expressed our intervention has given him "A new lease of life" he became more motivated during our continued involvement

- Improved engagement with services as trust was built and outcomes were positive.

-Improved Quality of life with plan for new accommodation re-establishing contact with family in Scotland as well as financial independence and control.

5.16 Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS)

5.16.1 The reporting year 2017/18 has seen a continuation of increasing numbers of Deprivation of Liberty Safeguards (DoLS) requests to both authorities. Compared to the previous reporting year of 2016/17, Central Bedfordshire Council (CBC) has experienced a 23% increase in the number of DoLS applications and Bedford Borough Council (BBC) has experienced a 3% increase.

5.16.2 Nationally, the number of requests continues to rise with a large number of supervisory bodies experiencing a backlog of cases. For 2016/17 there was a reported backlog of 108,545 cases in England. To date, CBC and BBC do not have a backlog.

5.16.3 According to national statistics for 2016/17, the average number of days from applications being received to being completed across England was 120 days. This means that many people assessed under the safeguards are potentially subject to a period of unlawful deprivation, if a decision is made that a standard authorisation is required to lawfully deprive of liberty. Both CBC and BBC remain committed to ensuring assessments are undertaken within the statutory timescales, where possible.

5.16.4 Many Supervisory Bodies nationally have backlogs going into the 1000's and are using a prioritisation tool, others have also de-prioritised some environments such as acute hospitals meaning people in these settings do not get assessed, whilst others have been using 'desk-top' assessments in some circumstances meaning people may not actually be seen by a BIA at each authorisation. In Central Bedfordshire and Bedford, we currently have no backlog, every setting is treated as important and every assessment and authorisation involves a Best Interest Assessor visiting the actual person.

5.16.5 Impact and Numbers 2017/18:

	CBC	BBC
Number of Applications received in reporting year	1581	1319
Number of Applications completed in reporting year	1497	1251
Assessments in progress (as of 31st March 2018)	57	68
Requests accompanied with an Urgent Authorisation (assessment to be completed within 7 days)	983	693
Number of Authorisations granted	1017	994

5.16.6 Government updates

Liberty Protection Safeguards (LPS) - The Law Commission published its final report and draft legislation in March 2017. In March 2018, the Government published it's response to the proposals and draft bill. They acknowledged there was a 'pressing urgency' to reform DoLS, and this would be considered 'when parliamentary time allows'.

In June 2018, The Mental Capacity (Amendment) Bill was published and this starts the reform of the current system. This is a somewhat different Bill to the Law Commission's report. It is not anticipated that Royal Assent would be granted before early next year, and, given that a transition period will be required before the DOLS can be replaced by the LPS, it is likely that the amended Act would not be fully in force until 2020 at the earliest, and potentially 2021".

6. Bedfordshire Commissioning Group (BCCG)

6.1 Safeguarding Adults continues to be a high priority for Bedfordshire Clinical Commissioning Group (BCCG). BCCG is represented on the Safeguarding Adults Board (SAB) and SAB subgroups.

6.2 As a commissioning organisation, BCCG has embedded safeguarding and associated performance indicators in the contractual requirements of commissioned health services. BCCG requires and obtains assurance that commissioned health services are meeting safeguarding requirements, and this formed part of the quarterly quality contract monitoring processes. In addition, regular meetings took place between the Designated Nurse for Safeguarding Adults and providers lead and named safeguarding professionals.

This year BCCG has:

- Revised the Safeguarding Adult & Children policy (2018). This was approved by the CCG Governing Body, and was disseminated across the local health economy.
- Supported NHS England (NHSE), in both developing and piloting a Safeguarding Assurance Tool (SAT). This is an online tool developed to assist CCGs in providing compliance assurances around safeguarding adults and children. This tool has now been rolled out widely across the region, with arrangements in place for reviews, including peer reviews.
- Ensured the recognition and management of domestic abuse continues to be a priority across the local health economy. BCCG has reviewed internal policies around domestic abuse and encouraged all providers to do same. BCCG attends the local operational multi agency domestic abuse groups where local pathways and training are being developed. BCCG has worked with the local authorities to develop an 'Aide Memoir' for GPs around Domestic Abuse.

- The BCCG safeguarding team have delivered training to CCG staff, GP and primary care practitioners on a range of safeguarding themes. For example, sessions have been delivered on WRAP (workshop raising awareness of prevent), prevent basic awareness, safeguarding adults including domestic abuse, human trafficking and modern slavery and the Mental Capacity Act (MCA) and deprivation of Liberty safeguards (DoLS). In addition, level 1 and 2 training has been delivered to student midwives from the University of Bedfordshire.
- BCCG has undertaken joint quality assurance visits with the local authorities to nursing and care homes. This was to identify areas of concern before they reach the threshold for safeguarding or to identify areas for improvement following alerts being raised. BCCG has monitored for trends and has offered support and guidance on making improvements where required.
- The BCCG safeguarding team has provided a safeguarding health advisory and support role for GP and primary care colleagues; Adult Social Care; CQC and NHS provider services.

Our focus for the next year is to:

- Continue our work around domestic abuse by holding a learning event for GPs and raising awareness of and embedding MARAC (multi-agency risk assessment conferences) processes into GP practices.
- Ensure learning from current Domestic Homicide Reviews and Safeguarding adult reviews is shared, incorporated into training and is being considered within BCCG commissioned services.
- Respond to the forthcoming 'NHS England Roles and Competencies for Healthcare staff' document and consider the implications for the learning and development needs of NHS staff locally.

7. Bedfordshire Police

7.1 Our strategic priorities have focused on understanding the needs of our diverse communities with a particular focus on safeguarding adults and children with vulnerabilities that may put them at increased risk of harm.

7.2 This year, the 'Signposts Hub' was launched within Bedfordshire Police. The purpose of Signposts is to ensure that we engage with every victim of crime and conduct an individual needs assessment which is used to understand what support individuals feel they need to overcome the impact of the crime and to prevent them from becoming a victim again.

7.3 Bedfordshire Police have successfully worked with the SAB partnership to review our adult safeguarding referral process. The beginning to end process has been reviewed and redeveloped placing the vulnerable adult at the centre of the process and improving ways of carrying out effective and responsive safeguarding in partnership.

7.4 Bedfordshire Police are delighted to have led the Mental Health Street Triage Partnership for a second year and this pilot initiative is now embedded as a dedicated service which ensured that people experiencing mental health crisis receive an appropriate and sensitive emergency response from the joint team of police, paramedics and mental health nurses.

7.5 Bedfordshire Police were the first Police Force to pilot the College of Policing Vulnerability Training in 2017 and we also developed and introduced 'An Officer's Guide to Vulnerability' handbook which has been issued to all police officers and staff. All officers have received the Domestic Abuse Matters Training and all Response officers have receiving mental health awareness training.

7.6 Our communications team have worked with subject matter experts and have developed a series of electronic interactive toolkits for subjects including Domestic Abuse and FGM. Our intranet hosts a rich variety of practical advice and information for subjects including modern slavery, coercive control, 'cuckooing' and County Lines, HBA and CSE. These resources also include access to supporting online training and awareness which all officers are able to access. Several of these training packages are mandatory such as modern slavery and coercive control.

7.7 We work in partnership within the Vulnerable Adult Risk Assessment Conferencing to support some of the most vulnerable adults in Bedfordshire according to their specific needs. Similarly, we work with partnership boards and problem solving groups focusing on modern slavery, county lines, MARAC.

