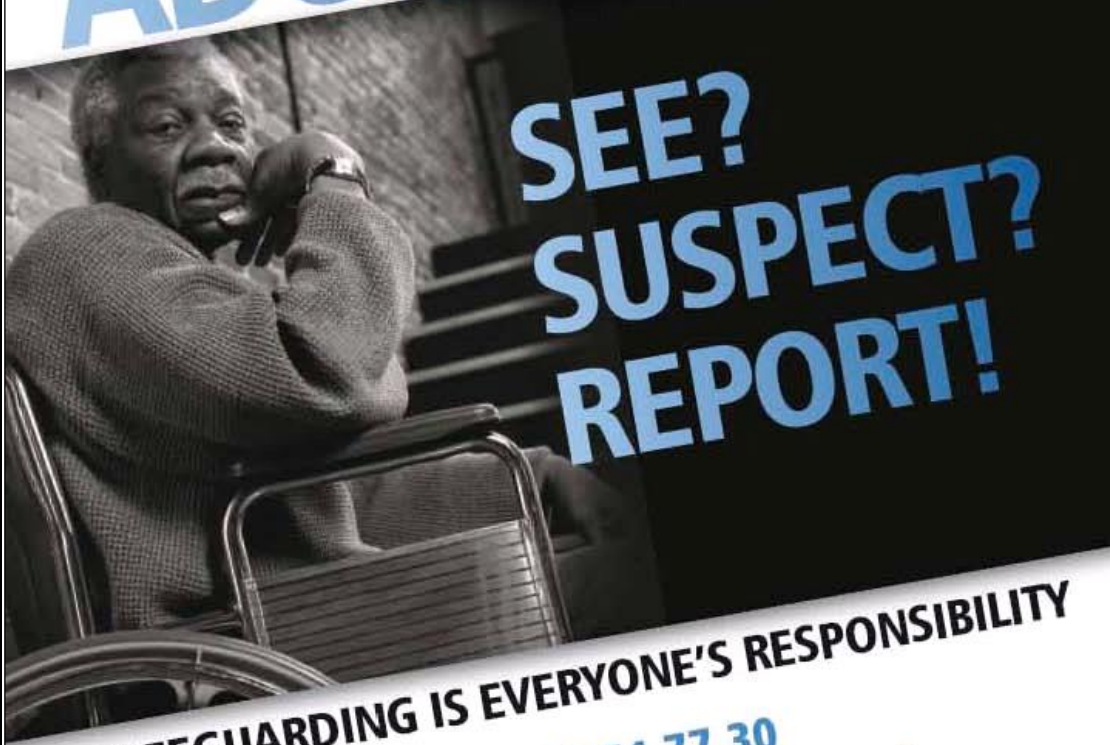




**Luton Safeguarding
Adults Board**
Working in partnership
to protect adults at risk



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Annual Report 2014-2015

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Introduction/Foreword

This Annual Report provides an account of the work of the Luton Safeguarding Adults Board in 2014-2015. It introduces also the Board's business plan for the year ahead. It provides an opportunity to demonstrate the Board's commitment to safeguarding adults at risk of abuse or neglect in Luton.

Nationally, the Care Act 2014 has placed Local Safeguarding Adults Boards on a statutory basis in primary legislation for the first time. This has meant that by 1st April 2015 the Board had to be compliant with the requirements of the Act, the detail of which is contained in statutory guidance issued by the Department of Health. Boards must comply with this guidance. I can confirm that the Board is compliant with the Act's requirements, which include having as core partners the Local Authority, the Clinical Commissioning Group and the Police. The Board has always published an annual report, which is now a statutory requirement in which, as here, the findings of a serious case review (Adult G) are presented. The Board has also had annual business plans, now also a statutory requirement and now has a policy for commissioning and managing safeguarding adult reviews, which succeed serious case reviews as the opportunity to learn from serious incidents.

The Board has taken the opportunity provided by the Care Act 2014 to review all its policies and procedures. In particular I would draw your attention to two procedures – one for implementing the new duty in the Care Act 2014 to enquire into situations where it is believed an adult may be at risk of abuse or neglect; another for escalating concerns. The Board has also taken the opportunity provided by the Care Act 2014 to review the structures that it uses to learn from serious incidents, to monitor the quality of adult safeguarding work, to identify and respond effectively to local issues, and to ensure that all agencies work together effectively to safeguard adults at risk of abuse or harm. The Board is particularly mindful of the introduction into national adult safeguarding policy requirements of self-neglect, modern slavery and institutional abuse. It also continues to challenge agencies in relation to their response to sexual exploitation and hate crime.

The national statutory guidance for adult safeguarding, issued by the Department of Health, requires that adult safeguarding practice should be characterised by a focus on making safeguarding personal. The Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) have led on the development of this approach to practice over several years and the Journal of Adult Protection in its third issue for 2015 has published articles which give accounts of how local authorities have responded. Luton is participating for the second year and the Making Safeguarding Personal programme now extends to all local authorities in England. The approach means that practitioners should focus on identifying with the adult at risk of abuse or neglect the outcomes which they are seeking from a safeguarding intervention. Practitioners should work with the adult concerned to

enable these outcomes to be achieved and should explore other outcomes with the individual which they may not have initially considered.

The Board will test its new policies and procedures during 2015-16 to ensure they are robust and effective. This year the Board has introduced learning events for all partners to ensure that lessons are learned from local serious case reviews, and from reviews published by other Local Safeguarding Adults Boards. This is to ensure that lessons are embedded in organisational and individual practice. The Board will grow this activity, especially with a focus on issues which are known to challenge practitioners and managers across agencies, namely institutional abuse, self-neglect, capacity and deprivation of liberty assessments, and exploitation.

This illustrates the breadth and the challenges of adult safeguarding work. The remit of the Board is more extensive now and it is essential that Board members continue to appraise their own performance and challenge that of each agency which is a member and/or which provides services to adults who need care and support., The Board has challenged agencies with respect to how they work together, as is evidenced in the report with respect to the recommendations in the case of Adult G. The Board has also closely monitored the commissioning of new providers for health care in Luton. Board members will need to continue to work together, to evaluate their work and to continue to raise the profile of safeguarding adults with members of the public and communities of Luton. Continuing to develop partnership working, which includes working alongside and responding positively to the concerns of residents, is the only way to strengthen our ability to safeguard the rights and safety of those in need of support in Luton.

I am delighted to present this report to you, which I hope you will use to raise awareness of adult safeguarding and to identify issues that you can take forward in your own organisation or that you believe that the Board should focus on. This will be my last report as Independent Chair, with Brian Walsh assuming the role in October 2015. I have been honoured to chair the Board since 2008 and I remain very appreciative of the work conducted by all those in statutory and third sector organisations. Thank you to all of those who have contributed to supporting and protecting our most at risk adults in Luton.

Professor Michael Preston-Shoot

Independent Chair

August 2015

Executive Summary

This Annual Report covers the period August 2014 – July 2015. The performance data in the report covers the period 1 April 2014 – 31 March 2015.

The report includes a summary of national developments, reports and significant events as well as best practice guidance published during the year. It explains the structure of local safeguarding arrangements, including diagrammatically in Appendix 1. Developments, changes and key issues for local safeguarding adults work affecting both Luton Borough Council (LBC) and statutory partners form the major part of the report.

The report includes an analysis of performance information on both safeguarding and Mental Capacity Act Deprivation of Liberty Safeguards, focusing on key issues. The section, “Are We Making a Difference?” includes case studies that show the impact that safeguarding can have directly on the lives of individuals as well as the benefits of multi-agency working.

Acknowledgements

The Board would like to thank all staff, service users and carers from all agencies who have contributed to safeguarding and dignity and respect work in Luton.

National Developments

2014 was a significant year for Safeguarding Adults. The Care Act 2014 received royal assent in May 2014 placing safeguarding adults on a statutory framework for the first time from 1st April 2015.

The Care Act 2014 sets out a clear legal framework for how local authorities and other statutory agencies should protect adults with care and support needs who are at risk of abuse or neglect. New duties include the Local Authority’s duty to make enquiries or cause them to be made, and to establish a Safeguarding Adults Board. Statutory members of the Board are the local authority, Clinical Commissioning Groups and the police. Safeguarding Adults Boards must arrange Safeguarding Adult Reviews (SARs), as per defined criteria that are contained in the statutory guidance published by the Department of Health; and publish an annual report and strategic plan. All these initiatives are designed to ensure greater multi-agency collaboration and accountability as a means of transforming adult social care.

During 2014-15 the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) continued to develop the Making Safeguarding Personal programme, with significantly more Local Authorities

adopting the approach, including Luton. In addition the approach can clearly be seen within the Care Act 2014 Statutory Guidance Safeguarding Adults chapter, which supports the implementation of the Care Act 2014.

At the start of 2014 the Department of Health, following consultation, published [“Positive and Proactive Care: reducing the need for restrictive interventions”](#) – Guidance for all those working in health and social care settings: commissioners of services, executive directors, frontline staff and all those who care for and support people. This guidance was developed as concerns about the inappropriate use of restrictive interventions across health and care settings were identified by the serious case review and government response with respect to abuse of residents in Winterbourne View Hospital (DH 2012), the inquiry into Mental Health Crisis Care: Physical Restraint in Crisis in June 2013 by MIND, and a recent inspection of inpatient learning disability services by the Care Quality Commission (CQC). The guidance provides a framework within which adult health and social care services can develop a culture where restrictive interventions are only ever used as a last resort and only then for the shortest possible time.

The Supreme Court Judgement in March 2014 in relation to Deprivation of Liberty Safeguards (DoLS) widened and clarified the definition of deprivation of liberty. This has resulted in a significant increase in DoLS cases from hospitals and care homes nationally and locally. The judgement also widened the scope of DoLS to include adults living in the community, requiring such cases to be put to the Court of Protection for decision making.

In October 2014 the CQC announced their new regulatory model that has people right at its heart. They will ask the questions that matter most to people who use services, listen to their views, take action to protect them, and provide them with clear, reliable and accessible information about the quality of their services. Andrea Sutcliffe, CQC’s Chief Inspector of adult social care, introduced the “Mums Test” which requires inspections and inspection teams to consider whether the service is one that they would be happy for someone they love and care for to use. Following each inspection, each service will be rated: Outstanding, Good, Requires Improvement or Inadequate. The importance of rigorous inspection by the CQC as well as monitoring and audits by Local Safeguarding Adults Boards cannot be overstated as the Serious Case Review into events at Orchid View residential home for older people uncovered.

Safeguarding Developments and Changes in Luton

Since the introduction of the Deprivation of Liberty Safeguards in 2009, professionals in health and social care may decide to apply to deprive an individual of their liberty because they believe the person lacks capacity to consent to the care arrangements or would come to harm if those care arrangements’ were not in place. If a hospital or

care home feels it necessary to deprive a person of their liberty – by limiting where they can go, or what they can do – it must get any such restrictions approved by the local authority. These must be the least restrictive in the circumstances. The person's views and best interests must be taken into account and decisions must be reviewed regularly. Those wishing to appeal can challenge any decision to curb their liberty in the Court of Protection. Similar safeguards apply where the person whose liberty is restricted is living in their own home, but the decision to deprive their liberty is taken by the Court of Protection, not the local authority.

On 19 March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”. The full judgement can be found on the Supreme Court's website at the following link: [Supreme Court Judgement, 19th March 2014](#).

This judgment has had a significant impact on the work of the Luton Borough Council Safeguarding Adults Team which is the single point of referral for all DoLS Authorisation requests in the Borough. The number of requests increased from less than one a week to up to 20, in the space of a matter of weeks. During 2014-15 there were a total of 437 DoLS requests compared to 29 in 2013-14. Nationally local authorities have struggled with the numbers of authorisation requests and in Luton there has been a substantial challenge to make sure that those people who may be being deprived of their liberty, are having this done in the least restrictive way and for the deprivation to be regularly reviewed.

Safeguarding alerts continued to rise during 2014-15 with 2,303 safeguarding alerts being received; a 42% increase compared to 2013-14. However the conversion rate of alerts becoming safeguarding referrals remained similar to 2013-14 with less than 1/3 being deemed to require a safeguarding response. Due to the increasing demand on safeguarding resources within the local authority, an independent review of the safeguarding and DOLS workflows was carried out and a number of recommendations were made which will be fully implemented later in the autumn of 2015.

The Safeguarding Adults Team located in the local authority will continue to be the single point of referral for all safeguarding concerns raised and for DOLS authorisation requests but will be restructured with two separate workflows with staff assigned to each.

The Luton Safeguarding Adults Board (LSAB) in preparation for the implementation of The Care Act 2014 reviewed the work of the Operations Board. The review concluded that the LSAB could best be served by the setting up of a number of work streams and these would be led by various partners from the LSAB. The Board reviewed its Terms of Reference and agreed a Memorandum of Understanding, thus

putting the Board on a more formal footing with core strategic partners and specialist professional membership.

A revised Multi Agency Policy and a Practice Guidance document were agreed and both reflect the new duties under the Care Act 2014, as well as the shift to a much more personal approach to safeguarding adults. Safeguarding adults training has also been reviewed to reflect the cultural shift from investigation to enquiry and to a more risk enabling approach.

A Memorandum of Understanding for the Board has been agreed, which outlines the roles and responsibilities of each of the strategic partners. A Safeguarding Adults Review Policy has also been agreed by the Board which replaces the previous Serious Case Review Policy.

Safeguarding adults does not operate in isolation from adult and children's operational practice, commissioning, contract monitoring, housing, the private and voluntary sector, utility companies, licensing departments and community safety. It must be viewed as integral, as everybody's business, in all that services do to provide for the people who live in Luton. To that effect there has been more joined up working, with safeguarding being recognised as fundamental to all that the local authority and its strategic partners want to achieve. The recent high profile cases of modern day slavery in Bedfordshire, of human trafficking across the country, of child sexual exploitation in Rotherham, forced marriage and female genital mutilation have highlighted the need for joined up approaches to tackling these serious threats to the safety of our children and adults who are at risk of abuse. The LSAB reflects the need to work across agencies in its strategic plan and its action plan for the forthcoming 12 months.

Update on the activity of the Purchasing & Quality Assurance team in relation to Safeguarding

Since our last update in September 2014 there has been a further strengthening of our links with the Safeguarding team in Luton. With the introduction of the Care Act the Escalation Concerns procedure has been refreshed to include the revised safeguarding and Care Act requirements. The procedure is linked to the Safeguarding policy for Luton and both documents have been approved by the LSAB.

The Care Act 2014 gives local authorities in England responsibility for market shaping, to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area. This will be for the benefit of the whole population, regardless of how the services are funded e.g. commissioned by Luton Borough Council or otherwise.

Market oversight is a fundamental element of the market shaping cycle. The Purchasing and Quality Assurance Team in partnership with Regional ADASS

colleagues has developed a regional risk strategy for the Eastern region. It defines what the risk is and how this will be managed across the region and locally.

The Purchasing & Quality Assurance Team has a proactive approach to risk management. There are currently 62 statutory commissioned services in Luton. Effective engagement and contract management is in place to manage the risk of provider failure. The team are able to identify the risks early enough to mitigate the impact. Potential risks relate to financial, performance or quality failure. Mechanisms and information sharing protocols are in place where partners and stakeholders can be informed of potential indicators of poor performance or provider failure. This includes information shared from the CQC relating to ALL services in Luton.

Findings from domiciliary homecare audits demonstrated that there has been an improvement in the quality standards of these services from last year. Where there have been quality issues identified these have been addressed quickly in conjunction with the Council's Escalation Concerns Procedure.

Further analysis of the annual reviews and ongoing contractual relationship management has been undertaken. This identified a number of key themes, as described below, which require greater emphasis and service development moving forward, to ensure that service delivery is maintained at the appropriate standards:

- Further partnership work to further develop competency in managing potential issues relating to Deprivation of Liberty.
- Further initiatives to increase staff retention and thus improve care continuity.
- To increase the number of calls delivered being monitored through the electronic monitoring system

The analysis has also highlighted areas of high quality provision in the following areas:

- Staff demonstrated a good understanding of dignity and respect
- Staff were aware of how to gain consent
- Staff promoted service users independence
- Spot checks carried out by the provider to monitor staff practice
- Auditing of staff training and supervision records

As part of the monitoring process there has been a targeted focus on ensuring that all Providers have a "tested" service specific Business Continuity Plan in place. Where shortfalls are identified this has been addressed through the Escalation Concerns Procedure or support has been provided to ensure that the required standard is met. A contingency plan has been developed to manage Provider Failure and will be shared with stakeholders and partners, including Safeguarding. The plan will be tested and lessons learned identified through the test that impact on the procedure will be reflected in a revised process. This will also include formalising the procedural arrangement with Care Management.

The Purchasing & Quality Assurance Team recently undertook a programme of service user and relative engagement to seek their views and experiences of the

domiciliary care service they receive. This enabled the team to contact 209 service users.

The team continue to gather local intelligence from a host of professionals which is used to inform our pre-risk assessment of providers on a quarterly basis. The team use the ADASS contract monitoring toolkit for statutory and non-statutory services, the focus for both toolkits is the outcomes that are achieved for service users. This data is shared regionally with our ADASS partners. The reports include comparative scoring by authority and provide, these are disseminated through the appropriate Director.

In the period of April 2014 – March 2015 the team conducted 94 service reviews in total which represented 100% of all statutory and non- statutory services at the time. 19 organisations (3 domiciliary, 2 Nursing, 1 supported living & 9 Residential 4 day services) failed to perform to the expected standards and moved to Provider Performance status under the Council's Escalation Concerns Procedure. Of the 19 services, 3 (1 Nursing, 2 Residential) failed to make the necessary improvements and were escalated to stage two serious concerns status.

Two providers were under Provider performance status on more than one occasion in a 52 week period from the date of the original review but none of those reached stage two.

The Provider Forum convenes on a quarterly basis providing a platform for colleagues and providers to disseminate information and share best practice. The forum includes a representative of the LSAB, providing a valuable link and resource. Information regarding the change in legislation relating to mental capacity, DoLS and Child Sexual Exploitation has been shared with Providers in this way.

Update on Safeguarding Training run by Luton Borough Council (LBC)

Luton Borough Council (LBC) devised a safeguarding programme informed by a Workforce Needs Analysis, where staff across the Council and Private, Voluntary and Independent (PVI) agencies identified the needs of their workforce. Safeguarding training is mandatory for all LBC staff according to their role and responsibilities. Within 13/14 LBC introduced a combined safeguarding training for children and adults, to ensure all staff are aware and understand their safeguarding responsibilities. The remainder of the programme is centred on the knowledge and skills required by staff within the Adult Social Care Sector in accordance with their role, responsibilities and duties under the safeguarding umbrella.

The table below depicts the programme commissioned based on the workforce needs of both LBC and the PVI Sector. The number of staff booked on training was 671, however the actual number of staff attending reduced to 548, again this was reflective of both statutory and PVI employees.

| | No Events | | Delegates | |
|---|-----------|-----|-----------|-----------|
| | Planned | Ran | Attended | Cancelled |
| Chairing Safeguarding Meetings | 1 | 1 | 10 | 6 |
| Safeguarding Adults at Risk Responding to Reports and Concerns of Abuse | 6 | 3 | 35 | 20 |
| Safeguarding Adults Basic Awareness | 15 | 12 | 183 | 37 |
| Safeguarding Adults Basic Awareness Refresher | 4 | 4 | 33 | 2 |
| Safeguarding Adults Financial & Material Abuse - Stage 1 | 2 | 1 | 5 | 0 |
| Safeguarding Adults Financial & Material Abuse - Stage 2 | 2 | 2 | 11 | 2 |
| Safeguarding Investigations | 2 | 2 | 15 | 15 |
| Safeguarding Investigations – Refresher | 2 | 1 | 7 | 0 |
| Safeguarding Adults Positive Risk Taking | 2 | 1 | 7 | 0 |
| Minute Taking for Safeguarding Meetings | 1 | 1 | 15 | 2 |
| Mental Capacity Act Basic Awareness | 16 | 5 | 149 | 11 |
| Mental Capacity Act - Putting it into Practice | 3 | 0 | 46 | 16 |
| Deprivation of Liberties - Putting it into Practice | 3 | 0 | 32 | 12 |

The safeguarding training programme incorporates The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training programme; in addition this year it included Adult Positive Risk Taking, as it was identified that staff would benefit from developing their knowledge and skills in this area. The course focused on the areas outlined below:

- Understanding risk and risk factors
- Whose risk is it anyway?
- Risk in the context of value based practice.
- Analysing risk
- Assessing risk
- Working In Partnership to minimise risk
- Review and monitoring positive risk taking

The Corporate Learning & Development Team (CLDT) follows a Quality Assurance process, using a variety of methods to triangulate results of the service/training provided. This process enables CLDT to identify any amendments/updates/ improvements required to ensure training packages remain fit for purpose. Impact evaluations are sent to delegates and their line managers 3-6 months after course completion. Delegates are invited to provide further feedback to monitor how much impact attendance at the learning events has had on their practice. The table below reflects the responses. Please note the table reflects the collective data based on the number of returns.

| | Competency Rating Pre Course | Competency Rating Post Course | Competency Rating Post Course 2months | Learning in Practice | Positive Impact | Comments |
|------------------------------------|------------------------------|-------------------------------|---------------------------------------|----------------------|-----------------|--|
| Basic | 6 | 9 | 9 | 45% | 86% | Safeguarding issue with a patient that came into the unit. The training helped me to look at the whole picture rather than taking things at face value. Also helped understand the people that need to be informed and the process generally. |
| Positive Risk Taking | 6 | 9 | 8 | 100% | 100% | It has helped me to be less risk averse. I now think differently when supporting a client or when advising other around risk. |
| Responding to Reports and Concerns | 7 | 9 | 9 | 50% | 100% | I have been able to discuss SOVA procedures more openly with clients & carers. My communication skills have been more open & "non questioning" I have been able to provide information received from the training when reflecting /discussing clients within team meetings |

Priorities for 2015-18

The Three Year Strategic Objectives provide direction and continuity to each of the work streams, as described in the LSAB Annual Business Plan, ensuring that achievements of the Board are built upon each year.

Governance, Leadership and Partnership

- Multi-Agency Safeguarding Hub (MASH) type models of operational practice have been explored and considered.
- Effective working relationships of the Board have been sustained and developed, ensuring appropriate representation, membership and links to wider networks/Boards are embedded.
- Strategic links and key shared workstreams have been identified and included as relevant into the LSAB Business plan. For example, shared agendas relating to:
 - Luton Safeguarding Children Board
 - Luton Community Safety Partnership
 - Radicalisation (PREVENT)
 - Homelessness and adults at risk
 - Substance misuse and adults at risk
- Strategic links with Bedfordshire are maintained through the PAN Beds group and opportunities explored to develop more efficient ways of working for county-wide partners.
- Making Safeguarding Personal is embedded in all aspects of safeguarding adults work, and adopted by all partner agencies.

Policies, Protocols and Procedures

- There is a full range of policy, procedures and guidance in place that meets the requirements of the Care Act 2014 and provides a framework within which organisations can work together effectively to respond to abuse and neglect, and reflects developments in national guidance and legislation, as well as national/regional/local learning, and new approaches to safeguarding.

Emerging Issues

- Ensuring effective transition arrangements between Children's and Adult Services.
- Ensuring join-up with Community Safety Partnership and Bedfordshire Police on Hate Crime by raising awareness of hate crime and improving and maximising identification of possible cases through the triaging and screening of safeguarding alerts.

- Ensuring the early identification of cases of sexual exploitation and ensuring victims are given the support they need to stay safe.
- Raising awareness of Modern Slavery and ensuring that cases are quickly identified and victims given the support they need.

Training and Workforce Development

- Developed a training and workforce framework safeguarding adults strategy that incorporates local/regional and national policy, procedures and learning, and meets the needs of stakeholders involved in the safeguarding process.

Safeguarding Adults Reviews and Professional Practice

- Safeguarding Adults Review procedures reflect best practice as established through local/regional and national learning as well as any relevant legislation.
- Effective systems have been developed and maintained to share the learning within Luton from Safeguarding Adults Reviews occurring both locally and nationally.

Auditing and Competency Framework

- Measures and processes effectively capture the outcomes of safeguarding adults work in Luton (such as improved levels of safety, improved sense of wellbeing, reduced levels of risk, successful achievement of outcomes desired by adults at risk).
- There is consistent recording and reporting of safeguarding information across partner organisations in Luton, enabling sharing of intelligence at both a strategic and operational levels.

Communication and Community Engagement

- Systems and resources have been developed that raise public awareness and understanding of safeguarding adults work.
- Adults who have experienced, or are at risk of abuse and neglect shape and influence the development of safeguarding practice.
- All stakeholders and clients who experience the safeguarding process have opportunities to inform and influence the development and improvement of that process. The Board will work to increase engagement from professionals and groups where there is less engagement.

Mental Capacity Act

- Where mental capacity cannot be presumed in relation to adults who need care or support services, mental capacity is formally assessed and subsequent decisions are reached in line with the Mental Capacity Act.

- Independent Mental Capacity Advocate (IMCA) instructions are made as required.
- Deprivation of Liberty Safeguards (DoLS) practice is in line with national requirements.
- Auditing of DOLS cases to understand the implications and impact of the Supreme Court ruling of 19 March 2014.
- Auditing and quality assurance methods will ensure good practice in decision making where people lack capacity and have representation from friends and family or advocacy.

Deprivation of Liberty Safeguards Activity

The past twelve months has seen a significant increase in the number of DOLS authorisation requests made to the Council, which acts as the Supervisory Body under the amendments made to The Mental Health Act 1983. This increase has been reflected nationally in England and Wales, where the Act applies, following what has come to be known as the Cheshire West Ruling in March 2014.

The Association of Directors of Adult Social Services published guidance for on the use of DOLS following the Cheshire West Ruling and amended and amalgamated the forms used in a bid to try to streamline the process.

Chart 1 below details the increase. Meeting the high demand has placed a burden on the Council to ensure that it meets it's legislative duties. It has also had an impact on the Safeguarding Adult Team, which is the single point of contact for all DOLS applications and has responsibility for managing the administrative process of the DOLS. This includes sourcing qualified assessors to carry out the six assessments that are required. A separate process of applying directly to the Court of Protection is in place for those people who are living in supported accommodation, Chart 1 does not reflect these applications.

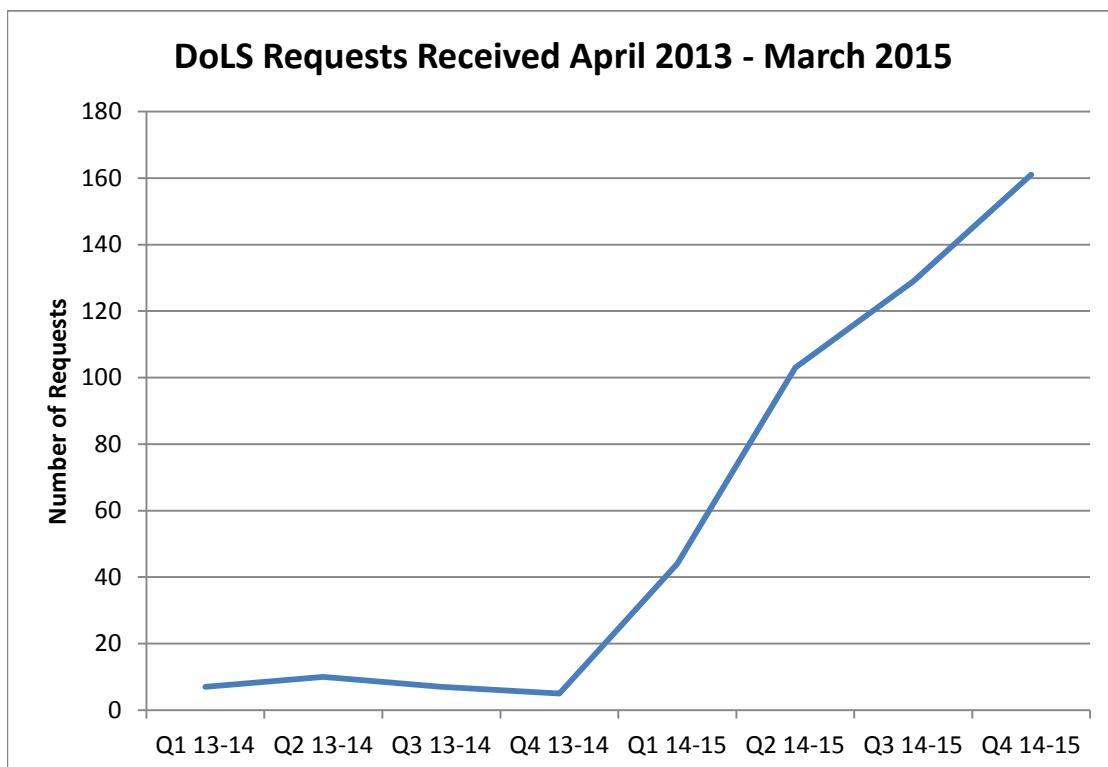


Chart 1

Chart 2 shows the number of assessments by month during 2014-15. This gives an indication of the impact on a month by month basis to the Safeguarding Adults Team, who are the single point of referral for all DoLS authorisation requests within the borough.

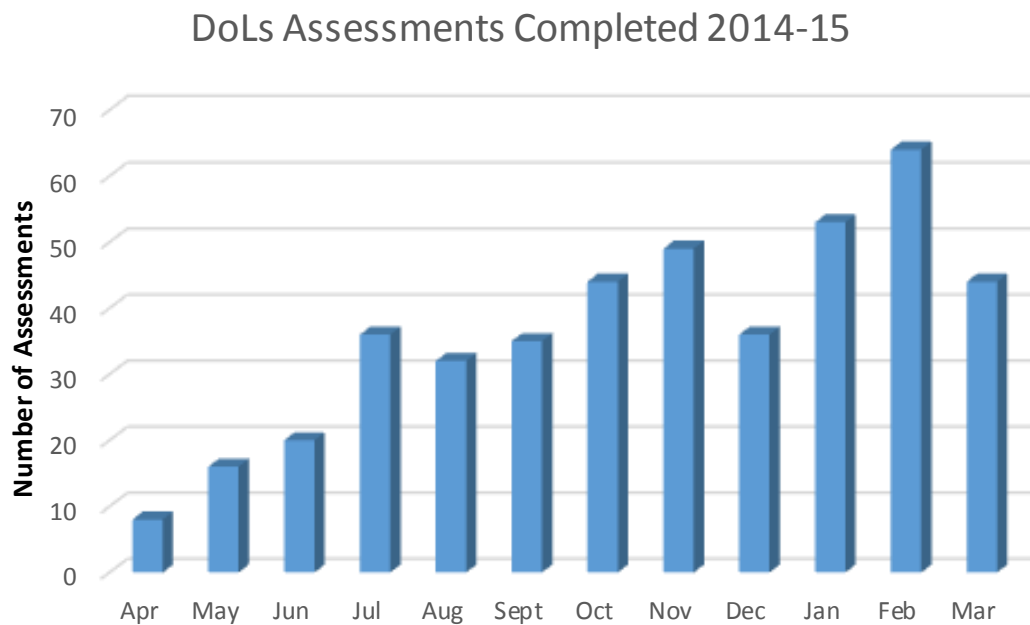


Chart 2

Chart 3 shows that of these assessments, the majority were authorised.

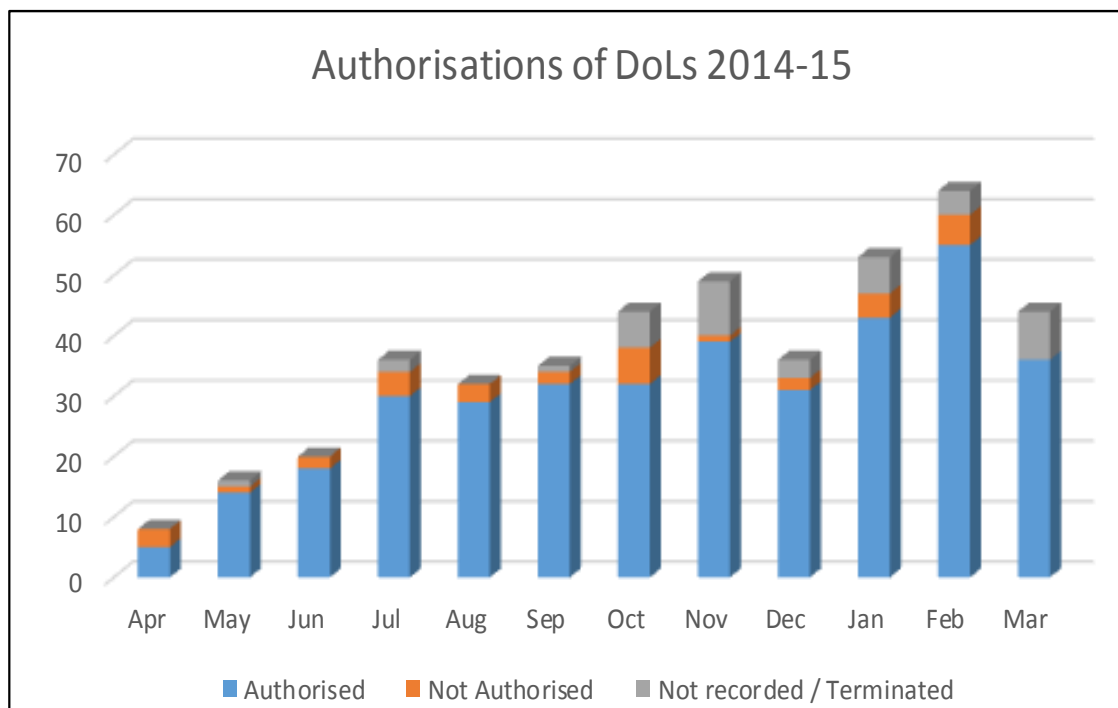


Chart 3

Chart 4 shows the type of setting where the DoLS assessment was carried out.