8. Safeguarding Adults Reviews reporting during the year

8.1 Safeguarding Adult Review (SAR) within the Bedford Borough.

The Safeguarding Adult Board took the decision to commission a Safeguarding Adults Review into the circumstances leading up to the tragic death of Miss A who died in as a result of a road traffic accident in August 2016 whilst residing at a nearby residential home.

The placement in Bedfordshire was commissioned and monitored by Sussex Partnership NHS Foundation Trust.
The purpose of the SAR was to establish whether there are were any issues in relation to interagency working in line with the Bedford Borough and Central Bedfordshire Multi Agency Policy and Procedures, whether anything could have been done differently to prevent the abuse and neglect, and whether there are any lessons to be learned to enhance partnership working, improve outcomes for adults and families, and prevent similar abuse and neglect occurring in the future.

8.2 The SAR highlighted a number of concerns around the effectiveness of multi-agency involvement, contribution to assessment and understanding of risk;

- At key stages of Miss A's care and at the time of the decision to move Miss A from a private hospital setting to a residential setting.
- In the way information relating to risk and support needs was shared with staff directly responsible for Miss A's care and support.
- In the referral to and responses from the AMPH service.

The terms of reference also included involving and supporting Miss A's family and throughout the SAR and the family were invited to contribute to the report.

8.3 The SAR report whilst acknowledging the complexity of Miss A's support needs, highlighted learning across agencies and recommendations were made to address these, including actions for the commissioner, service provider, local mental health trust, and the Police. Recommendations were made to improve practice in risk assessing and care planning, risk management and escalation, use of the Mental Capacity Act 2005, access to local mental health services and support, and consideration of the diagnosis of Autism and good practice in working with adults with autism.

The implementations of the recommendations will be monitored through the SAB SAR Subgroup.

The SAR Report, Executive Summary and Addendum have been published on the Bedford Borough Website http://www.bedford.gov.uk/health_and_social_care/help_for_adults/safeguarding_adults/safeguarding_adults_reviews/published_sars.aspx

9. Sub Group Activity

9.1 Safeguarding Adults Review Sub Group

The SAR Subgroup is now well developed and meets on a quarterly basis. The purpose of the group is to consider whether referrals meet the criteria as defined by the Care Act 2014 for a Safeguarding Adult Review. Whilst not all cases meet the criteria for a formal SAR, the group is able to identify trends and issues that need highlighting to the Board. This has included concerns for people using mental health services and of the performance of the Approved Mental Health Professional (AMHP) service. The group also receives reports relating to Learning Disability Mortality Reviews and Serious Incidents of relevance to the Safeguarding Adults Board.

9.2 PAN Bedfordshire Sub-Group

The PAN Bedfordshire sub group holds two meetings annually to focus on training across agencies, agree priorities and plan joint events across Bedfordshire.

All agencies have an individual safeguarding training programme and common themes this includes, Domestic Abuse, PREVENT and Self Neglect amongst others.

Bedford Borough Council and Central Bedfordshire Council, provide a programme of safeguarding training, using commissioned trainers and training is aimed at all levels with a rolling program of basic/introductory training for Safeguarding and Mental Capacity Act through to more advanced training for practitioners undertaking S42 enquires and for managers who are chairing case conferences. Specific training is also offered to providers conducting S42 enquiries, to support them in undertaking enquires into their service.

The Bedfordshire Clinical Commissioning Group currently provide training for GP's across Bedfordshire. This training is also for all clinical staff and safeguarding leads within the practice surgeries. The training has been opened up to their own employees and to paramedics. It covers a range of topics such as Domestic Abuse, Modern Slavery and PREVENT. Additional training has been planned on Domestic Abuse for GP practice surgery staff to attend.

Bedfordshire Police have also introduced dementia awareness training for all officers and in addition to this the Office of the Police and Crime Commissioner for Bedfordshire has funded training on “County Lines, Gangs and Young People” and in “Modern Slavery”.

The MCA and DoLS leads from both local authority safeguarding teams and the Bedfordshire Clinical Commissioning Group have provided MCA and DoLS awareness training to a variety of agencies across Bedfordshire, including bespoke training for agencies when specific issues in these areas have been identified.

A number of joint events have taken place through the year including a learning event on Legal Literacy, Human Rights Training and an MSP Conference with key note speaker Dr Adi Cooper OBE, held in November 2017 which was well attended. As part of the Bedfordshire MSP conference, workshops addressed what was needed to work in a personal centred way.

The PAN Bedfordshire group discussed that it would be useful to develop and establish a multi-agency safeguarding training plan to include training which would be implemented countywide, the proposals for this are currently being developed.

The group have also overseen the completion of the Mental Capacity and Deprivation of Liberty Safeguards Competency Framework and have been involved in the review of the Mental Capacity Assessment forms including practice guidance to support more evidence based mental capacity assessments.

9.3 Operational Sub Group

Key activities of the Operational Sub Group during the year have included:

- A multiagency staff confidence survey around safeguarding was undertaken in order to identify gaps in training and training needs in particular organisations. It showed that that there were training needs and the board has considered a multi-agency training proposal which would maximise training opportunities for local authorities and partner agencies.
- During the SAB development day in 2017, partner organisations suggested potential data that they could individually provide to include within their quarterly reporting in order to show a more detailed picture of safeguarding activity. This work is still in progress across Bedfordshire and task and finish groups are currently being held to review the dashboard.
- Reviewing the volume and pathway of incident reporting to better understand where risks and challenges lie, which has led to focused work being undertaken with the police.
- Continuing to monitor on a quarterly basis the activity of the statutory members of the SAB.

- Reviewing agency activities on a quarterly basis which forms the operational quarterly report.
- Partner agencies are required to produce single agency in depth report to provide assurance about safeguarding arrangements.
- Considering high risk complex cases to ensure appropriate actions are in place.
- Providing a forum to discuss issues relating to provider concerns to ensure appropriate measures are in place.
- Discussing emerging themes, topic, issues at both national and local level.

Below are highlights of how partner agencies have participated in a variety of task and finish groups have done during the year to implement the strategy.

9.4 Task and Finish Groups

- Escalation Policy Task and Finish Group

  A Task and Finish group was held including operational sub group members in order to review the CBC and BBC Escalation Protocol following a case in which the Escalation procedure failed. Changes were made to the protocol to ensure that it was more detailed and clear including a clear instruction outlining at which stage the formalisation of the protocol occurs.

- Themed Audit Sub Groups

  Themed Audit sub groups are being held in line with the thematic business plan. Two to three cases are being selected and audited on both a single agency and multi-agency level to identify good practice and possible learning for the board. Attendance of these groups include the operational group members. So far, audits have been conducted on cases regarding the Quality in the Care Market and the Exploitation of People with Care and Support needs including Domestic Abuse and Modern Slavery. As the business plan progresses audits will be conducted on cases involving People in Positions of Trust, Young People Transitioning into Adulthood, End of Life Care and Making Safeguarding Personal.

- Policies and Procedures – PAN Bedfordshire Approach

  In September 2017, the CBC and BBC Policy and Procedures were reviewed an updated by the authorities and partner organisations. Additionally, it was agreed that a PAN Bedfordshire approach should be adopted and Luton Borough Council were invited to be a part of the reviewing process. CBC, BBC and LBC now share the Safeguarding Policies and Procedures.