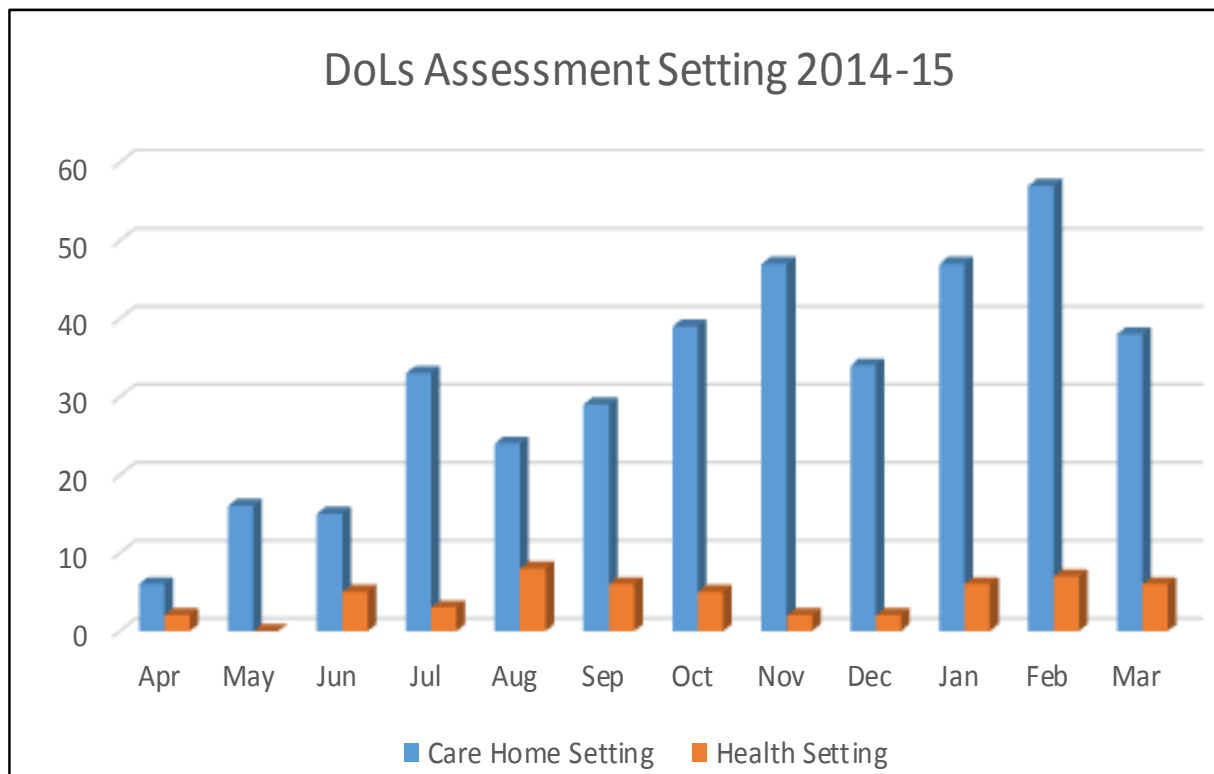


Chart 4

Safeguarding Adults Activity

The Safeguarding Adults Team received 2,303 safeguarding alerts in 2014-15, a 42% increase compared to 2013-14. As shown in Chart 1, this continued a trend of an increasing number of safeguarding alerts since the start of 2013-14, although numbers received per quarter was relatively constant throughout the year. Based on previous published information for 2013-14 and measured per 100,000 people, Luton's alerts and referrals are high compared to other councils.

Chart 1 shows that of the safeguarding alerts received, 545 (24%) proceeded to investigation, compared to 574 (35%) in 2013-14. There was a 5% reduction in the number of alerts proceeding to investigation in 2014-15, compared to 2013-14.

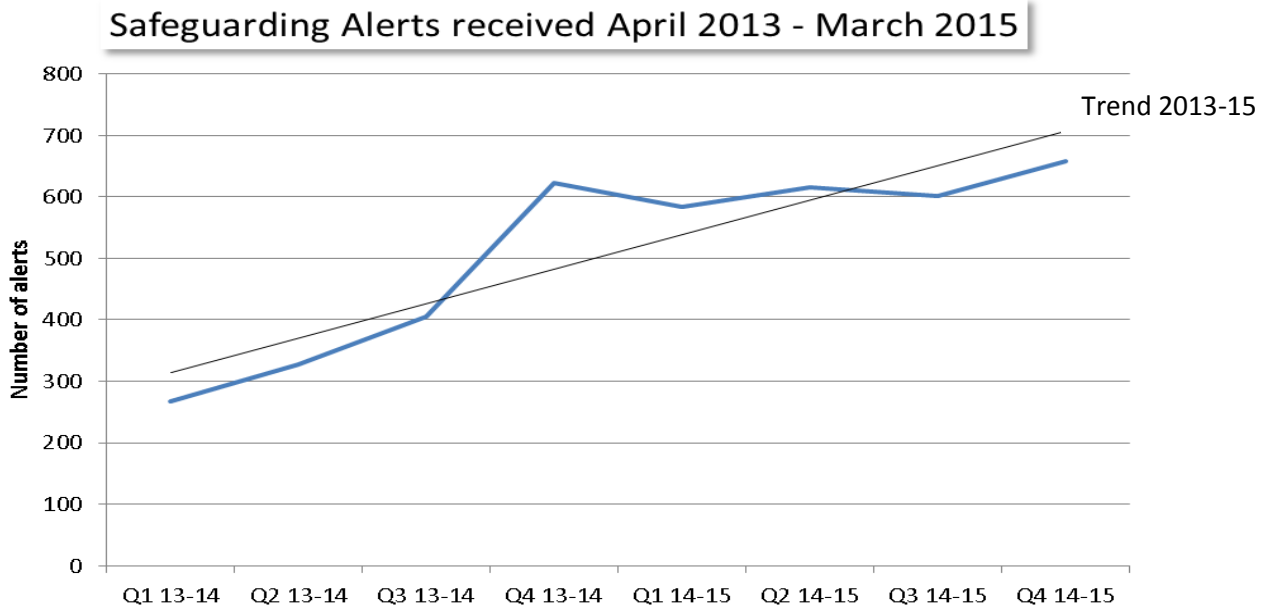


Chart 1

Chart 2 shows that of the alerts that proceeded to investigation, 21% (113) of alerts that proceeded to enquiry were fully or partially substantiated, compared to 29% in 2013-14.

The majority of safeguarding investigations were unsubstantiated.

While a high percentage of cases result in no further action under safeguarding, these alerts are signposted to the most appropriate service for a response for example referred to care management.

Although alerts are not included in the statutory Safeguarding Adults Return (SAR) we have continued to count them, as they give an indication of the awareness of safeguarding issues amongst professionals and in the community. As all alerts need to be assessed by the Safeguarding Adults Team, they also indicate the workload of the team.

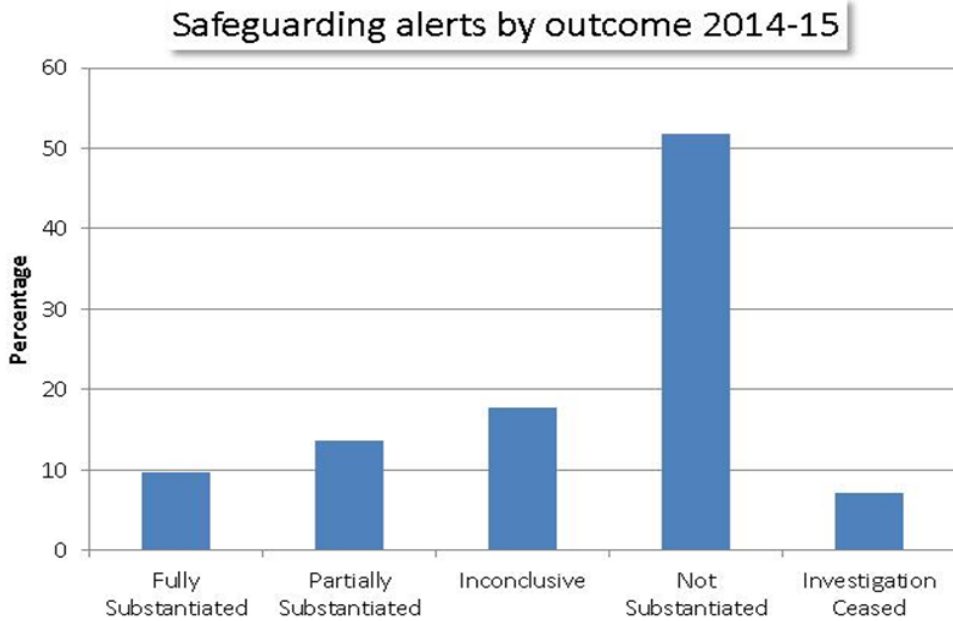


Chart 2

Chart 3 shows the types of abuse investigated in 2014-15. As in previous years neglect was the most common type of reported abuse. Neglect and Acts of Omission was the most commonly investigated type of abuse (35% of enquiries), followed by Physical Abuse (22% of enquiries). There was no significant difference in the proportion of types of abuse in 2014-15 compared to 2013-14.

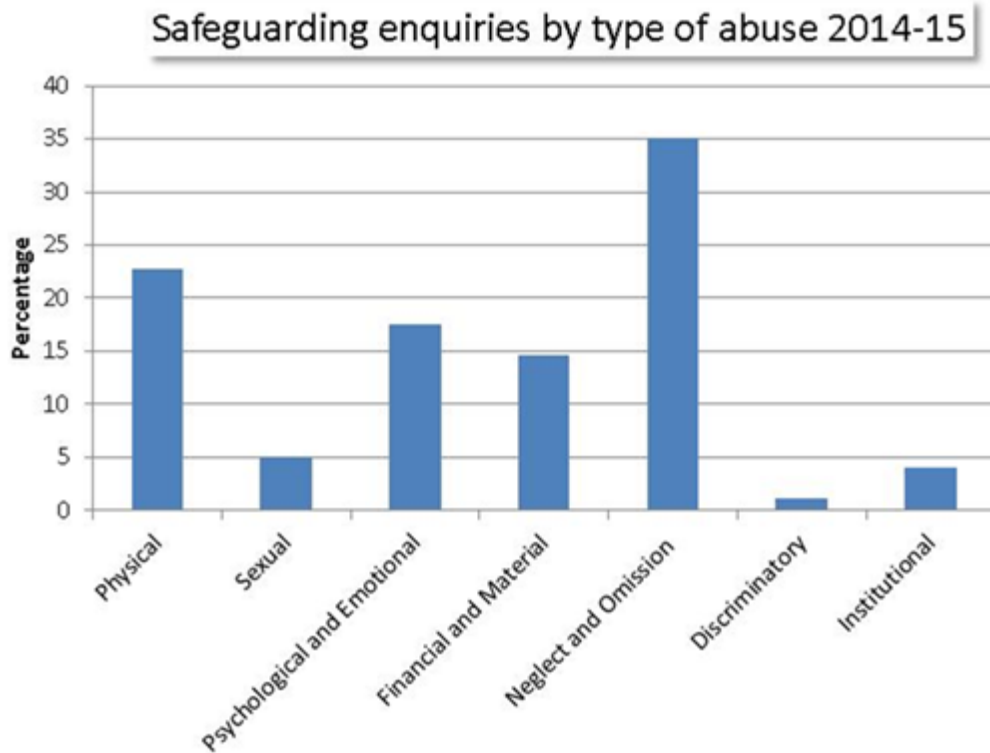


Chart 3

Chart 4 shows the location of alleged cases of abuse or neglect, and as in previous years, the most common location was the home. There was a slight rise in the proportion of these cases, with 56% of alerts that proceeded to enquiry were from the alleged victim's own home, compared to 51% in 2013-14.

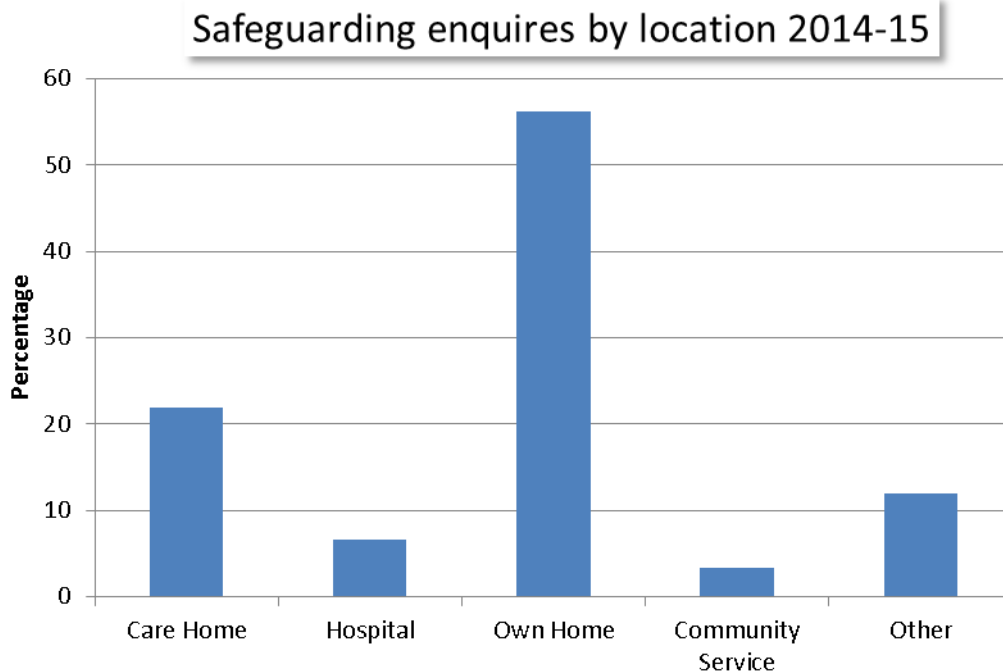


Chart 4

Chart 5 shows that of the safeguarding enquires made during 2014/15, 57% were about possible abuse of women, a reduction in the 64% seen in the previous year. 43% of enquiries related to men.

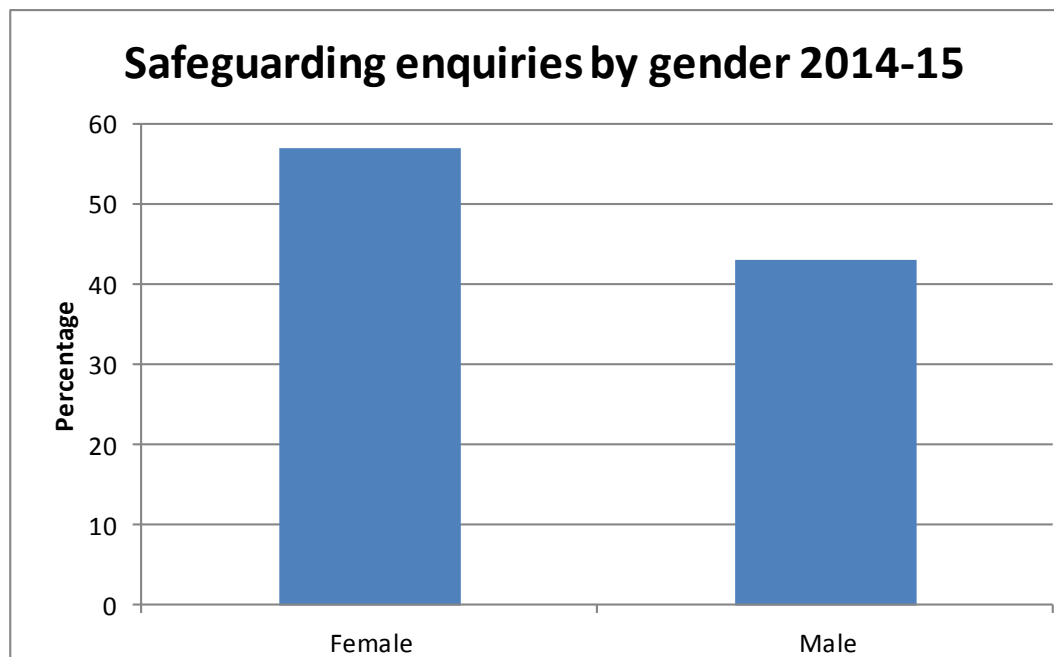


Chart 5

Chart 6 shows safeguarding enquiries by age group. This follows a similar pattern to previous years with the majority, 62%, concerning people over the age of 65. 38% concerned adults in the 18-64 category. From 2015-16, further breakdown will be provided for this group.