- People in Positions of Trust Protocol Task and Finish Group

  A Task and Finish group was held in order to develop a protocol around dealing with concerns and allegations regarding People in Positions of Trust (PiPoT). Attendance to this meeting included operational group members. A PiPoT protocol has now been developed and this can be located within BOX for board members to enforce should a concern arise.
- Self-Neglect and Hoarding Task and Finish Groups

  Self-Neglect and Hoarding Task and Finish groups are being held in which the Fire Service and Housing are in attendance as well as operational group members. The purpose of these Task and Finish groups are to create both a Self-Neglect and Hoarding Policy adopting a PAN Bedfordshire approach across CBC, BBC and LBC. This work is currently in progress and organisations are contributing to multiple sections to include within the policy.

- Data Dashboard Task and Finish Group

  The Data Dashboard work is still in progress and Task and Finish Groups are currently being held to review the Dashboard in order to make it more achievable. Attendance to this group includes Pan Bedfordshire group members and the local authority's performance team. The Task and Finish group is currently reviewing the four stages of the safeguarding journey and considering what data can realistically be collected under each stage within each organisation to effectively inform the quarterly report.

10. Safeguarding Adults Board Business Plan

10.1 The 2017 - 2019 Business Plan covers:

• Theme 1 – Safeguarding Adults Board Resilience - board members understand and deliver their roles and responsibilities

• Theme 2 – Emerging Challenges – the Safeguarding Adults Board develops greater understanding of common challenges, including high risk in the community, quality in the care market, safeguarding young people moving into adulthood and responses to safeguarding issues related to people in positions of trust

• Theme 3 - Making Safeguarding Personal – the Safeguarding Adults Board develops ownership of personalised responses to safeguarding

The 2017 - 2019 Business Plan is attached to this report on Appendix B.

10.2 Throughout the year, the Business plan is reviewed and updated at the board as well as at post board meetings and the development day. Ongoing activities are as follows;

- The board are undertaking quarterly themed quality audits in line with our thematic board meetings to identify good practice and areas for improvement.

- Single Agency Reviews are now being completed in every Operational Subgroup of the board and a timetable is in place.

- A staff survey has been conducted to identify gaps in safeguarding training. More training is now taking place and multi-agency approach to training is currently under discussion and development.

- Across Bedfordshire, work has started considering the data set being reported to the SAB and the PAN Bedfordshire task and finish group are currently undertaking a review. More work is required to further define data requirements.

- The board is considering issues relating to the PREVENT agenda and is sourcing information on a national basis whether this informs local practice.

- The requirements have been drawn up for the development of the planned SAB website.

- There has been development of multiagency forums ongoing sharing intelligence regarding modern slavery, exploitation, domestic abuse, county lines and cuckooing to ensure that these matters are better identified amongst professionals.

- The Board has been provided with assurance on the current picture of the care market within Bedfordshire. Reports were provided by Central Bedfordshire Council, Bedford Borough Council and the Bedfordshire Clinical Commissioning Group.

- A multiagency task and finish group has developed a “Persons in position of trust “(PIPOT) guidance.

- The development of Mental Capacity Act 2005 competency framework has been completed.

- The escalation procedure has recently undergone a review and was agreed by all partner organisations and SAB members.

- A Pan Bedfordshire conference focused on Making Safeguarding Personal (MSP) was held in November 2017, headlining a national speaker.

- The Pan Bedfordshire multiagency Safeguarding Adults policy and procedures were reviewed in September 2017. For the first time Luton Borough was involved making it relevant across Bedfordshire.

- There has been an embedding of the Safeguarding Adults Review (SAR) subgroup and the remit has been widened to get reports on Serious Incidents and Learning Disability Mortality review of relevance to the Safeguarding Adults Board.

- The Board commissioned a Safeguarding Adults review in line with the Care Act 2014. Please refer to section 11 of this report.

- Following presentations to the Board regarding the development of the Vulnerable Adults Risk assessment conference, multiagency meetings are now in place.

11. Looking forward, priorities for 2018-2019;

- Summary of Making Safeguarding Personal stocktake undertaken by agencies.
- Produce a report to assist the SAB in considering a partnership wide approach to risk enablement, building on lessons learnt from the VARAC and other multi agency risk assessment approaches as well as the development of a Risk Framework.
- Ongoing development of a Self-Neglect and Hoarding protocol.
- Ongoing programme of themed audits to be conducted on topics linked to our business plan.
- Focus on End of Life Care, invite commissioners and Better Care Fund leads to present to the SAB on developments in end of life care provision.
- Review transition pathways in relation to young people who have been victims of serious abuse such as CSE or domestic abuse
- Annual Review of Pan Bedfordshire Policies and procedures.
- To further understand local protocols in relation to modern slavery and exploitation relating to people with care and support needs.
- Collate and review current mechanisms for collecting feedback from people who have been through safeguarding across partner agencies, considering how this information is used to effectively coordinate and deliver safeguarding arrangements.
- Using past MSP reports, research the approaches taken by other SABs or single agencies on engagement with people using services to produce a set of proposals for the SAB.

12. Appendices

APPENDIX A: Safeguarding Adults Board Membership & Attendance 2017 – 18

HMP Service Bedfordshire have recently joined the SAB as a partner agency and have attended SAB meetings to which they were invited.

Organisation	Number of Meetings Attended (4)
East London NHS Foundation Trust	4
Children's Board	2
Police	4
Ambulance	2
Fire	0
Bedford Hospital	4
Luton and Dunstable Hospital	1
Healthwatch Bedford Borough	3
Healthwatch Central Bedfordshire	3
Clinical Commissioning Group	4
POHWER Advocacy	3
Community Safety	1
Probation	4
HMP Service	2**(2)**

APPENDIX B: SAB Business Plan 2017-2019

	Action	Outcome	Steps Required	Timescale and progress	RAG Progress at May 2018
1.1	Develop and implement a SAB dedicated website	Accessible website is available which provides public visibility of safeguarding and also provides space for sharing of professional material between partners and agencies.	New website to be commissioned. Functionality/ specification to be defined and developed Initiate CBC procurement process	January 2019 (revised timeframe from September 2018)	Some work undertaken to determine key functionality. Research undertaken into websites used by other SABs Further progress dependent on appointment of SAB Business Manager
1.2	The SAB develops a programme of themed audits/reviews of key safeguarding issues to test effectiveness of arrangements	The SAB is sighted on the quality of practice across partners in delivering safeguarding, and is better able to identify areas where learning and development is required.	SAB to agree the schedule of themed audits. Set up meetings and venues to coincide with Operational Sub Group and SAB; publish a programme of themed audits to run through year.	September 2017 Complete	Complete
1.3	Single Agency in Depth Reviews to continue to be conducted regularly at Sub Groups to promote learning.		Ensure reporting to Ops Sub Group and SAB Develop timetable for Single Agency Reviews to be reported to Ops Sub Group		Complete, now part of business as usual
1.4	The SAB establishes a mechanism to regularly review priorities common to the LSCBs, CSPs, and HWBs.	A regular report comes to the SAB which sets out the priorities of all strategic partnerships and areas of joint working. SAB Members feel confident that they understand the local community, including its strengths and challenges	Establish a mechanism in Bedford to regularly review priorities common to SAB, LSCB's, CSP's and HWB's. Ensure relevant community profiling activities undertaken by partner agencies are shared with SAB for information and action Liaise with the CSP analysts to explore possibilities for sharing community profiling and other data.	September 2018	Awaiting date for annual strategic Chairs meeting. Increase share of information and data across partnerships.

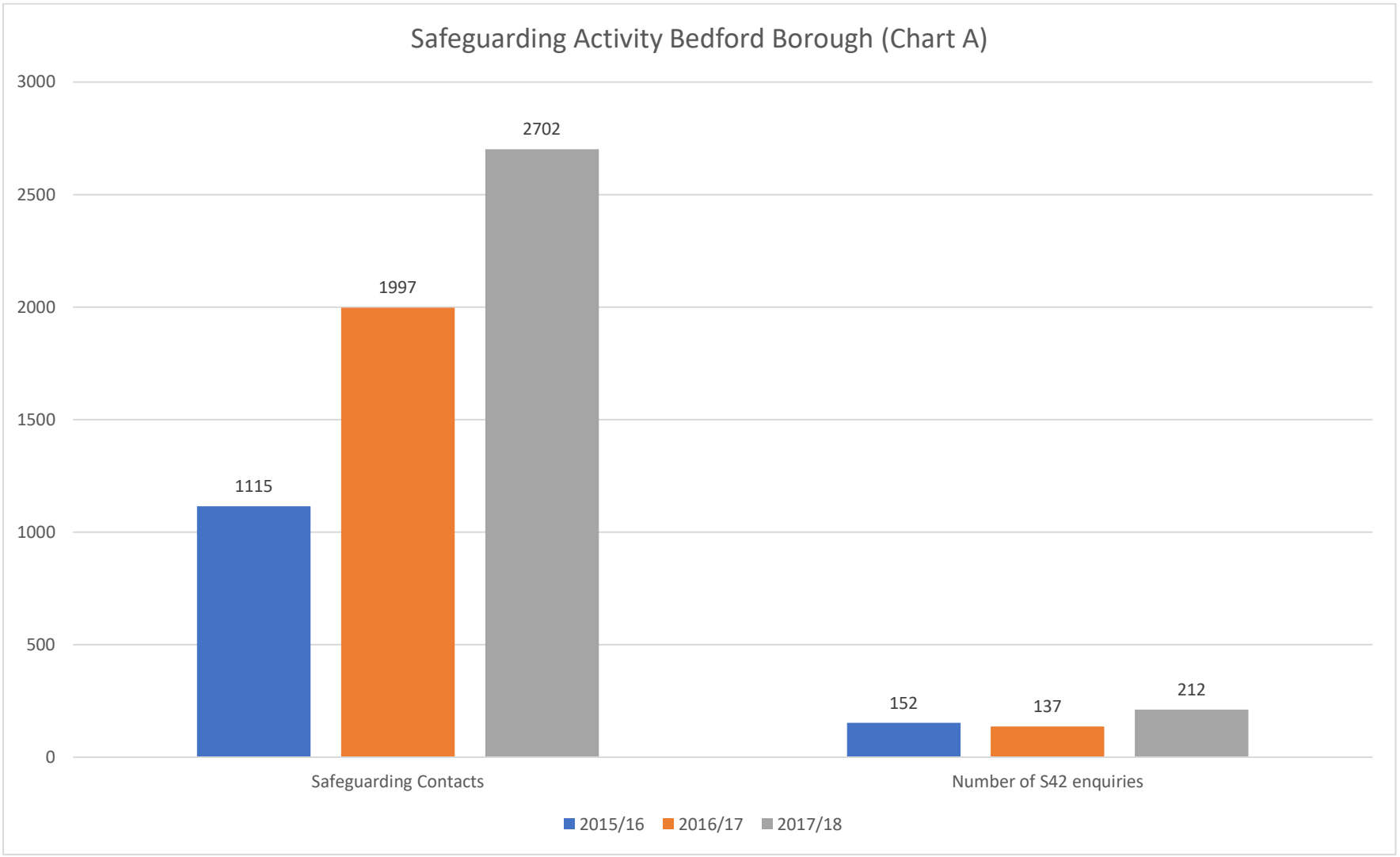
	Action	Outcome	Steps Required	Timescale and progress	RAG Progress at May 2018
1.5	Work towards a multi-agency approach to safeguarding training and improving understanding of gaps and emerging topics	The SAB is better able to determine where there are gaps in current training and to identify where there is a need for additional multi agency training.	Complete, analyse and report on the staff confidence survey. SAB to decide whether the confidence questionnaire is distributed beyond the SAB members organisations	June 2017 Complete June 2017 Complete	Complete
1.6	To develop an annual multi-agency safeguarding requirement for safeguarding training and improving understanding of gaps and emerging topics	Capture an annual training plan Focus on the areas that we need on a multi-agency level	Continue to collect data on provision of safeguarding training across partner agencies by updating the current programme through the bi annual pan Bedfordshire sub group Work with Luton BC to scope potential for a multi-agency training programme	September 2018	Aim to produce an annual multi-agency training/learning programme.
1.7	A SAB dataset is developed that collates relevant information via agreed outcome statements to support the SAB to understand local issues.	The SAB has a dataset that provides a ready insight into the current activity and performance in the delivery of safeguarding both current, and over time. Through this it is able to interrogate areas of variation or concern. The dataset signposts to areas of good practice and concern, and proposes action and further activity, enabling SAB Members to have a good understanding of performance across the local area	Refine the current draft dataset to key areas for the SAB Present draft report to the SAB for approval Develop routine methodology and schedule for following up and interrogating data so as to inform quarterly reporting to the SAB and operational sub group. Prepare quarterly reports of the dataset to the SAB, including progress, areas of concerns, trends and direction of travel Work with Luton BCl to scope potential for a cross SAB approach to data collection	June 2017 Complete June 2017 Complete April 2019 Under development/ ongoing April 2019	Improvements have been made to quality and comparability of data being reported to the SAB. More work required to further define data requirements.