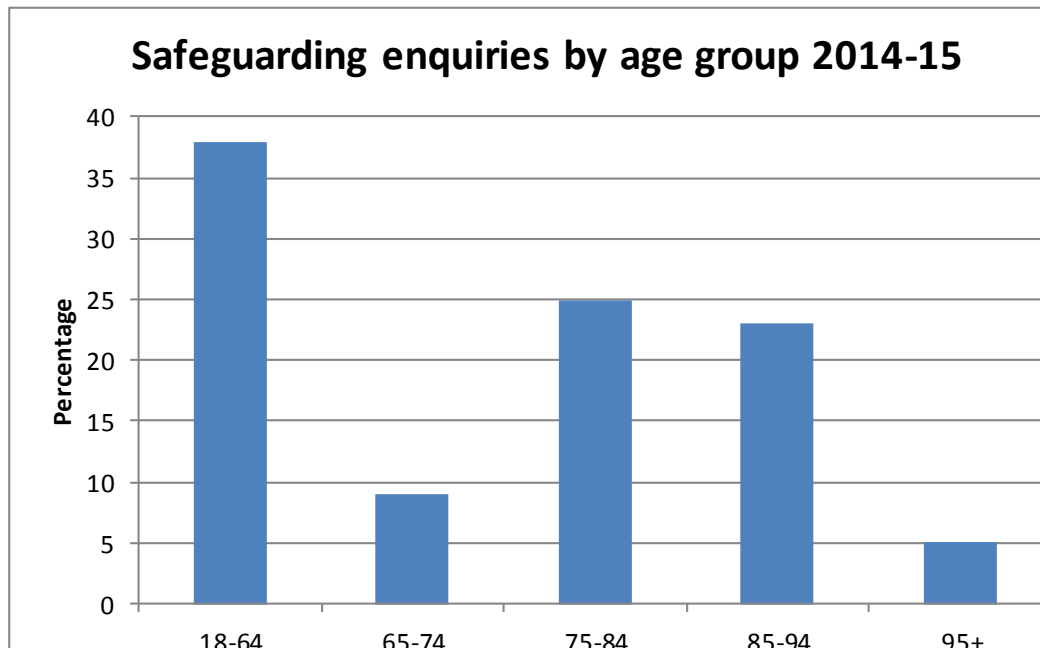


Chart 6

Chart 7 shows safeguarding enquiries by ethnicity, which is consistent in relation to the care management caseload.

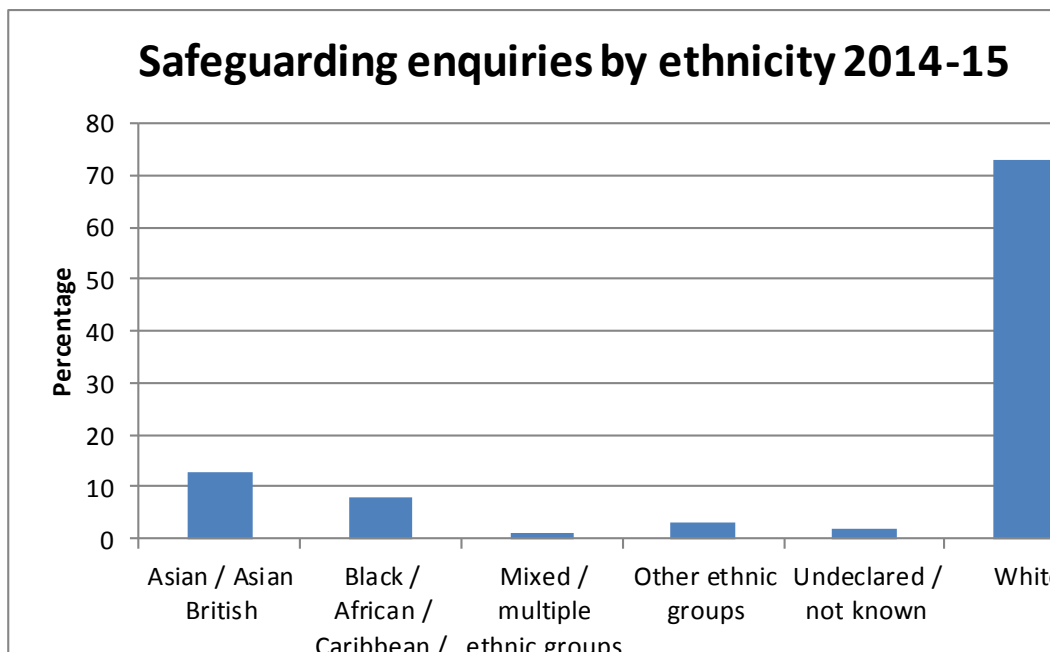


Chart 7

Safeguarding Adult Reviews

During 2014/15 there was one Serious Case Review carried out. This concerned the death of a Luton resident in his garage by a neighbour who later pleaded guilty of manslaughter on the grounds of diminished responsibility. The Executive Summary of the serious Case Review will be made available on the Safeguarding Adults web site on the Luton Borough Council webpages however a summary of the recommendations' is outlined below.

Summary Serious Case Review Adult G

This Serious Case Review (SCR) was commissioned by Luton Safeguarding Adults Board (LSAB) following the tragic murder of Z. It was written by Dr Paul Kingston and Dr Edward Tolhurst of Gerontological Concerns Ltd, utilising the chronologies of each of agency's contact with G and other relevant parties. The agencies involved were:

- Luton Borough Council
- Bedfordshire, Cambridgeshire and Hertfordshire Police Major Crime Unit Review Team
- South Essex Partnership University Mental Health Trust*
- NHS Luton Clinical Commissioning Group including G's GP
- Luton and Dunstable Hospital NHS Trust

* The Luton Mental Health and Wellbeing Service is now provided by East London NHS Foundation Trust (ELFT)

The two main individuals considered in the SCR are semi-anonymised as G (the perpetrator), and Z (the victim).

Circumstances leading to the Serious Case Review

On the afternoon of Tuesday 22nd October 2013, Z was fatally stabbed in the garage of his home in Luton. G was arrested for murder later that evening having given himself up to Police in Ryton near Coventry. Although there had been reported domestic abuse between G and his previous partners, this event on 22nd October was a random attack. However, since July 2012 and up to the day before the murder of Z, information obtained by the Police gave rise to concerns about G's radical religious views potentially putting him at risk from others in the community who would not agree with his views. This coincided with the deteriorating condition of his mental health. The criminal trial concluded in 2014 with G pleading Guilty to Manslaughter by way of Diminished Responsibility. He has received a custodial (hospital) sentence.

The Luton Safeguarding Adults Board made the decision to hold a SCR because G was known to some agencies and hindsight indicates that although G had no prior involvement with secondary mental health services, earlier and different action by agencies might have prevented this tragic murder.

Concerns about G were reported to the Council's Safeguarding Team at the beginning of September 2013 following a visit by the Police to his home in August 2013. These concerns centred on a planned public lecture that G had told police he was going to hold in the middle of October. G had also written a number of religious ideological books and sent emails to members of the Muslim Community and the concern was that his ideology could cause offence and that giving a public lecture would put him at risk.

The Safeguarding Team requested a mental health assessment. However there were delays in the Mental Health Trust becoming involved and their Crisis Resolution and Home Treatment Team (CRHTT) had only started to engage and assess him in the days (18th and 19th October) immediately preceding the murder.

On 21st October G made further contact with the Police by e-mail and phone. The content of the email and 25 minute phone call, which was terminated by G, contained extreme religious ramblings and threats. Following this the Police attempted to visit G at his home but he refused to let them in and they believed they had no power of entry. The Police spoke to a person they believed was G's lodger who indicated everything was alright. The police also spoke to staff in the CRHTT who attempted to make telephone contact with G to arrange a home visit. However CRHTT staff were unsuccessful in making contact by phone or when they made a home visit (cold call). The agreed plan was for a further visit to be arranged.

The Serious Case Review

The 36 page report includes the following sections: the Terms of Reference for the Review, the Methodology used, Facts and Key Events prior to the Review, Findings, Conclusions and Recommendations as well as tables listing materials scrutinised and references. The report considers in detail all contact by all agencies with G and other relevant parties since 2009 (1996 for GP records) and what information was shared/not shared within and between agencies and what action was taken/not taken. It also considers how people expressing extremist religious views where there may be mental health issues should be managed.

Findings and Recommendations

In this case the report writers found that:

- as in many other SCRs the failure to share information across agencies was a significant factor in the tragedy *as staff can only act on the information that is available to them at the time* (recommendations f, g and i);

- the use of different forms to capture concerns about ‘vulnerability’ and ‘safeguarding’ obscured concerns and delayed action (recommendations b-e);
- the case highlights the need for partner agencies to be more aware of the significance of extreme opinions and or religious views held by individuals and the risks these may pose especially when concerns about violence, including domestic violence, have also been made (recommendations h and i).

They concluded that there was a systematic failure across the agencies responsible for safeguarding to address G’s longstanding mental health condition which they believe required attention as far back as 2011. His mental health deteriorated further in 2013 to the extent that G became a danger to himself and by 21st/22nd October also a danger to the public, resulting finally in the catastrophic incident. Despite failings by agencies the report writers praised the outstanding work of one police officer involved in the case.

The SCR report writers made ten recommendations which have been accepted by the LSAB. These are included here in full.

- a) Individual agencies should have a ‘first point of contact’ named individual responsible for actioning ‘Safeguarding’ concerns. This role should mirror the role suggested under section 14.101 of the Care and Support Statutory Guidance: Issued under the Care Act 2014 (DoH, 2014); [ALL]
- b) The process and forms utilised between the Police Force Public Protection Unit and the Safeguarding Systems in other agencies within the local health and social care geography should be made formal and explicit; [ALL – but should be led by LSAB]
- c) Prompt efforts should be made to develop a ‘common nomenclature’ to describe the work considered as ‘Adult Safeguarding’ in the main agencies working in this field. This should include a thorough review of policies/protocols and any systems of referral, paper or other that are commonly used by agencies. It is especially important to have consistent referral mechanisms, whether electronic or hard copy; [ALL but led by LSAB]
- d) The ‘Safeguarding’ structure in Luton should revisit how policies and procedures assist agencies to differentiate concerns of a ‘vulnerability’ nature from disquiets of a ‘safeguarding’ category (or adults at risk using Care Act nomenclature); [ALL but led by LSAB]
- e) The ‘Safeguarding’ structure in Luton should consider how multi-agency cooperation can be facilitated and enhanced; [LSAB]
- f) Police sharing of intelligence on extremism or religious extremism needs urgent consideration; [POLICE]

- g) Police agencies should evaluate their procedures for sharing intelligence and most importantly methods for allocation of accountability to act on this intelligence; [POLICE]
- h) Consider how the statutory agencies after 1st April might respond to concerns related to 'Safeguarding concerns', and overlaps with extreme opinions of an extremist or religious nature; [ALL, LSAB]
- i) Information sharing systems between all agencies connected with Safeguarding in Luton should be assessed for their 'Fitness for purpose'; [ALL led by LSAB]
- j) Mental Health Services should assess what mechanisms are in place to differentiate 'mental health sequelae of a religious presentation' from 'extremist religious opinions' found in an individual with 'other' mental health challenges. [note there is a growing literature in this area, for example see Borum, 2014]; [to be actioned by East London NHS Foundation Trust (ELFT) the new Mental Health Service Provider]

Are we making a difference?

In order to ascertain if safeguarding interventions are making a positive difference in people's lives, safeguarding officers are asked to discuss this with the person who is at risk of abuse. The safeguarding adult team has been involved with the Making Safeguarding Personal project implemented by the Department of Health. *"Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process". Making Safeguarding Personal Guide 2014.*

The Council is developing a quantitative recording mechanism based on customer satisfaction. Through case audits we also try to ascertain more qualitative information and will develop a short questionnaire to be sent to all service users at the end of the safeguarding intervention.

Case studies

Case Study 1: Mr. K

An Adult Safeguarding Concern was raised regarding emotional abuse and neglect in a Nursing Home towards Mr. K.

Mr K was deceased at the time the safeguarding alert was raised but it was decided to progress with an investigation as other people potentially could be at risk of abuse.

The background to the alert was that Mr. K was coming to the end of his life due to cancer and it was agreed with Mr. K and his family that he transferred from a hospice to a Nursing Home. Having selected a home of their choice Mr K moved in but within a few days the family were distressed at the quality of care being provided by nurses and carers. There were issues with moving and handling, transfers, staff attitudes, personal care not being attended to quickly enough and medication issues. Mr. K was eventually moved back into the hospice where he sadly died due to his illnesses.

A multi-agency investigation took place, which was led by the Safeguarding Adult Team. It involved social workers, Luton Clinical Commissioning Group, Care Quality Commission, East of England Ambulance Service, nurses, carers, Macmillan nurses' and care providers. Reports were compiled from each service provider to provide a chronological report of Mr. K's journey and the incidents that occurred along the way in order to analyse and identify what did not go well and what training or actions could be implemented to improve the communication and service delivery between the providers and the service users and families

A review of the actions taken was reviewed to ensure all the recommendations had been implemented.

The safeguarding investigation benefited other service users in the following areas:

1. Full multi-agency collaboration in order to determine what went wrong and the learning gained from the allegations made to ensure better quality of care for others.
2. Improved service delivery in terms of quality and maintenance of personal dignity and respect.
3. Family were able to fully participate in the investigation, they were kept informed at all times and were satisfied with the outcomes.
4. Processes, in terms of transfer from one care facility to another, are now more streamlined and take into account that families must be made fully aware of the differences of the care provided between hospice care and nursing home care.

The investigation found that neglect had occurred. A staff member was suspended during the investigation and subsequently dealt with through the care home's disciplinary procedures. The staff were also provided with additional training to address issues of moving and handling.

Case Study 2: Mrs D

Mrs D is a widow. Her husband had been managing all the financial affairs before he died. He had also been her carer, due to her disabilities.

Mrs D was referred by a care agency as a result of alleged financial abuse by her support workers and personal assistant (PA). The support workers were providing personal care and her PA was employed for shopping and household chores.

Mrs D reported that she had lost £600, in addition to the £10 - £30 she was losing on regular basis.

Mrs D agreed to a safeguarding investigation which established that the PA had access to all Mrs D's finances, bank card and pin number and that there was no accountability as to how her money was being spent. It further transpired that a support worker was also taking advantage of the fact the Mrs D did not have control over her own finances. The investigation involved liaising with the police, bank and care agency and included holding a strategy meeting to agree a way forward.

The safeguarding investigation resulted in a referral being made to Luton Borough Council safe custody team as a protective measure for Mrs D's finances. Mrs D agreed to this because although she could manage small amounts of money she realised that she needed assistance with the other more complex money management around paying bills etc. A new PA who has excellent references is now employed by Mrs D. The social worker has arranged for her shopping to be done regularly and for Mrs D to have a regular allowance so that she has more autonomy with how her money is spent. These measures have reduced the risk of financial abuse from others and improved Mrs D's quality of life.

There is an on-going investigation by the police as this case may lead to a criminal prosecution. Mrs D has provided a statement to aid the investigation. The support worker will be subject to internal disciplinary proceedings once the police investigation has concluded. The PA is no longer employed and is also subject to a police investigation. Referrals have not yet been made to the Disclosure and Barring Service as the police investigation has not yet been completed

Mrs. D from the onset declined the involvement of advocacy support but opted for her social worker to play a key role. The local authority has been advised to ensure that as part of the care plan review process, social workers scrutinise financial information and take steps where there are discrepancies.

Case Study 3: Mrs H

Mrs H lives in a Luton care home and is funded by another local authority. Her nephew had been dealing with her finances but the safeguarding alert raised detailed that he was not paying her financial care contribution or giving her any personal allowances. She had no toiletries, nor money to pay for hairdressing, clothes or any other items that she might need or want. When first seen by the safeguarding officer, she was dressed in mismatched, worn out clothing.

The Social Worker completed a mental capacity assessment which confirmed the findings of an earlier one. This assessment established that Mrs H did not have capacity to understand or manage her finances. The safeguarding enquiry revealed that Mrs H's nephew had not been coping with managing his Aunt's finances and had struggled to access appropriate support. A best interest decision was made in which it was agreed (following the Safeguarding Social Worker's recommendation) that the placing local authority took over responsibility for Mrs H's finances, securing her placement so she can remain in the care home as is her wish. Mrs H's personal allowance is made available to her so she can buy new clothes, have her hair done and have toiletries of choice.

Mrs H has capacity to make choices regarding her personal appearance and previously had taken a pride in her appearance. An additional positive outcome is that prior to the safeguarding enquiry, Mrs H's nephew has stopped visiting his Aunt as he was worried about being approached about the monies. This was unfortunate as he had been her only visitor. He has now resumed his relationship and visits on a regular basis.