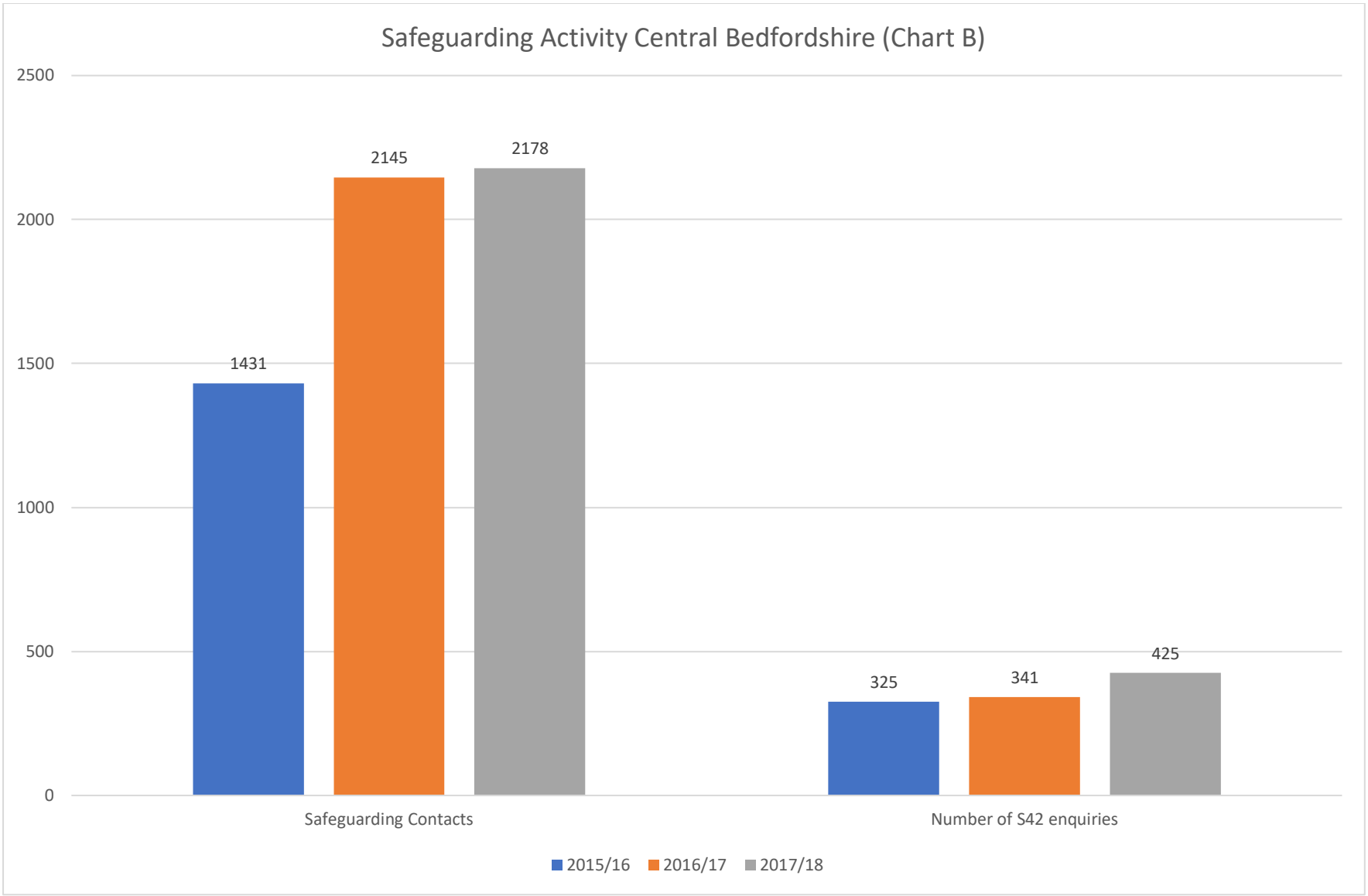
	Action	Outcome	Steps Required	Timescale and progress	RAG Progress at May 2018
2.1	Develop the SAB's knowledge of working with high risk issues in the community	The SAB develops a greater understanding and oversight of the risks faced by vulnerable groups. The SAB develops a greater understanding of the risk of exploitation of people with care and support needs	Maintain SAB involvement in the development and implementation of the VARAC. Conduct an engagement exercise with housing providers and local housing forums to establish gaps in knowledge, local intelligence and planning. Produce a report for the SAB with recommendations to further develop the interface with housing services. Develop intelligence on and staff awareness of people with care and support needs affected by Domestic Abuse, Modern Slavery, and Cuckooing/ County Lines. Analyse existing data in these three areas to identify themes and patterns in reporting and response. Compare with national data and themes. Produce a report for a thematic SAB meeting which focuses on the safeguarding data as well as good practice across partner agencies. Invite member organisations to prepare and contribute to a thematic SAB meeting on this area.	September 2017 December 2018 June 2018	Focus of June 2018 Board meeting
2.2	Develop the SAB's knowledge of safeguarding quality in the care market	The SAB develops a greater understanding of the current risk associated with the care market and its implications for safeguarding adults.	Analyse existing data relating to adult social care providers to identify themes and patterns in reporting and response. Produce a report for a thematic SAB meeting which focuses on the safeguarding data as well as good practice across partner agencies. Invite member organisations to prepare and contribute to a thematic SAB meeting on this area	June 2018	Partners have reported to Board meetings on issues around quality and fragility of care market. Assurance that systems are in place to oversee quality issues. Access to appropriate care currently not compromised by market fragility factors.

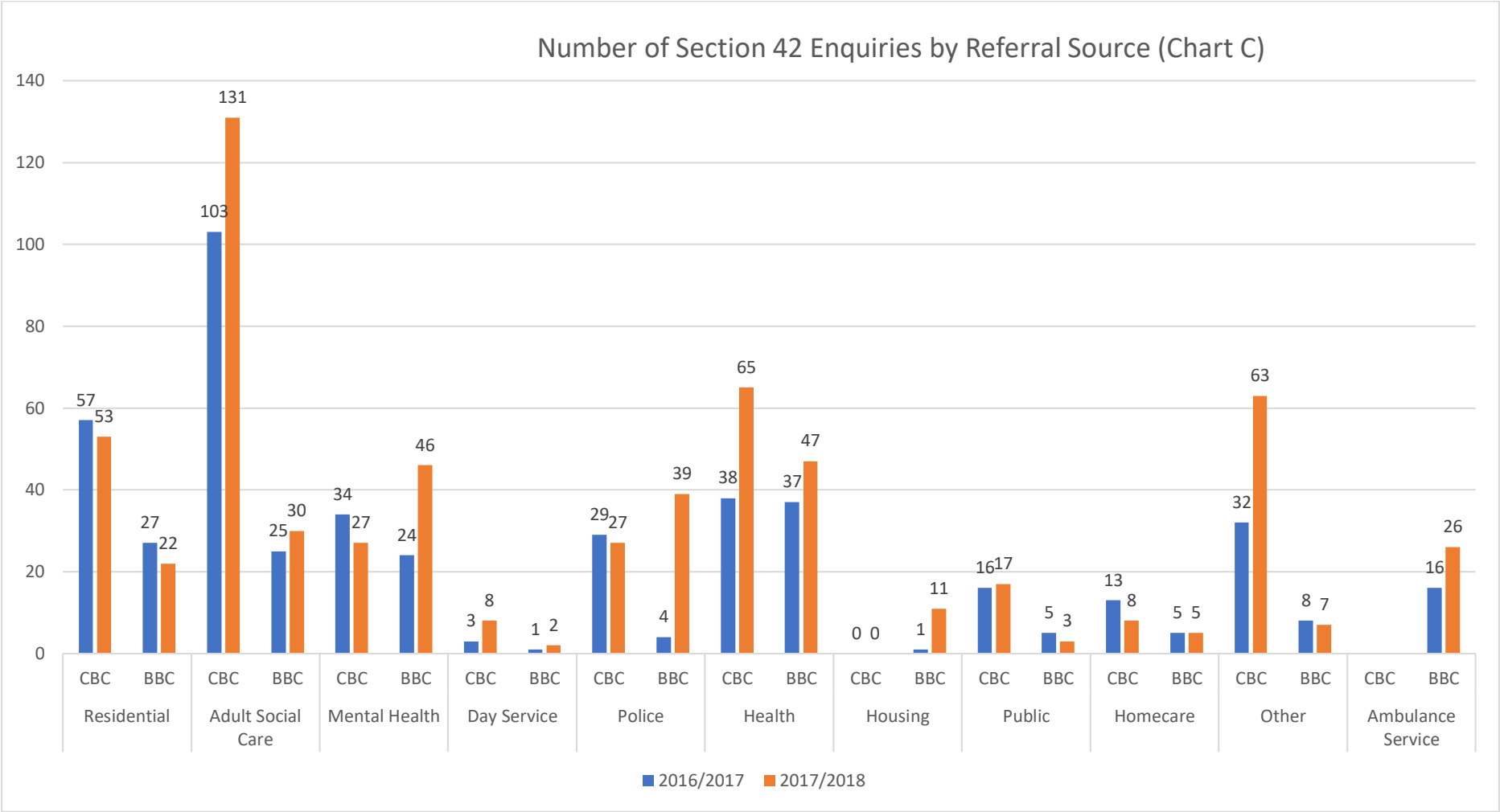
	Action	Outcome	Steps Required	Timescale and progress	RAG Progress at May 2018
2.3	Develop the SAB's knowledge of safeguarding end of life.	CCG to focus on palliative care strategy and safeguarding implications,	Focus on end of life care. Undertake a themed review of end of life care safeguarding cases. Produce a report on themes and learning. Invite commissioners and Better Care Fund leads to present to the SAB on developments in end of life care provision.	January 2019	Scheduled for Jan 2019 Additional questions identified for exploration: - arrangements for review and safeguarding of CHC funded patients - How many CHC patients are funded out of area and mechanisms for reviewing those?
	Develop the SAB's knowledge of safeguarding young people moving into adulthood.	SAB develops a greater understanding and oversight of the risks faced by young people who have experienced abuse as children and who may continue to be at risk as adults. Input from LSCB on how young people transitioning into adulthood is tackled.	Review transition pathways in relation to young people who have been victims of serious abuse such as CSE or domestic abuse Invite Luton BC to present to the CBC and BBC SAB on the progress of the integrated MASH.	December 2018 December 2018 December 2018 December 2018	Scheduled for future Board meeting Additional questions identified for exploration: - Are special needs schools, and children's disability services aware of adult safeguarding? - How are young people without specific care and support needs leaving children's social care services safeguarded as young adults? - Where does the safeguarding responsibility lie for care leavers aged 18-25? Are Leaving care teams equipped to undertake section 42 enquiry, are there training needs?
2.5	SAB leads on agencies' responses to safeguarding issues related to people in positions of trust	Confidence and competence in dealing with safeguarding issues related to people in positions of trust is boosted. SAB is reassured agencies are able to take appropriate action in respect of their staff who are implicated in safeguarding concerns	Develop lessons learnt from recent cases involving people in positions of trust by audit. Identify what actions partners take from abuse within their organisations. Review national guidance and develop a local policy and procedure.	December 2018 December 2017	Possible audit sub group Complete

	Action	Outcome	Steps Required	Timescale and progress	RAG Progress at May 2018
3.1	SAB member organisations to take stock of progress in embedding personalised responses to safeguarding situations	The SAB is confident that its members understand personalised responses to safeguarding situations and are taking steps to address risk adverse cultures where they persist.	Undertake making safeguarding personal stock take or self-assessment. Produce a report for a thematic SAB meeting which focuses on safeguarding intelligence as well as good practice across partner agencies. Invite member organisations to prepare and contribute to a thematic SAB meeting on this area.	September 2018 September 2018	MSP Conference held in Nov. Workshops addressed what was needed to work in a personal centred way. Ongoing audits. MSP Stocktake – SAB Development Day.
3.2	SAB to consider strategies and approaches used to 1. support front line staff in person-centred methods for working with risk and 2. support staff to enable a shift in culture	The SAB is confident that staff working in safeguarding or high-risk situations have the tools and skills to response in a personalised way.	Collate and review current mechanisms, such as toolkits, policies and procedures, quality improvement projects and pilots in use across the partnership to assess the degree of support currently in place Undertake survey with staff to understand how they approach working with risk. Produce a report to assist the SAB in considering a partnership wide approach to risk enablement, building on lessons learnt from the VARAC and other multi agency risk assessment approaches.	December 2018 September 2018 September 2018	
3.3	SAB to consider how partner agencies meaningfully engage people using services and vulnerable members of the public in planning and shaping safeguarding services.	The SAB has greater visibility to discharge its functions in co-production with people who use services, their representatives and members of the public.	Collate and review current mechanisms for collecting feedback from people who have been through safeguarding across partner agencies, considering how this information is used to effectively coordinate and deliver safeguarding arrangements. Using past MSP reports, research the approaches taken by other SABs or single agencies on engagement with people using services to produce a set of proposals for the SAB.	December 2018 December 2018	

APPENDIX C


Safeguarding Activity Bedford Borough (Chart A)
3000
2500
2000
1500
1000
500
0
1115
1997
2702
152
137
212
Safeguarding Contacts
Number of S42 enquiries
2015/16
2016/17
2017/18


Safeguarding Activity Central Bedfordshire (Chart B)
2500
2000
1500
1000
500
0
1431
2145
2178
325
341
425
Safeguarding Contacts
Number of S42 enquiries
2015/16
2016/17
2017/18