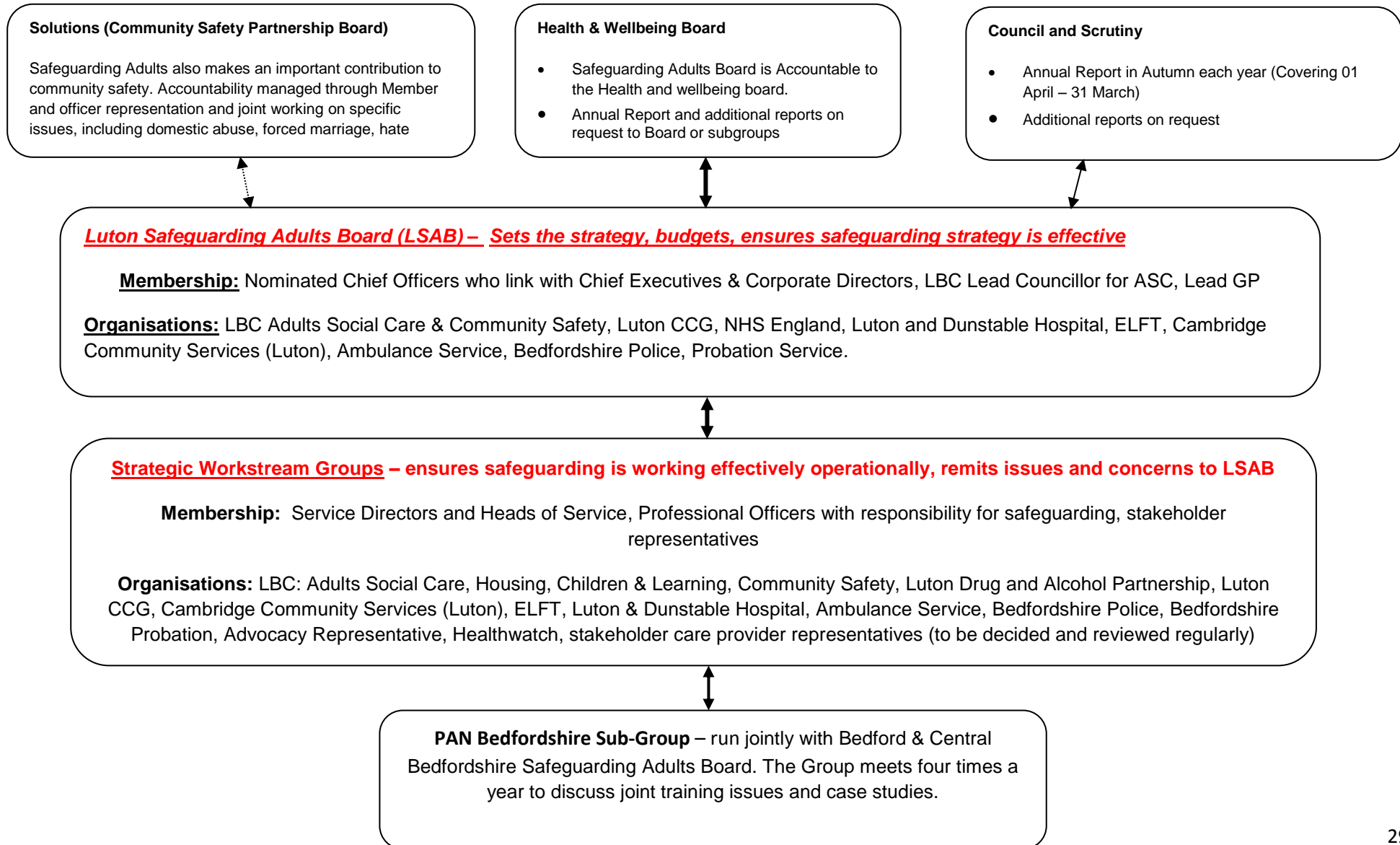
Case Study 4: Mr S

Mr S lived in his own property in Luton. A range of services were attending providing personal care and nursing care, but none were making effective reports or referrals over the uninhabitable state of the property. It appeared that various services including, care agencies, district nurses and mental health services, made the assumption that someone else was dealing with the issues of the property. They were also focussing narrowly on their individual remit without considering either the effect the environment was having on Mr S or his ability to manage his living environment.

Mr S had a history of poor physical and mental health including heart failure, diabetes and paranoia. At the point of referral his mental health had deteriorated resulting in him being admitted to a mental health unit under section 2 of the Mental Health Act 1983. The Police were called to assist with this. A referral was made to the Luton Borough Council safeguarding adult's team by an Adult Mental PH on the day Mr S was admitted.

The safeguarding investigation brought agencies together and clarified roles and responsibilities. An environmental health notice was served on the property and a short stay accommodation was arranged for Mr S following his discharge from hospital. Arrangements are in place to have the property cleared, repaired and restored back to a habitable standard. A Capacity assessment concluded that Mr S did not have capacity in this regard to 'state' of property and the potential impact of this on his health and so a best interest decision was made. The aim is for Mr S to return home as is his wish and to be supported in maintaining his mental health. The future care plan will need to accommodate provision for maintaining the environment. It has been arranged for Environmental Health to visit to complete essential clearing and repairs. Mr H is being supported now by a SW in one of our Community Teams to oversee on going issues re property repair and is carrying out regular capacity assessments in regards to this.

Appendix 1: Luton Safeguarding Adults Board – Structure and Accountabilities



Strategic Work Streams

The various work streams of the Board have been established to provide for continuous learning and development of practice in relation to the Board's Vision and Strategic Aims. Although these form separately identifiable workstreams, each is influenced by the others, and are coordinated and held accountable through the Board governance, leadership and partnership arrangements.



Appendix 2: Partner Reports

The statutory partners on the Board now present quarterly reports to the Operational Board and also produce a summary statement for the annual report. Several of the partners for example the Luton and Dunstable Hospital, the Mental Health Trust – South Essex Partnership Trust (SEPT), Ambulance Service, the Police and Probation Service are also members of the Joint Bedfordshire Safeguarding Adults Board, which is one of the drivers for closer working across Bedfordshire. The reports are included below in the following order:

- Luton Clinical Commissioning Group/NHS Luton
- Cambridge Community Services (Luton)
- The Luton and Dunstable Hospital
- East of England Ambulance Service NHS Trust
- South Essex Partnership Trust (SEPT)
- Bedfordshire Police
- Bedfordshire Fire and Rescue
- Advocacy Service – POhWER

Highlight report of key issues arising during 2014-15

Introduction

This annual report for Adult Safeguarding is produced to reflect on the progress in Adult Safeguarding in Luton Health System between April 2014 to March 2015

CCGs are statutorily responsible for ensuring that the organisations, from which they commission services, provide a safe system to ensure all adults are safeguarded.

One of LCCG'S values is to ensure we will act to safeguard the vulnerable and reduce inequalities. This value remains at the heart of all our commissioning planning and decision-making. We work in partnership with all agencies in Luton to achieve this and ensure that all Health providers commissioned by LCCG understand their role in the health and wellbeing of vulnerable adults.

As part of authorisation the CCGs have to demonstrate that there are appropriate systems in place for discharging their responsibilities in respect of safeguarding, including;

- Plans to train their staff in recognising and reporting safeguarding issues.
- A clear line of accountability for safeguarding reflected in their governance arrangements.
- Appropriate arrangements to co-operate with local authorities in the operation of LSAB,
- Ensuring effective arrangements for information sharing and working with key partners from providers and the local authority.

This report will update on the processes implemented within LCCG to ensure these responsibilities are met.

Governance

Adult Safeguarding is a statutory function and the responsibility is held by the Director of Quality and Clinical Governance who is also the representative for Luton CCG on Luton's Adult Safeguarding Board (LSAB).

The Designated Nurse and Doctor for Adult Safeguarding are line managed by the Director of Quality and Clinical Governance with the designated nurse also attending the LSAB.

The Head of Adult Safeguarding was a member of the Luton Safeguarding Operational Adult Board, which from April has been taken over by Work streams which was identified in the board's vision and strategic plan, the work streams will be chaired by different agencies from the board and will consist of:

- Governance, Leadership and partnership.
- Policies, protocols and procedures.
- Emerging Issues.
- Training and workforce Development.
- Communication and community Engagement.
- Safeguarding adults review and professional practice.

- Performance audit and quality assurance which the director of clinical governance for the LCCG will be chairing with the co-chair being the designated nurse for LCCG

LCCG reports to the LSAB regularly and has submitted four reports this financial year. Monthly reports are submitted to LCCG Patient Safety Quality Committee (PSQC), which is a responsible sub-committee of the LCCG board safeguarding vulnerable adults.

The Key Health Professionals and Adult safeguarding Leads across Luton meet Quarterly with the Head of Adult Safeguarding and Designated Nurse chairing the meeting to ensure good partnership working and communication providing a forum to share learning and actions from the multidisciplinary team (MDT).

The Designated Nurse receives supervision and peer support from the Professor for Leadership and Adult Safeguarding at the University of Bedfordshire. As well as the Head of Adult Safeguarding giving supervision to the three main providers Safeguarding Lead the Luton and Dunstable Hospital, (L&D) CCS, ELFT.

Professional development is ongoing with the Designated Nurse and has attended training on:

- Sexual exploitation
- Prevent Trainer the Trainer WRAP
- Making Serious Case Reviews (SCR) Work
- Annual Safeguarding conference university of bucks
- Mental Capacity Act and consent conference specifically for the role of CCG'S leads
- 2 day Hydra Event for PREVENT
- FGM workshop
- Care Act and Responsibilities of the CCG'S

Improvements made in adult safeguarding during 2014-15

Prevention and raising awareness

Training

A seven month programme, one day every month was undertaken which started in May 2014 in conjunction with the Luton and Dunstable Hospital and the University of Bedfordshire for Adult Safeguarding leaders who become Champions. We had funded for 30 participants to attend which was 15 from the Acute Trust and 15 from the Community. There was a representative from 6 out of the 7 nursing homes within Luton, Continuing Health Care, and Safeguarding Lead for Cambridge Community Service, drug and alcohol worker, District Nurse, Community Matron, and the CCS Safeguarding Lead, Health Watch. The course focused on the principles of adult safeguarding, using clinical examples, to highlight high impact actions and harm prevention. The programme aimed to:

1. Strengthen leadership in safeguarding adults within health services and multi-agency partnerships
2. Support effective implementation of national and local multi-agency guidance
3. Influence and achieve sustained improvements in care and practice to safeguard adults at risk
4. Influence and improve existing adult safeguarding policy and practice within employing organisations
- 5.

The days included:

- Advanced Safeguarding within clinical practice, Care Act
- Mental Capacity Act / Mental Health Act
- Deprivation of Liberty Safeguards
- Consent
- Dementia
- Learning Disabilities
- Domestic Abuse (MARAC) (MAPPA)
- Serious Case Reviews
- Legal and Ethical Aspects of Safeguarding
- Communication and Leadership
- PREVENT
- Discharge Planning
- Real Life patient stories
- PREVENTION!!!

This course was a great success with great presentations and projects which has led for another course to be starting in September 2015 again with the Luton and Dunstable Acute Trust and the University of Bedfordshire.

Joint Training with the Children's designated nurse for GP practices in Luton was embedded in 2014 and future dates in the future to also in co-operate the MCA and DoLS Lead.

Gelifish

Gelifish is the Web portal for all LCCG staff which is accessed by commissioning and primary care staff including Luton General Practitioners (GP).

There is an Adult Safeguarding site with the information reviewed regularly to ensure it is accurate and up to date all new legislation, policies, processes is also emailed out separately to all providers and the Safeguarding Champions in the community.

Workforce Development

MCA/DOLS

March 2014, the Supreme Court delivered a judgement in relation to conjoined appeals of "Cheshire West" and "P & Q". The precedent created has significantly widened the definition of deprivation of liberty. In short, it is now clear that if a person lacking capacity to consent to the arrangements, is subject both to continuous supervision and control and is not free to leave, they are deprived of their liberty. This has significantly widened the definition of deprivation of liberty and it is clear that people living in domestic and supported living arrangements are now also potentially subject to DOLS.

NHS England has secured 6.1 million pounds for the system to deliver the House of Lords Inquiry into MCA.

In line with the recommendations NHS England Hertfordshire and South Midlands Area team have supplied each CCG with a sum of money to support MCA and DoLS development in their area.

In order to monitor the impact of this funding the following outputs will be required from each area at the end of the financial year. This will enable NHS England to demonstrate our contribution to the Government's plan as well as ensuring value for money:

- Submission of a self-assessment summary report from each CCG for the period 2014/15. This report will give an assessment of the extent to which MCA is complied with within their geographical area and be discussed and signed off by the CCG Director of Nursing. This will include reference to any evidence used to reach this conclusion and any gaps or proposed future activity for 2015/16. This will take into account the views of relevant stakeholders across the local system.
- Submission of a case study from the CCG for sharing through the national programme – this should highlight MCA good practice in implementing the least restrictive option.
- Numbers of health professionals trained as Best Interest Assessors in 2014/15 for each CCG area

LCCG and BCCG have jointly recruited an MCA and DOLS Lead to cover the three Boroughs, the first priority will be to ensure all GP'S are sufficiently trained and competent in MCA and DOLS. The new Lead commenced work on the 1st June 2015 with a month's induction period and will meet the appropriate organisations and individuals.

Also under the Care Act, any assessment of people's needs must take account of how their needs may fluctuate over time including fluctuating of capacity. This includes assessment of carers' needs and how professionals can take full account of the extent of fluctuating needs. The issues to consider when assessing fluctuating Capacity the new lead will be ensuring this is communicating across the three regions.

Partnership working

Medication

The Head of Adult safeguarding has worked with BCCG developing a policy in regards to covert medication including the MCA act this has been signed off and shared with all the appropriate people/ agencies and been placed on Gelifish

Domestic Abuse / Multi Agency Risk Assessment Conference (MARAC)

Over the last 12 months there has been a consistent rise in referrals to MARAC from both the Police and the non-police agencies. This has coincided with a restructure within Beds Police which now means front line officers complete the Domestic Abuse, Stalking and Harassment) - Risk Assessment (DASH). Nationally most police areas have experienced increases in MARAC cases when this model is adopted.

| Indicator | 2014/15 | 2013/14 |
|--|----------------|----------------|
| Number of referrals to MARAC cases (high level domestic abuse) | 507 | 365 |

During this past year a process has been put into place to request information from GPs to contribute to the MARAC where possible. However, at times information isn't shared quickly enough from MARAC as the GP'S need this information through a secure email which can

take longer and be a resource issue from MARAC the designated Nurse for Children is taking the lead for this concern.

The first Bedfordshire Domestic Abuse Scrutiny Panel was held on Monday 9th February 2015 at Bedfordshire Police Headquarters. A wide variety of police resources were in attendance and five cases were selected for review. They focussed on the victim pathway and it was facilitated by Safe Lives (formally CAADA). A synopsis of the review is due which will highlight any recommendations resulting from the panel alongside a summary of good practice and challenges in each individual case. Further scrutiny panels shall be scheduled in due course and will focus on the end to end process with an emphasis on partnership working which will include health.

The designated nurse is part of the MARAC group and specifically asked to attend if there is Health related issues.

Prevent

Prevent strategy aims to stop people becoming terrorists or supporting terrorism and to prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.

To work with sectors and institutions where there are risks of radicalisation that we need to address. Prevent is part of existing safeguarding responsibilities for the health sector, not an additional job. Healthcare workers have the opportunity to refer vulnerable individuals for support in a pre-criminal space by:

Recognising vulnerable adults, children and young people who may be at risk of radicalisation;

Working in partnership to reduce risk and protect the individual and the Designated nurse attends the prevent forums and sits on the CHANNEL panel which has gone from Bi-Monthly to Monthly with an escalation of alerts There are three tiers to PREVENT and Luton is in tier two making Luton a priority area and now as a priority area we report directly to London region (NHS England) Edward Farrell who is the Prevent Manager instead of East Midlands/East of England. All providers and GP'S are aware of this change which changed in the beginning of April 2015.

The role within the group is for information sharing with colleagues within the other agencies and to ensure that any vulnerable patients are identified and provided with the necessary support to prevent radicalisation occurring it is to give adequate and necessary support as part of a proportionate multi-agency partnership.

Channel

Channel is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorist-related activity.

The process forms a key part of the Government's Prevent strategy. Channel works in a similar way to existing successful partnership initiatives which aim to safeguard individuals who are vulnerable and protect them from harm, such as initiatives concerned with drugs or involvement in knife and gun crime. The process provides a mechanism for safeguarding

vulnerable individuals by assessing the nature and extent of the potential risk they face before they become involved in criminal activity and, where necessary, provide a support package tailored to an individual's needs. Terrorism is a very real threat to all our communities and terrorists seek to exploit those who are most vulnerable. That is why it is vital that we all work together to support those who are at risk of radicalisation – regardless of faith, ethnicity or background.

Channel is about working together to support vulnerable individuals at an early stage and providing them, where appropriate, with advice and support to divert them away from terrorism.

| | |
|------------------------------------|----------|
| Channel Figures | 22 cases |
| Prevent Figures – since April 2014 | 70 cases |

As to the figures for Channel, we go by calendar year and we had 22 in 2014 and we are up to 10 for this year, but would be expecting an increase due to the new legislation and the on-going training it has entailed across all statutory agencies.

Since April 2014 we have had 70 separate Prevent cases, and this would seem to match the historic cases of prevent having about three times the number of referrals than Channel, though more of these cases may come into the Channel arena now we have the joint meetings.

Joint working with Children safeguarding

Forced Marriage

Statutory guidance “The Right to Choose” originally issued under s.63 Q (1) of the Family Law Act 1996. The statutory guidance is different to the multi-agency practice guidelines in that it provides advice and support to all frontline professionals who have responsibilities to safeguard all adults, with or without learning disabilities from the abuses associated with forced marriage.