Number of Section 42 Enquiries by Referral Source (Chart C)
140
120
100
80
60
40
20
0
CBC
BBC
Residential
Adult Social Care
Mental Health
Day Service
Police
Health
Housing
Public
Homecare
Other
Ambulance Service
57
53
27
22
103
131
25
30
34
27
24
46
3
8
1
2
29
27
4
39
38
65
37
47
0
0
1
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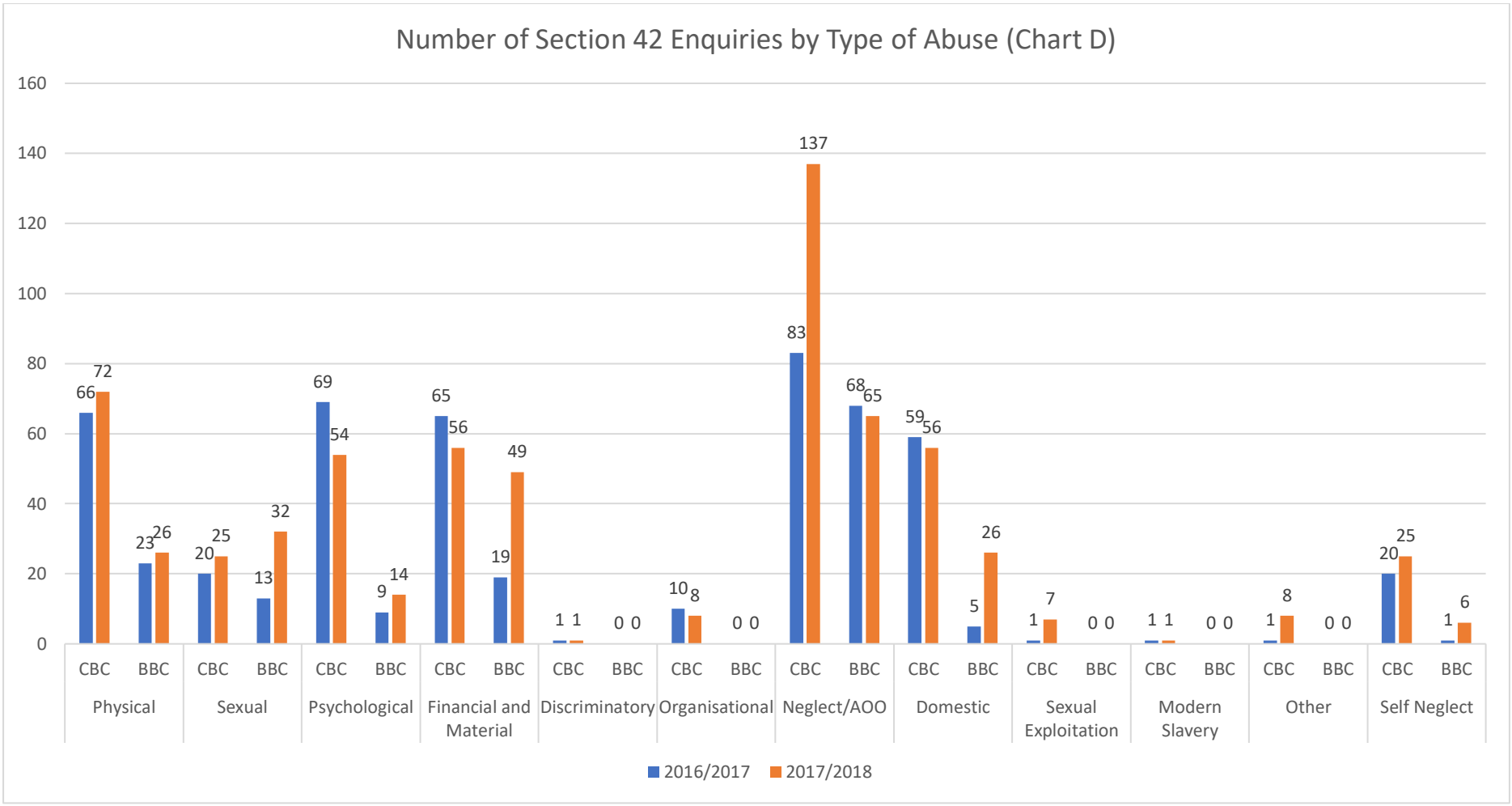
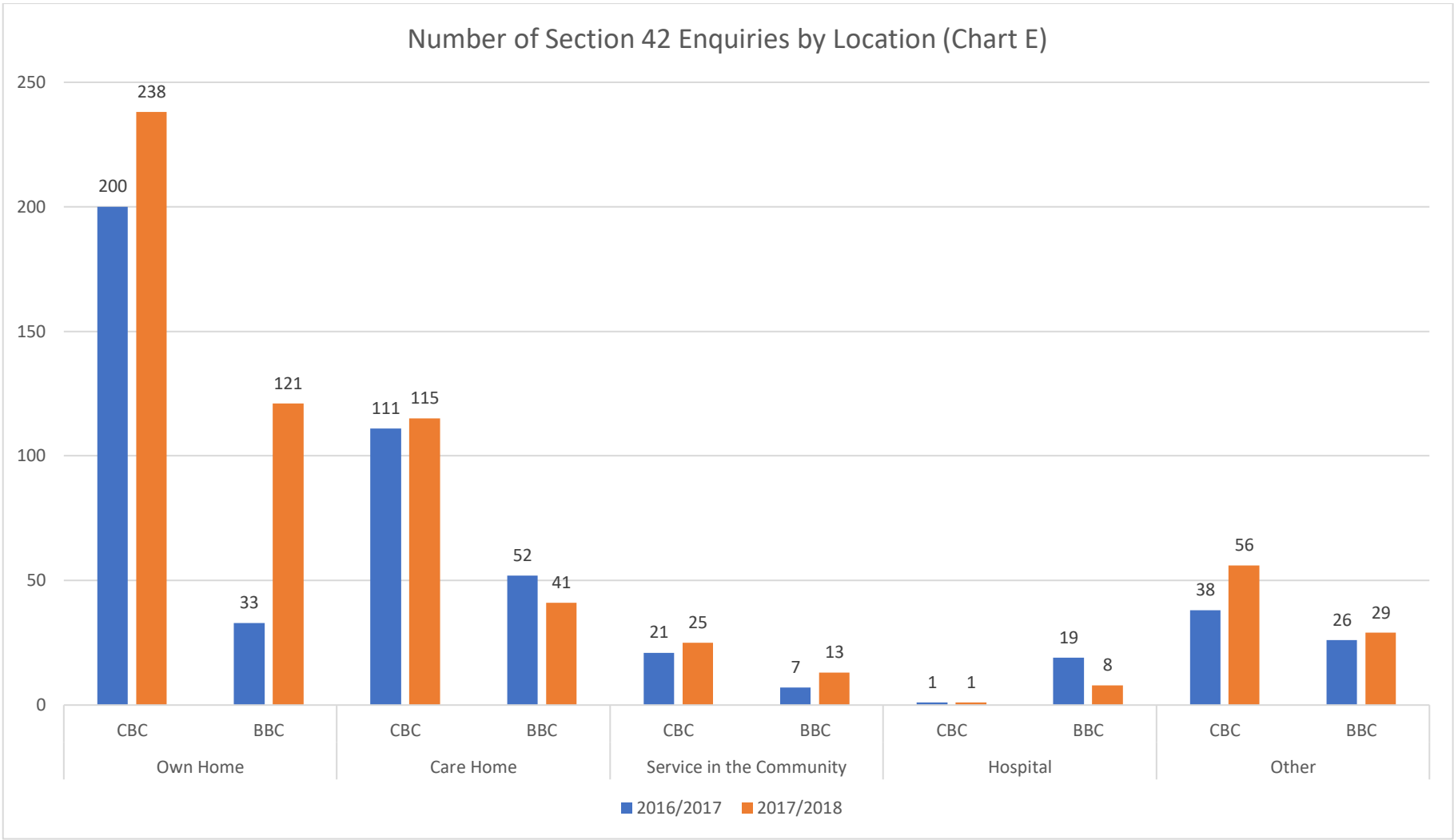
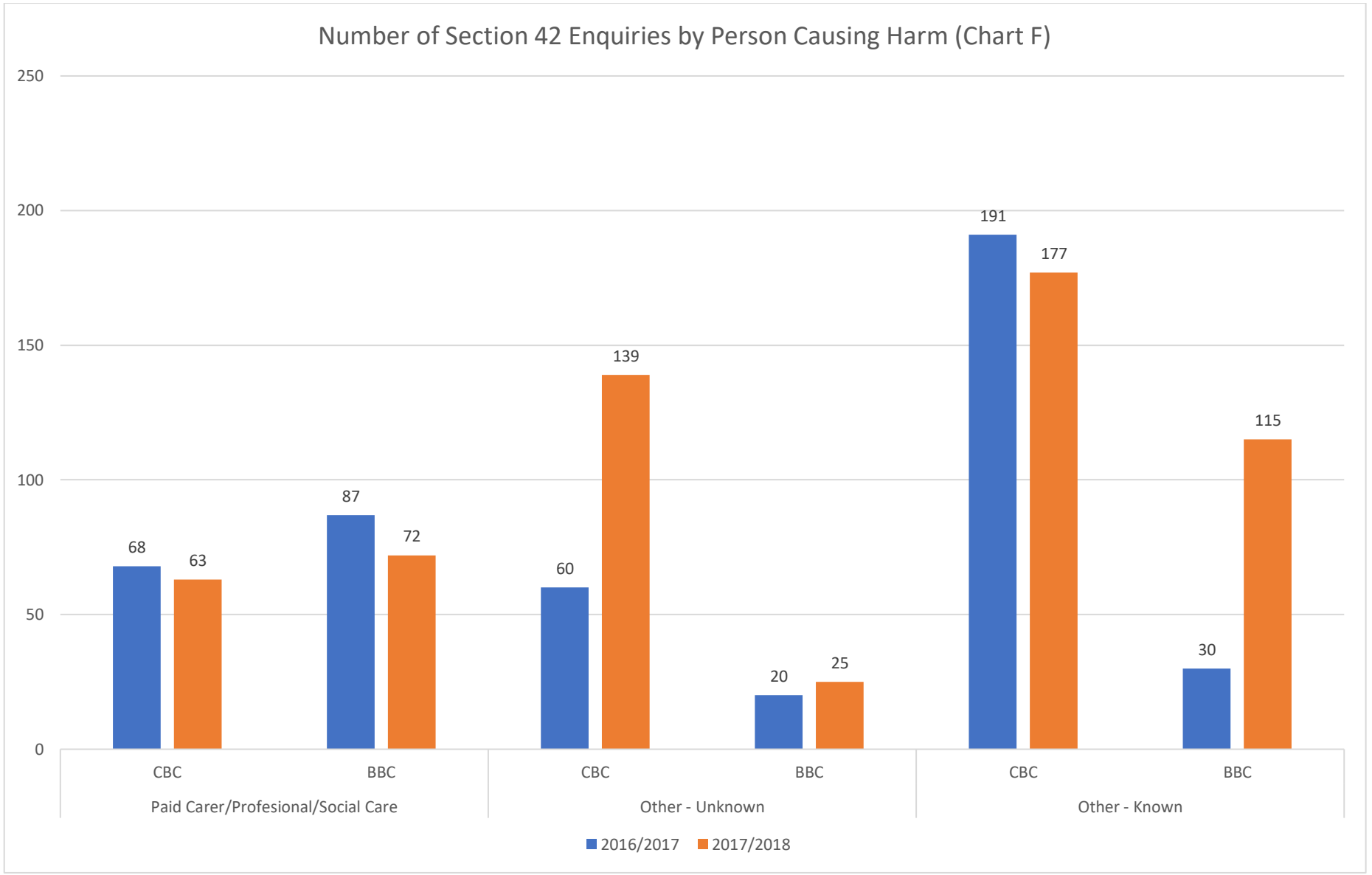
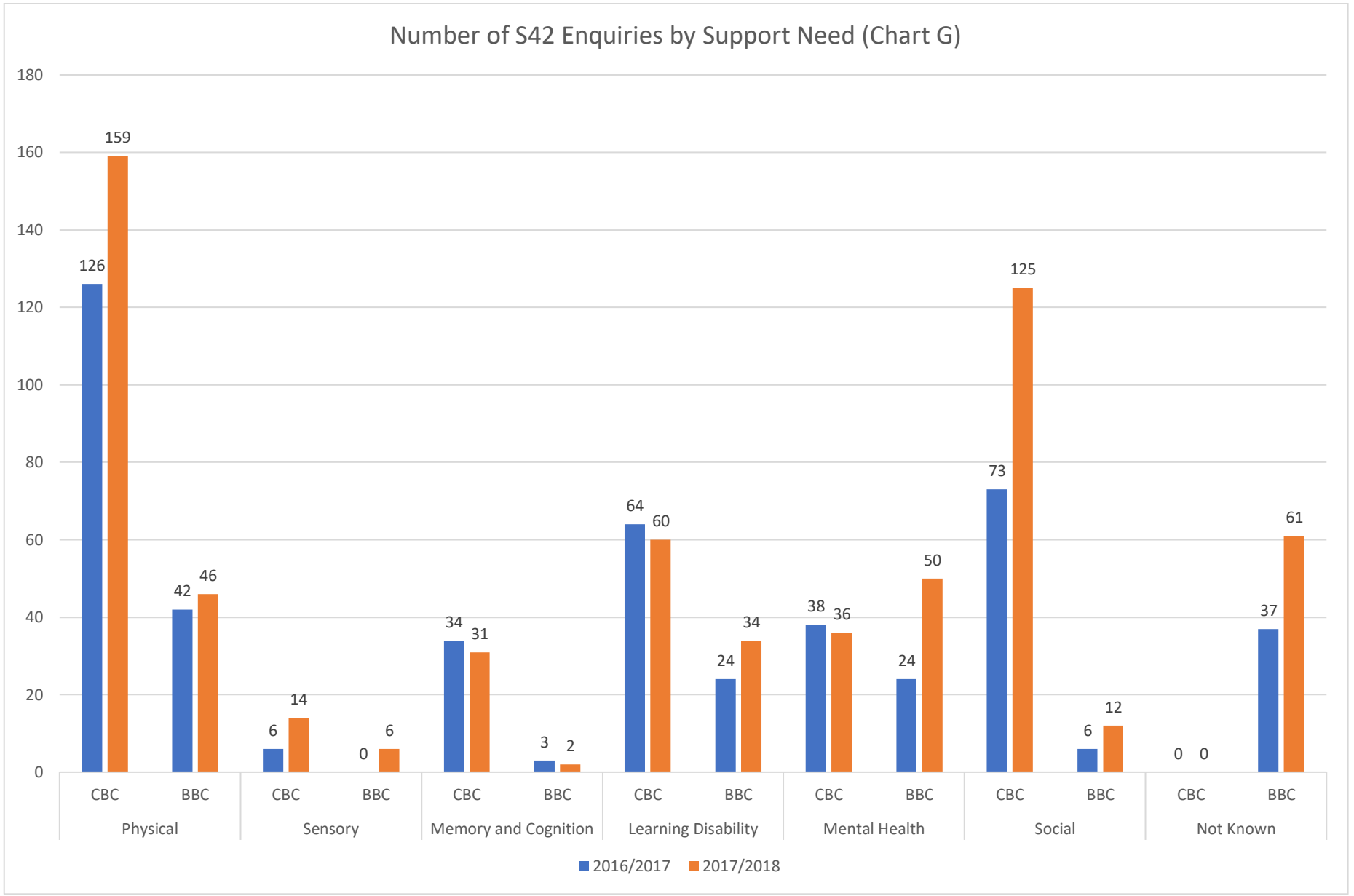
17
5
3
13
8
5
5
32
63
8
7
16
26
2016/2017
2017/2018