It also outlines the responsibilities of Chief Executives, Directors and designated professionals within those agencies involved with handling cases of forced marriage.

It also covers issues such as staff training, developing inter-agency policies and procedures, raising awareness and developing prevention programmes through outreach work. This has been updated to Gelfish and all safeguarding leads and champions

Operation Boson / Tackling Serious Youth Crime Meetings

The Designated Nurses for Children and Adults are part of the Operation Boson meetings as a spokesperson for health. The Designated Nurse's attend monthly meetings and take actions back into the provider's organisations. The group evolved and included representatives from health agencies and became the Guns and Gangs Coordination Meeting from January 2014 now called Tackling Serious Youth Crime.

Operation Boson continues but the Tackling Serious Youth Crime Coordination Meeting has a wider remit looking towards protecting the local community, engaging with community groups and working towards preventing young people from engaging in violence and gang activities.

It is a statutory requirement for the Luton & Dunstable University Hospital Emergency Department to share basic anonymous information regarding gun and knife crime with the police as part of a public health approach to violence prevention in England.

There are two objectives to this concern about gangs and violence:

1. To ensure the Operation Boson objectives are met to maintain community safety and deal with the known nominal.
2. To consider future progress on the public health approach to violence prevention in Luton by improving on data collection and closer working between health and the Community Safety Partnership.

The Panel at the meeting has developed a clearer way of working in that there are assigning leads to the priority areas. The Head of adult safeguarding is the lead for mental health as CCG is part of a statutory group. The role includes:-

The cross-cutting themes are identified issues that feature in many of the plans, and the thinking behind having a 'lead' for each is that that person is likely to have the knowledge or expertise in:-

- How mental health links with the priority areas (i.e. how mental health impacts on domestic violence, ASB, hate crime, alcohol related crime and disorder, sexual exploitation, SYV) – and if not known, identifying how we may be able to get this information and liaise with the appropriate people and update the safeguarding boards.
- Being a general contact for the priority leads to find out how/ where they can link into issues of mental health and how this should be tackled.

Quality assurance

Quality Schedules for Providers

As part of the commissioning process Quality Schedules are included in contracts, to ensure good data flow and compliance to the required standard. The Designated Nurse monitors the adult safeguarding aspects quarterly, for all main health service providers; Luton & Dunstable University Hospital, Cambridgeshire Community Services (CCS) East London Foundation Trust (ELFT)

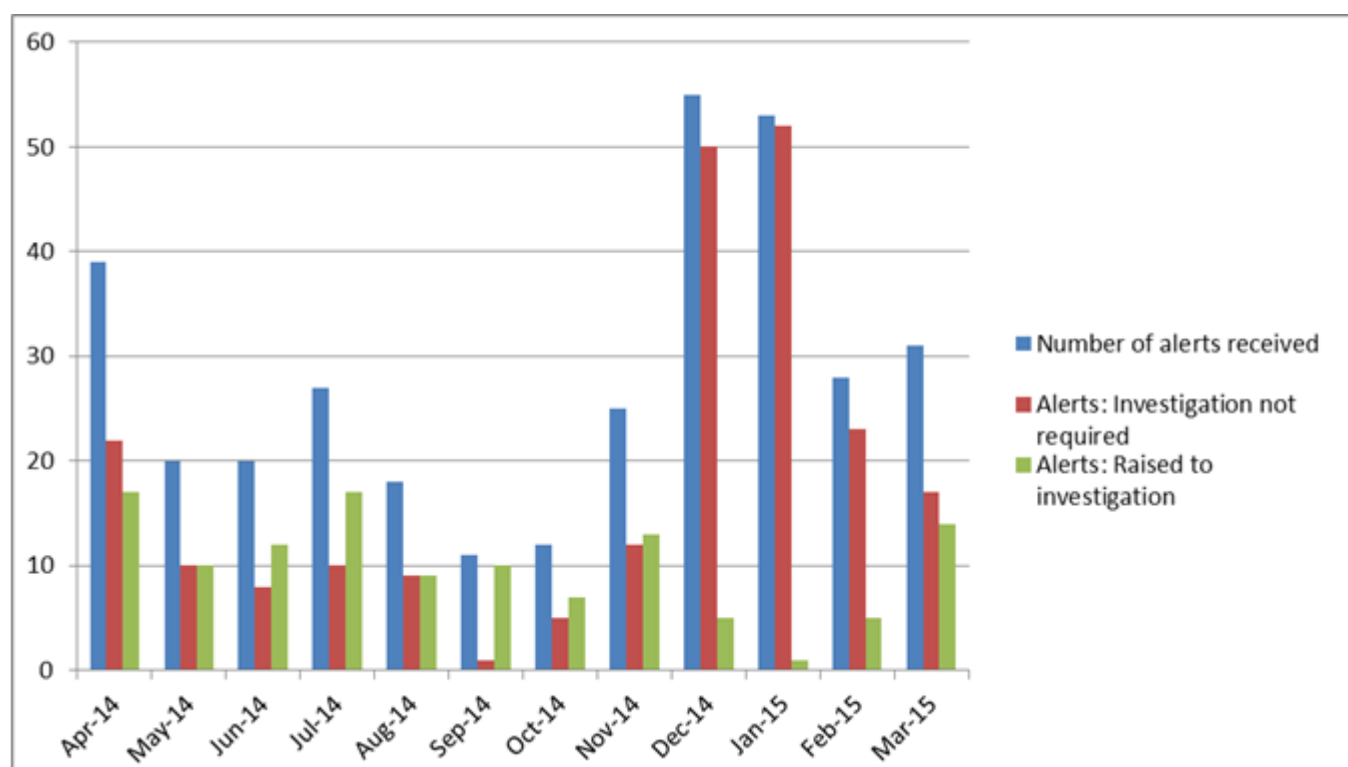
Safeguarding Data

As part of the work as a Commissioner it is to ensure learning across the NHS. All the health related safeguarding alerts are scrutinised by the Head of Adult Safeguarding to identify any themes and trends. This facilitates proactive work to ensure learning is shared across the health system and with key partners. The themes and trends are also reported to PSQC who challenge on learning and embedding of any required service changes. The providers demonstrate learning and service change at the Quarterly Quality Meetings which are a requirement of the contract and Adult Safeguarding is a standing agenda item.

The following data is based on alerts received by and against L&D, CCS, ELFT (formerly SEPT), Nursing Homes as well as sectors including Ambulance service, Beds Police and Care Agencies.

Table 1: Safeguarding Alerts April 2014 - March 2015

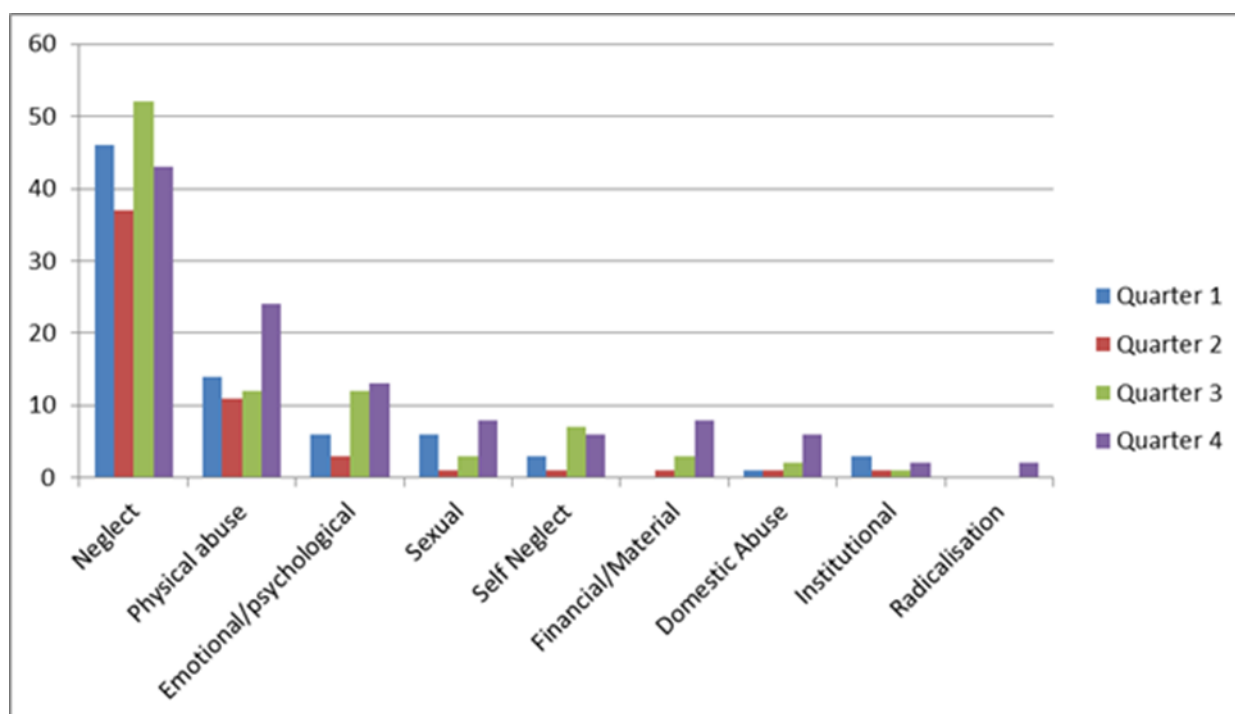
| | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 | Total |
|-------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| Number of alerts received | 39 | 20 | 20 | 27 | 18 | 11 | 12 | 25 | 55 | 53 | 28 | 31 | 339 |
| Alerts: Investigation not required | 22 | 10 | 8 | 10 | 9 | 1 | 5 | 12 | 50 | 52 | 23 | 17 | 219 |
| Alerts: Raised to investigation | 17 | 10 | 12 | 17 | 9 | 10 | 7 | 13 | 5 | 1 | 5 | 14 | 120 |
| Alerts: Partially Substantiated | 2 | 1 | 2 | 2 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| Alerts: Substantiated | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| Alerts: Unsubstantiated | 7 | 1 | 2 | 3 | 1 | 1 | 4 | 4 | 0 | 0 | 0 | 2 | 25 |
| Alerts: Not determined/inconclusive | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 4 |



In the months of December 2014 to February 2015, alerts had increased vastly as all alerts including non-health related alerts were being received by the LCCG. For the period between December 2014 and February 2015; more than 50% of the alerts received were not raised to a safeguarding investigation which included alerts received by Beds Police for Domestic Abuse alongside self-neglect alerts. In the month of September 2014; 10 alerts out of 11 were raised to a safeguarding investigation and 1 alert was partially substantiated and 1 alert was fully substantiated.

Table 2: Types of primary abuse for Quarter 1 – 4 (April 2014 - March 2015)

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total Abuse |
|-------------------------|-----------|-----------|-----------|-----------|-------------|
| Neglect | 46 | 37 | 52 | 43 | 178 |
| Physical abuse | 14 | 11 | 12 | 24 | 61 |
| Emotional/psychological | 6 | 3 | 12 | 13 | 34 |
| Sexual | 6 | 1 | 3 | 8 | 18 |
| Self Neglect | 3 | 1 | 7 | 6 | 17 |
| Financial/Material | 0 | 1 | 3 | 8 | 12 |
| Domestic Abuse | 1 | 1 | 2 | 6 | 10 |
| Institutional | 3 | 1 | 1 | 2 | 7 |
| Radicalisation | 0 | 0 | 0 | 2 | 2 |



Neglect has been the main category for safeguarding alerts received into LCCG since April 2014 followed by physical abuse and emotional/psychological abuse. For the period April 2014 - March 2015, there was an increase in the referrals for financial abuse and domestic abuse.

Within the category of neglect there are four main themes these are:

- Pressure Damage
- Inappropriate discharge/L&D
- Nursing Homes
- Medication errors

Mental Health Services Alerts

Alerts have appeared to be raised against two particular wards in every quarter.

Human Trafficking

Two alerts were raised in quarter 3 in relation to human trafficking and these alerts did go to safeguarding investigation and the police are leading on these.

Discharges

The Head of Adult Safeguarding meets with the Lead for Adult Safeguarding and the Integrated Discharge Manager at the Hospital bi-monthly to discuss any issues regarding discharges. This monitors themes and patterns and taking appropriate learning and actions is evident that this is a real positive approach. Learning which have come from this is communication within all disciplines have steadily improved joined up working within multidisciplinary teams to ensure that everyone is sharing assessment and are aware of any issues for a safe discharge. This was also used as a project with the safeguarding champion's course with a community nurse and a nurse from the acute trust which showed good transparency between the both. This project has been shared to other areas.

LCCG Quality Assurance

The LCCG Quality Team are reviewing and supporting providers with site visits. This was welcomed by the providers and is communicated with the CQC and the LBC Quality Assurance Team to ensure there is no duplication of visits. The reports are also share with the appropriate people to ensure transparency and urgent meetings are held with all organisations if there is any concerns or issues from the site visits.

Nursing Homes

In Luton we have 7 Nursing homes run by a range of different Providers.

A quarterly meeting has been implemented to discuss Safeguarding concerns and preventative work chaired by the Head of Adult Safeguarding LCCG. The first meeting was well received with all the managers attending. There were lots of discussions, good outcomes with good actions and it was agreed by Nursing Home Managers to be recurrent quarterly meetings. From this there has been a vast amount of work with the acute trust nursing homes and GPS regarding admittance to hospital and the patients discharge.

A verbal feedback is given monthly regarding all nursing homes at the monthly PSQC and a written report quarterly is also provided.

GP'S

All practices now are CQC registered with inspections underway. Around 85% of GP'S in Luton are on System One. The Safeguarding Template for System One has also been launched by the Named GP for Adult Safeguarding.

The Head of Adult safeguarding has ensured GPs are updated with information via the intranet Gelifish as the portal for information relating to Adult Safeguarding, the final guidance for the Care Act was shared and followed up with an email and been incorporated into their training that is being delivered verbally. There are good links between GPs and the CCG Safeguarding Office/Designated Nurse with invitations to the practice managers' meetings. Queries raised by GPs are either answered by the Head of Adult Safeguarding or by the Named GP for Adult Safeguarding. Joint training workshops for safeguarding adults and children have been implemented.

Safeguarding sharing information contact list has been sent out to ensure GP'S are aware who to signpost patients to appropriately, this has also been implemented into the adult safeguarding and children's training. Reviews of patient management by GPs in specific

adult safeguarding cases are carried out by the Named GP for Adult Safeguarding in conjunction with the Head of Adult Safeguarding and the local authority and the Local NHS Area Team.

Improvements planned in adult safeguarding during 2015-16

CARE ACT

The Care Act 2014 which came into force from April 1st 2015 has adopted a much more personalised and outcome-focused approach. This approach to adult safeguarding grounded in good social work practice and delivered with partners, is about the person rather than the process. We know that procedurally driven arrangements can disempower the professional as well as, most importantly, the adult themselves and their friends and family.

Changes

The changes that needed to be in place by April 1st 2015, included a Safeguarding Adult Board (SAB) as described in the Act, information sharing agreements between agencies, Designated Adult Safeguarding Managers, arrangements for the provision of advocacy and an agreed process for carrying out Safeguarding Adults Reviews. Most of these were already in place but will develop and improve over time as agencies gain experience and confidence in the new arrangements. The Head of adult safeguarding and designated nurse is the named Designated Adult safeguarding Manager for the LCCG.

The fundamental shift however revolves around professional practice; practice that puts the adult and their wishes and experience at the centre of safeguarding enquiries and which seeks to enable people to resolve their circumstances, recover from abuse or neglect and realise the outcomes that they want. This is why we keep reiterating that this “is not business as usual”. We know that this shift has already started in many places, often supported by the Making Safeguarding Personal programme being led by ADASS and LGA. That practice too will grow and evolve over time and we will need to ensure that is disseminated and used to inform future support, on training, Making safeguarding personal was imbedded within Luton In March 2015 which is being led by Luton Borough Council and jointly worked with other agencies including LCCG.

However, culture change is always more difficult to achieve in reality than it is to talk about. In recognition of that, we thought it timely to offer a steer about how a personalised approach should be articulated and designed at a local level. A working group has been developed which the designated nurse is part of.

To look at Making Safeguarding Personal, values, standards and guides, roles, responsibilities and accountabilities, and that it is proportionate to any concern. At the heart of this will be engagement and interpersonal skills, the use of a range of social work and legal actions that arrive at the outcomes the individual wants.

Safeguarding under the Care Act is not about the quality of health and care services; providers have the primary responsibility for this, with commissioners (LCCG) providing external challenge and review and CQC ensuring that the fundamental standards are met and taking enforcement action as necessary.

That is not to say there is not a role for the local authority or social workers where care services are poor, particularly in supporting the adult(s), families and reviewing care plans. However, Safeguarding Adults Boards (SAB) has a much broader strategic role than those covered by operational section 42 enquiries. They will provide challenge and hold partners to account across their localities, including services that are commissioned by the NHS and private individuals as well as those commissioning services. SABs will have a strong

interest in where services are failing to protect people from abuse or neglect and in what remedial action is planned / taking place. SABs will want to be assured that improvements take place and are sustained over time which the Director of Quality and Clinical Governance attend and the head of adult safeguarding and designated nurse also attend. Also part of the care act is Self-Neglect and the designated nurse is part of a working group of taking this forward with the new MCA and DoLS lead and are both working with the fire service regarding Hoarding.

Cambridge Community Services (Luton)

Highlight report of key issues arising during 2014-15

Implementation of Care Act 2014

Lessons Learned

Policy Review

Information Sharing

PREVENT agenda

Improvements made in adult safeguarding during 2014-15

Prevention and raising awareness

- Training Package updated and enhanced to reflect changes within the new care act and highlight emerging trends, such as domestic abuse, sexual exploitation and modern Slavery.
- Raising awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards at each training session and discussion as to how this can be implemented into practice.
- Notice boards in all staff areas updated to reflect current information.
- Intranet pages for safeguarding updated to reflect current reporting requirements and latest information regarding the Care Act 2014
- Contribution to CCS communications cascade newsletter.
- All staff required to attend PREVENT awareness training at corporate induction, training package developed and implemented.
- Bespoke training package for inpatient unit provided.
- Named Nurse attending individual team meetings
- Joint working with Children's Services to raise awareness of female genital mutilation and sexual exploitation.

Workforce Development

- Implementation of Safeguarding Supervision sessions for all staff to attend if required. 1.5 hour session alternate months, to discuss any experience regarding safeguarding issues staff would like to reflect on and explore with colleagues
- Implementation of self-neglect surgery sessions to enable staff to discuss concerns and management plans of those hard to engage individuals.
- Implementation of lessons learned feedback sessions.
- Provided attendees to Safeguarding Champions course, now completed and Champions integrated into workforce.

Partnership working

- Named Nurse attendance at the following partnership forums:
- LSAB Ops Board- Providing reports. Issues regarding information sharing discussed and actions implemented.
- Safeguarding and Prevention meeting- Meeting in person to resolve issues related to care providers, Process agreed and undertaken. Providing monthly report regarding incidents reported to CCS regarding care homes and care agencies.
- Integrated Patient Safety Group, Sharing learning and group discussion.
- Care Bill implementation Group – Discussion and actions in relation to the implementation of the Bill and subsequent Act. Now dissolved.
- Tackling Serious Youth Crime- Information sharing and attendance at meetings, now attended by Kerrie Ward.
- MARAC- Information Sharing

- Chanel Panel- Information Sharing and attendance at meetings.
- Information Sharing Group- development of protocols.
- Attendance at LSAB business planning away day
- Improved links with Learning Disabilities Services.

Quality assurance

- Provision of new CCS Adult Safeguarding Policy, awaiting ratification and implementation.
- CQC self assessment audit undertaken.
- CQC inspection
- Completion of Pan London audit tool.
- Named Nurse Adult Safeguarding has attended the following:
 - Safeguarding Champions Course
 - Root Cause analysis training
 - Challenging Conversations training
 - Safeguarding Management responsibilities
 - Safeguarding Initial Investigations
 - Health Wrap- Train the Trainer
 - Responding to Concerns
 - Administration of Medication
 - Domestic Abuse training
 - Financial and Material Abuse training.
 - FGM training
 - Safeguarding investigators training
 - All Mandatory training up to date.
 - Annual appraisal completed
 - Conferences Attended – Action on Elder Abuse/ Patient Safety/ Making Safeguarding personal

Annual training figures – Please see attachment

Improvements planned in adult safeguarding during 2015-16

- Implementation of Safeguarding Audits to support quality assurance
- Providing lessons learned events to whole organisation
- Introduction of more Safeguarding Champions within the organisation
- Focus on making safeguarding personal
- Focus on Communication and Public Engagement - LSAB Sub Group

**2014 - 2015 SystemOne Annual Report –
Adult Safeguarding**

* Data still outstanding from LBC.

| | Apr 14 | May 14 | June 14 | Jul 14 | Aug 14 | Sept 14 | Oct 14 | Nov 14 | Dec 14 | Jan 15 | Feb 15 | March 15 |
|--|-----------|-----------|------------|-----------|-----------|------------|-----------|-----------|-----------|-----------|-----------|-------------|
| No of alerts raised against LCS: | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 3 | 2 | 0 | 0 | 3 |
| Types of Abuse: | | | | | | | | | | | | |
| Neglect | | | | 1 | | 1 | | 3 | 2 | | | 2 |
| Physical | | | | 1 | | | | | | | | |
| Institutional | | | | | | | | | | | | |
| Discriminatory | | | | | | | | | | | | |
| Emotional/Psychological | | | | | | | | | | | | |
| Sexual | | | | | | | | | | | | |
| Financial/ Material | | | | | | | | | | | | |
| No of alerts against LCS: Substantiated | | | | | | | | | | | | |
| No of alerts against LCS: Not Substantiated | | | | | | 1 | | 3 | | | | |
| No of alerts against LCS: Partially Substantiated | | | | | | | | | 1 | | | |
| No of alerts against LCS: Did not meet threshold | | | | 2 | | | | | | | | 2 |
| NFA from Adult Safeguarding Team/ Information only | | | | | | | | | 1 | | | 1 |
| No of alerts raised by LCS staff | 16 | 6 | 10 | 11 | 12 | 10 | 10 | 14 | 10 | 10 | 14 | 9 |
| Types of Abuse: | | | | | | | | | | | | |
| Neglect | 9 | 4 | 5 | 6 | 9 | 7 | 7 | 10 | 7 | 5 | 11 | 4 |
| Physical | | 2 | 4 | 2 | 1 | 2 | 2 | 2 | 2 | 3 | 1 | 3 |
| Institutional | 3 | | | 2 | | | | | | | | |
| Discriminatory | | | | | | | | | | | | |
| Emotional/Psychological | 2 | | | | 1 | | 1 | 2 | | 1 | 1 | 2 |
| Sexual | | | | | | 1 | | | | | | |
| Financial/ Material | 2 | | 1 | 1 | 1 | | | | 1 | 1 | 1 | |

| | | | | | | | | | | | | |
|---|---|---|---|----|---|---|---|----|----|----|---|----|
| No of alerts raised by LCS: Substantiated | | | 2 | * | 1 | 3 | | 1* | * | * | | * |
| No of alerts raised by LCS: Not Substantiated | 6 | 2 | 1 | 1 | 1 | 4 | | 3* | * | * | | 1* |
| No of alerts raised by LCS: Partially Substantiated | 1 | | 1 | 1 | 4 | 1 | 1 | 3* | 1* | * | 3 | * |
| No of alerts raised by LCS: Did not meet threshold | 5 | 3 | 5 | 7* | 3 | 2 | 8 | 4* | 3* | 2* | 5 | 1 |
| Information only/ NFA from Adult Safeguarding Team | 4 | 1 | | * | 2 | | 1 | 2* | 3* | 5* | 6 | 1 |
| Inconclusive/ Not determined | | | 1 | * | 1 | | | * | 1* | | | |

Updated 01/07/2015

Yellow - No information available from LBC at this time

Lessons Learned and actions from Safeguarding referrals made in 2014/15 against CCS Luton

- Lack of knowledge in regard to pressure ulcer care- Review of training and competencies in wound and pressure area care underway
- Omissions in Record Keeping- Review of record keeping and implementation of rolling training programme. Review of electronic recording system to and improvements made to support record keeping.
- Ineffective leadership within teams- Review of Leadership and structure within the teams. New structure currently being implemented.
- Failures in communications- Review of electronic recording system to and improvements made to support communication. Feedback sessions implemented to inform staff of safeguarding issues, serious incidents and complaints.

Luton and Dunstable Hospital NHS Foundation Trust

1. Local priority: Prevention and raising awareness

National priority: Prevention - It is better to take action before harm occurs

The process where safeguarding alerts are raised within the Trust are forwarded to Luton Borough Council (LBC) has been further modified to provide greater efficiency and transparency. Previously alerts were sent from the Safeguarding team to LBC via the discharge administration team via secure email. This has now changed with the safeguarding lead or safeguarding administrator emailing alerts directly to the secure email address. This has also helped to provide greater assurance to the safeguarding lead when attempting to ascertain the progress of investigations.

During the last year occasional difficulties have been experienced with receiving information from LBC in a timely manner. In particular, not receiving alerts, screening tools or risk assessments until after the deadline response dates. After discussions with the safeguarding managers and also the administration teams at both the Trust and LBC this process has improved greatly with alerts being investigated in a timelier manner. However, we will continue to ensure that this improvement is maintained.

Training & Development

The Adult Safeguarding Lead has worked with the Training and Development team to review the statutory training programme for 2015/16. The main aim is to ensure that all staff groups are captured through mandatory training sessions. Also by reviewing all the programmes the training can be tailored for specific groups of staff. In addition to this we are keen to further develop the training provided by the learning disability team with the ultimate aim of combining the Safeguarding, Dementia and Learning Disability sessions on mandatory training.

It has been identified through various nursing audits and CQC peer reviews and practice issues that there is insufficient awareness and knowledge regarding Mental Capacity and Deprivation of Liberty Safeguards. The Adult Safeguarding Lead in response to this has instigated a programme of additional training sessions for all wards and departments ranging from micro training sessions based on the ward to lengthier training sessions incorporated into Ward meetings and training days. The uptake from all these areas has been very good and there is a forward plan to ensure these sessions continue during next year. The impact of this training and the knowledge and awareness of staff will continue to be evaluated through the Peer CQC reviews as well as audits to be undertaken by the Adult Safeguarding Lead.

In addition to this a thorough review of all Safeguarding was undertaken to ensure that all training delivered is pertinent to the individual staff groups. This has resulted in the training sessions being modified dependent on the target audience. Furthermore, it has identified key training for certain core groups of staff such as all Band 6 and 7 clinical nursing staff will be required to attend MCA/DoLS training in the future and this is to be defined within the updated Adult Safeguarding Policy.

The Trust's Dementia and Safeguarding Leads attended the Virtual Dementia tour - train the trainer training. This training allows staff to experience what it feels like to be a patient with Dementia. It involves the participants to be de-sensitised to sight, sounds and their surroundings. This is very thought provoking training and invaluable if we are to care for our patients in a more empathetic and holistic way. There is a training plan to disseminate this

to all staff across the organisation and the sessions delivered thus far have been very well evaluated.

The Adult Safeguarding Lead continues to attend the Channel Panel as part of the Prevent programme and Government's counter-terrorism strategy. The aim of this is to ensure that vulnerable adults and children are prevented from being radicalised by extremist groups into terrorist type activity. With the restructuring of the Prevent programme nationally the Trust is now part of the London region for Prevent whereas previously it had been part of the Midlands and East group. There is a new lead for the London Prevent region - Edward Farrell Pickerill. There are bi-monthly regional meetings which will also include a training focus that we will be required to attend.

Awareness of Prevent is now included in the Induction and Mandatory training programmes. The existing Department of Health's Healthwrap training has been undergoing a period of review and updating. Once released Healthwrap 3 will be delivered to key areas within the organisation such as the Emergency department, short stay wards, Maternity and Paediatrics. In addition to this the Prevent lead attended a workshop and conference as part of the national review into the National prevent guidance. The new Prevent duty is due to be released in July 2015.

2. Local priority: Workforce Development

National priority: Accountability - Accountability and transparency in delivering safeguarding

There is a new Lead Nurse for Learning disabilities. A review of the overall training programme has developed opportunities for combined training and provides greater understanding of individual roles.

The Adult Safeguarding Lead continues to foster a closer working relationship with both the Dementia Specialist Nurse and learning disability team. In addition to this there are now regular meetings with the Chief Nurse to feedback progress and developments on key performance objectives and indicators.

The third Safeguarding Champions course has been completed and comprised of 15 members of staff from the acute setting and 15 members of staff from the community. The course has been very successful with one of the main benefits being the shared learning from different organisations. The programme reviewed and adapted from previous years. This year in particular, included sessions on Domestic violence, communication, leadership and the legal implications and process of safeguarding. The course was run in conjunction with Bedfordshire University and the Clinical Commissioning Group (CCG).

Safeguarding continues to support the Schwarz rounds with a review of a complex Safeguarding case presented in October. Schwarz rounds are a very powerful learning tool and this was a very emotive case with the Schwarz round exploring the learning and emotions that emanated from this particular case. Key personnel that were involved in the case at the time participated and provided insight into how even a year after the case they are still affected by the eventual outcomes.

As part of the preparation for the implementation of the Care Act in April all training sessions included information of the changes that the Care Act is making with regard to Adult Safeguarding. In particular this has focussed on the new types of abuse categories, the requirements for sharing information in the safeguarding setting and the Duty of Candour.

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's Adult Safeguarding Lead has continued to identify opportunities to further develop professionally and also increase knowledge and skills for the benefit of the Trust as a whole.

Serious Case Reviews

We continue to work with our safeguarding partners as part of the serious case review panel. From the 1st of April with the introduction of the Care Act this group will be known as the Safeguarding Adult review group. In the past year it has reviewed one particular case- Adult G with learning emanating from the investigation. As a Trust although we were not directly involved with Adult G there is still valuable learning in terms of the sharing of information. The final report is due in April 2015.

Serious Case review learning events commenced this year with historic cases reviewed for learning opportunities across all organisations. This was a good opportunity to learn collectively from the lessons highlighted by these cases and ensure we work together more cohesively in the future. Importantly it was also recognised on this day that following these complex cases that there is much improved working relationships across all, agencies.

Multi-Agency Working

The Adult Safeguarding Lead continues to attend the Multi-Agency Safeguarding Leads meetings organised and chaired by the CCG Adult Safeguarding Lead. These are very valuable meetings attended by all safeguarding partners and allow for constructive discussions surrounding current operational issues. From these discussions there is a robust action plan that has been developed to improve practice for all agencies in the future. These meetings are held quarterly.

There are now quarterly meetings with the nursing home managers in conjunction with the Integrated Discharge Manager and organised through the Head of Adult Safeguarding for the Clinical Commissioning group. These meetings are again very useful and beneficial for all and aim to discuss relevant issues from both the community and acute Trust perspective. Issues recently discussed include the standardising of times for patients to be discharged by from the hospital and improving the communication prior to and at the time of the patients being discharged back home.

The Adult Safeguarding Lead attended both local authority business development days to establish the onward robust safeguarding strategies for both Safeguarding boards.

Dementia Care

We have continued to work with our partners to promote and improve Dementia care. We actively took part in Dementia awareness week and had stands to promote this within the Trust. The Dementia friendly sessions facilitated by the Alzheimer's society and aimed primarily at non clinical staff continue on a monthly basis.

The Adult Safeguarding Lead continues to work closely with the Dementia Specialist Nurse to support both the Safeguarding and Dementia objectives. In particular to ensure that we actively participate in Dementia awareness week in May and also to identify an action plan for attaining the challenging CQUIN targets for 2015-2016. This in addition to the combined training programme that continues to be delivered.

As part of the Dementia awareness week there will be a tea party for inpatients and their careers, Virtual Dementia Tour training and Dementia awareness displays within the Trust.

Both the Adult Safeguarding and Dementia Lead Nurses continue to have an active role across the Trust by disseminating safeguarding mental capacity and Deprivation of liberty advice to medical and nursing staff in particular in relation to complex medical and discharge cases. They both continue to attend best interest meetings at the request of medical and social work teams and always work as the patients advocate.

Dementia CNS offering phone advice to carers has increased over the past few months. Carers taking the opportunity to have updates and seek advice using the contact details provided in carers leaflet, hospital website & ward posters.

The Delirium guidelines have now been developed and will be disseminated to Medical and Nursing staff through training. This in turn will meet the required CQUIN improvement goal specifications.

The Dementia Care pathway was launched in November 2014 at the ward managers meeting. The Dementia lead requested that it was disseminated to all staff in their departments by using an education board or having a dementia awareness week/month. She suggested the ward managers consider discussing the pathway at safety briefings daily with all staff becoming aware of the pathway. This is audited by the CNS.

Dementia carer feedback is crucial for improving the service. The phone calls to carers will now be supplemented with questionnaires to encourage more feedback. The predominant focus of feedback refers to carers receiving adequate updates on the wards. The Carer's expectation is to be approached and updated daily or each time they visit the wards.

Right Care initiative (2012) '*Dementia –friendly hospital charter*'. This outlines the contributing principles and standards for a Dementia friendly Hospital with the Trust being invited to become part of a National support network to improve hospital care for the person with dementia It requires self-assessment and intends to build a peer to peer support network, which includes sharing examples of good and best practice.

The Dementia Lead Nurse is attending relevant meetings to promote the need to include Dementia friendly design where possible. PLACE assessments now include Dementia Friendly design standard requirements and actions are being discussed and agreed.

Learning Disability Care

The Adult Safeguarding Lead is working with the Lead Learning Disability Liaison Nurse to review and revise the pathways for all inpatients and outpatient clinical areas. Once complete these will then be disseminated to the clinical teams.