Number of Section 42 Enquiries by Type of Abuse (Chart D)
160
140
120
100
80
60
40
20
0
CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC CBC BBC
66 72 23 26 20 25 13 32 69 54 9 14 65 56 19 49 1 1 0 0 10 8 0 0 83 137 68 65 59 56 5 26 1 7 0 0 1 1 0 0 1 8 0 0 20 25 1 6
Physical
Sexual
Psychological
Financial and Material
Discriminatory
Organisational
Neglect/AOO
Domestic
Sexual Exploitation
Modern Slavery
Other
Self Neglect
2016/2017
2017/2018


Number of Section 42 Enquiries by Location (Chart E)
250
200
150
100
50
0
200
238
33
121
111
115
52
41
21
25
7
13
1
1
19
8
38
56
26
29
CBC
BBC
CBC
BBC
CBC
BBC
CBC
BBC
CBC
BBC
Own Home
Care Home
Service in the Community
Hospital
Other
2016/2017
2017/2018


Number of Section 42 Enquiries by Person Causing Harm (Chart F)
250
200
150
100
50
0
68
63
87
72
60
139
20
25
191
177
30
115
CBC
BBC
CBC
BBC
CBC
BBC
Paid Carer/Profesional/Social Care
Other - Unknown
Other - Known
2016/2017
2017/2018


Number of S42 Enquiries by Support Need (Chart G)
180
160
140
120
100
80
60
40
20
0
126
159
42
46
6
14
0
6
34
31
3
2
64
60
24
34
38
36
24
50
73
125
6
12
0
0
37
61
CBC
BBC
Physical
Sensory
Memory and Cognition
Learning Disability
Mental Health
Social
Not Known
2016/2017
2017/2018