The Lead Learning Disability Liaison Nurse continues to facilitate the Patients Learning Disability Coffee morning. Former patients are invited to attend to discuss their experiences in the hospital and ways to improve the service were explored. The meetings have been expanded with patients from other community groups joining the meetings. The Lead

Learning Disability Liaison Nurse also working with both PowHer and the Bramingham Day Centre, Luton to develop specific tours of the hospital for autistic patients. The Lead Learning Disability Liaison Nurse alongside the Adult Safeguarding Lead is developing:

- ❖ A hospital welcome pack for learning disability patients who are admitted to hospital. This will provide them with details of who their key links are while in hospital and what to expect while they are here.
- ❖ Liaising with the Out Patients department to construct Easy read appointment letters and information for patients and carers.

The Adult Safeguarding Lead meets with the other Learning Disability (LD) Champions at meetings co-ordinated by the Lead Learning Disability Liaison Nurse. The aim of these meetings is to raise awareness of the challenges that LD patients experience when visiting the hospital. It also identifies key improvements and new ways of working to improve the patient's experience.

A CQC peer review was undertaken into the LD services provided within the Trust. The official written feedback is yet to be received however, the verbal feedback was very positive. It was felt that the overall patient experience was very good and the service and support provided by the Learning disability team to patients extremely good. An action plan has been developed to address the minor issues that this visit highlighted. The official feedback once received will be disseminated appropriately.

The Lead Learning Disability Liaison Nurse co-ordinated the care and management of a very complex case regarding a patient with extreme challenging behaviour who required urgent and invasive treatment. This required extensive liaison with the Trust staff especially in Theatres, Ward 21, the Consultant Surgeon, the Court of Protection, the Community Learning disability teams as well as the patient's residential home. The excellent communication and cross organisational working ensured that this patient had an excellent and positive experience. In addition to this it also had an impact on his future care as it was felt after this positive experience the patient could be seen in the hospital setting for his outpatient appointments rather than in an independent setting. This excellent example of communication and team working will be disseminated across all organisations via training from the LD team.

4. Local priority: Quality assurance

National priority: Protection - Support and representation for those in greatest need

Last year 299 safeguarding alerts were raised by the Trust and 80 against the Trust. The number raised by the Trust was a slight reduction in the previous year whereas the number against the Trust showed a slight increase.

The emerging themes from the alerts raised against the organisation were related to discharges and specifically medication and communication, issues relating to pressure damage, alleged neglect of care and poor communication and documentation. We have worked and continue to work with our external partners to address the issues highlighted by these alerts to improve the outcomes and experience for all our patients.

All discharge related alerts are reviewed at quarterly meetings between the Adult Safeguarding Lead, The Safeguarding Lead for the Clinical Commissioning Group and the Trusts integrated discharge manager. An action is developed from these meetings and any

developments or findings disseminated to clinical teams. Similarly we are working with our commissioners and local authority partners to support any developments that have arisen out of the safeguarding alerts raised by the Trust and subsequent investigations that have taken place.

Common themes for the alerts raised by the trust are neglect of care, psychological and physical abuse, domestic violence, financial abuse and self-neglect. The action points from safeguarding investigations is communicated back to the relevant departments via the Nursing Midwifery board, Ward Sisters meetings, Clinical Governance meetings and locally through individual ward and team meetings.

5. Local priority Involving People:

National priority: Empowerment - Presumption of person led decisions and informed consent

MCA and DoLS

In order to improve awareness and knowledge regarding Mental Capacity and Deprivation of Liberty Safeguards resulted in the instigation of a programme of additional training sessions for all wards and departments ranging from micro training sessions based on the ward to lengthier training sessions incorporated into Ward meetings and training days. The uptake from all these areas has been very good and there is a forward plan to ensure these sessions continue during next year.

The Adult Safeguarding Lead and Dementia Nurse Specialist have been actively involved in Best Interest meetings and case conferences in complex cases and particularly complex discharges. Both act as the patients advocate where appropriate and ensure appropriate decisions are made in the best interests of the patient and also relatives.

Making Safeguarding Personal

The Luton & Dunstable Hospital NHS Foundation Trust is committed to the principles of **Making Safeguarding Personal**, a project developed by the Local Government Association and the Association of Directors of Adults Social Services. The aim of Making Safeguarding Personal is to ensure that safeguarding is person-led and focused on the outcomes that they want to achieve. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that embraces involvement, choice and control as well improving quality of life, wellbeing and safety.

We will:

- Work with adults (and their advocates or representatives if they lack capacity) at the beginning to identify the outcomes they want to achieve.
- Review with the adult at the end of safeguarding activity to what extent their desired outcomes have been achieved.
- Record and monitor the results in a way that can be used to inform practice and account to the three respective Safeguarding Adults Boards.
- Develop a range of robust and appropriate responses that focus on supporting adult to meet their desired outcomes and reduce the risk of or recurrence of abuse.

6. Local priority: Outcomes and Improving Experiences

National priority: Proportionality – Proportionate and least intrusive response appropriate to the risk presented

The Trust will monitor safeguarding outcomes and patient experience by the implementation of Making safeguarding personal and by obtaining patients views of the safeguarding process.

Further outcomes and experiences will be monitored by the Dementia Specialist Nurse and Learning disability team for their respective patient groups. All learning from safeguarding investigations will be used to ensure that we constantly strive to improve the patients experience and ensure improved outcomes for all.

Highlight report of key issues arising during 2014/15, addressing the priorities

Implementation of the Care Act 2014-

All training presentations for adult safeguarding have been reviewed to include the main changes relating from the Care Act to Adult Safeguarding.

Mental Capacity and Deprivation of Liberty Safeguards-

From nursing audit and through practice related issues we identified that there was a poor level of awareness of the Mental Capacity Act and Deprivation of Liberty safeguards. A robust training programme was developed and delivered to wards and departments and this work will continue.

Process and information delays-

Difficulties were experienced by the Adult Safeguarding team in receiving alerts, screening tools and risk assessments from Luton Borough Council in a timely manner. After discussions with safeguarding managers and also the administration teams at both the Trust and LBC, this process has improved greatly and alerts are now investigated in a more timely manner. However, we will continue to ensure that this improvement is maintained.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

Prevention and raising awareness –

The process where safeguarding alerts raised within the Trust are forwarded to LBC has been further modified to provide greater efficiency and transparency. This has also helped provide greater assurance to the Adult Safeguarding Lead when attempting to ascertain the progress of investigations.

Workforce Development-

The introduction of administrative support for the Adult Safeguarding team and Dementia Nurse specialist has allowed the Adult Safeguarding Lead more opportunity for training and providing support in the clinical area. It has also meant that safeguarding information is shared with the wards and departments as well as external organisations in a timelier manner.

Partnership Working-

The Safeguarding lead continues to attend the Multi-Agency Safeguarding Leads meeting organised and chaired by the CCG Adult Safeguarding lead. These are very valuable meetings attended by all safeguarding partners and allow for constructive discussions surrounding current operational issues.

There are now quarterly meetings with the nursing home managers in conjunction with the Integrated discharge manager and organised through the Head of Adult Safeguarding for the Clinical Commissioning Group. These meetings are again very useful and beneficial for

all and aim to discuss relevant issues from both the community and acute Trust perspective.

Quality Assurance-

On-going review of all discharge related safeguarding alerts by the Trusts safeguarding lead as well as the Safeguarding Lead for the CCG and the Integrated discharge manager has produced a robust action plan and various improvements to ensure discharges are facilitated more smoothly.

Training and Development-

A review of the Adult Safeguarding training programme has identified key training priorities for the next year. In particular greater emphasis on Mental Capacity and Deprivation of Liberty training and the implementation of Healthwrap 3 training in the next year. It has also enabled us to focus on what specific training is required for individual staff groups and this will be further outlined in the revised Adult Safeguarding Policy.

Virtual Dementia Tour-

The Trust is now implementing the Virtual Dementia Tour training following the acquisition of the training package and both the Adult Safeguarding lead and Dementia Nurse Specialist attending the train the trainer training. This has resulted in greater awareness of the patients experience for someone who has Dementia. This is an extremely powerful learning tool and will continue to be disseminated across the organisation.

Improvements planned in adult safeguarding during 2015/16 addressing the priorities

- ❖ A review of the Adult Safeguarding policy to incorporate changes implemented with the Care Act 2014.
- ❖ A review of the Mental Capacity Act and Deprivation of Liberty safeguards policy to ensure this is compliant with new changes in legislation.
- ❖ Increase establishment to support role of Dementia Nurse specialist
- ❖ Development of safeguarding handbook for staff
- ❖ Development of Safeguarding newsletter to be produced quarterly
- ❖ Review and updating of Safeguarding resource folders to ensure they are compliant with the Care Act
- ❖ Improved monitoring of Deprivation of Liberty safeguards administration
- ❖ Prevent Healthwrap 3 training for target areas
- ❖ Implementation of Making safeguarding personal

Highlight report of key issues arising during 2014-15

Awaiting finalisation of the Trust Restructure.

Improvements made in adult safeguarding during 2014-15

Prevention and raising awareness

The Trust continues to keep safeguarding integral to all appropriate work streams. Professional Update themes for 2014/15 were:

- Frontline Staff: Face to face 'back to basics' and Mental Capacity Act.
- All support staff: Duty of Care, Whistleblowing and types of abuse.
- Patient Transport (Non- Patient facing) Staff: Duty of Care, Whistleblowing and types of abuse- a more in depth understanding.
- Patient Transport (Patient facing) Staff: Duty of Care, Whistleblowing, types of abuse a more in depth understanding and Mental Capacity Act 2005.
- Frontline Staff: Face to face 'back to basics' and Mental Capacity Act. Workbook: Mental Health and a Mental Capacity Case Study
- A revised Capacity to Consent Assessment Form has been distributed and is available on all vehicles.

Workforce Development

- Staff training for safeguarding continues to be integral to all staff cohorts. Consistent messages regarding safeguarding, consent and capacity remain pivotal to training and education.
- Safeguarding Senior Locality Managers (SLM) are working with the LSABs around the Eastern Region; this partnership working is increasing Knowledge on and development of Safeguarding.

Partnership working

The Trust commits to working in partnership with all LSABs around the Eastern Region and every effort is made to ensure consistent attendance of a Trust member of staff at key meetings. This continues to be a challenge due to the escalation of the work load and pressure on operational members of management staff. This has had an impact upon attendance at Board Meetings. This duty falls to the Safeguarding Sector Locality Manager within the appropriate areas. Trust staff are actively engaged in DHR, CDOP and Partnership Learning Reviews.

Quality assurance

Auditing of referrals and checking of quality and pathway options continues to be an integral part of the work undertaken by the Trust safeguarding hub office.

The Trust safeguarding team is currently unable to follow up feedback regarding referrals due to a lack of capacity within the team. This is being addressed in the new structure.

The table shown below highlights the referrals made within Bedfordshire and Hertfordshire, as combined figures for both children and adults.

| Month | June | July | Aug | Sept | Oct | Nov | Dec | Jan 15 | Feb | March | April | May | June |
|-------------|------|------|-----|------|-----|-----|-----|-----------|-----|-------|-------|-----|------|
| Beds | 182 | 176 | 168 | 153 | 142 | 227 | 184 | 192 | 230 | 207 | 267 | 211 | 221 |

Improvements planned in adult safeguarding during 2015-16

These will form part of the Safeguarding Plan which will be finalised on appointment of the Safeguarding Leads as part of the Trust Restructure.

SEPT

1. Local priority: Prevention and raising awareness

A series of preventative and awareness raising initiatives have been implemented this year within the Trust. This includes service user interviews, competency framework for staff and the distribution of lessons learnt cases. Audits have evidenced that staff awareness and response to Safeguarding issues has improved in the timeframe process and quality of investigations.

2. Local priority: Workforce Development

The Trust compliance with safeguarding training has been above 90% for 2014/15. Training has been delivered via E-Learning and face to face programmes. Compliance with timeframes for investigating safeguarding cases has remained above 91%.

3. Local priority: Partnership working

The Trust have been active members of the LSAB and other sub groups. The Trust Safeguarding team have regularly worked in partnership with other NHS organisations, police, advocates and voluntary sector.

4. Local priority: Quality assurance

The Safeguarding team have completed a number of audits. The outcomes have been consistently of a high standard and show continued improvement in the quality of safeguarding and engagement with service users and family members.

5. Local priority: Involving People

The Trust continues to use a Safeguarding Questionnaire for those subject to investigation. Feedback is reported regularly and influences the process of engaging service users, their families and advocates. Service user interviews involved meeting with a person subject to an investigation to ascertain their views and experiences. Feedback has been mainly positive; areas of improvement include ensuring the person is informed along all steps of the process. These lessons learnt are fed back to clinical teams and service managers

6. Local priority: Outcomes and Improving Experiences

The Safeguarding team have continued to support staff and advising on robust risk assessments and the least restrictive and intrusive options when supporting service users.

Highlight report of key issues arising during 2014/15, addressing the priorities

- Good outcomes from internal audits
- Compliance with staff knowledge and skills continues to improve
- Good partnership working

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

- Raise awareness of the safeguarding guidance within the Care Act 2014
- Continue to improve skills of staff working in Community Health Services
- Ensure smooth transition of safeguarding services to East London Foundation Trust who will be taking over Mental Health Services in Luton and Beds (Except Robin Pinto and Woodlea units)

Bedfordshire Police

Highlight report of key issues arising during 2014/15, addressing the priorities

Management Structure and Resources

There has been a balance throughout the reporting year to be made of consistency and stability in personnel versus bringing in to the Department varied experiences to enhance investigation skills.

D/Supt Sharn Basra and DCI Liz Mead are both accredited PIP 3 SIOs with Major Crime Background. DCI Nick Bellingham brings the intelligence and pro-active investigative experience.

2014- 2015 has been challenging for Bedfordshire Police with both financial and resourcing pressures. However, recommendations from the PPU Lean Review continue to be implemented and compliment the FQIP (Force Quality Improvement Plan) that restructures the Force and will continue to deliver a robust service whilst supporting the needs of our communities.

2014-15 saw the first recruitment of police constables in over 4 years and over a hundred are going through at various stages of their probationary period, with further recruitment is planned. In addition there have been transferees with experience recruited direct to the Force and three of these individuals were immediately placed within the PPU.

Domestic Abuse

Domestic abuse investigations and process has seen a number of changes throughout the year with new processes being implemented and new line management. These changes have been challenging but have gone well, with the frontline officers being given further training in domestic abuse and vulnerabilities concentrating on threat, harm and risk to all.

The HMIC Domestic Abuse re-inspection was held in November 2014, this was a brief inspection as new changes had been implemented. It was acknowledged that the changes were valuable but to ensure the inspection was of value to the force it has been agreed that they will revisit to review the force response to Domestic Abuse.

The new process for the management of Domestic Abuse was implemented in January 2015 in regards to recording, risk management and the investigation processes for domestic abuse incidents. We are reviewing our end to end process in regards to officers investigating crimes and safety planning with the victims.

The first Bedfordshire Domestic Abuse Scrutiny Panel was held on Monday 9th February 2015 at Bedfordshire Police Headquarters. A wide variety of police resources were in attendance and five cases were selected for review. They focussed on the victim pathway and it was facilitated by SafeLives (formally CAADA). A synopsis of the review is due which will highlight any recommendations resulting from the panel alongside a summary of good practice and challenges in each individual case. Further scrutiny panels shall be scheduled in due course and will focus on the end to end process with an emphasis on partnership working.

The HMIC Inspection report from October 2015 has been recently received and is overwhelming positive and reveals good progress against the 17 original recommendations.

The final quarter of 2014/15, saw a 7% increase in DA conviction rate.

DVDS and DVPO'S

The Home Secretary announced a national rollout of Domestic Violence Protection Notices and Orders (DVPN/O's) and the Domestic Violence Disclosure Scheme (DVDS) and Bedfordshire Police introduced both schemes in June 2014.

The Domestic Violence Disclosure Scheme introduced recognised the need for consistent procedures for disclosing information that enables a new partner of a previously violent individual make informed choices about whether and how to take forward that relationship.

A Domestic Violence Protection Notice and Order is aimed at perpetrators who present an on-going risk of violence to the victim with the objective of securing a co-ordinated approach across agencies for the protection of victims and the management of Perpetrators.

Both DVDs and DVPOS were used successfully throughout 2014/15 by Bedfordshire Police.

Improvements made in adult safeguarding during 2014/15, addressing the priorities

SPOC Roles were created in the PPU for Adult Safeguarding. Ds Michelle Welsh is the Lead for Bedford and Central Bedfordshire and Ds Richard Eymor is responsible for Luton.

The Care Act places certain responsibilities on agencies and one of these is that the police should have a Designated Adult Safeguarding Manager (DASM) to manage cases involving allegations or concerns raised involving a person in a position of trust. The Act says that Forces should have a DASM who will provide a consistent and dedicated response for our partners to liaise with in matters of concern. The DASM will therefore need to be an officer with sound knowledge of multi-agency working and adults at risk investigations. In Bedfordshire Police, DCI Liz Mead has this role.

Future development

A county-wide MASH is under review and consultation with agencies' looking at their roles within it. The pilot within Bedford is still in its infancy but has shown closer working together between partners.

The referral process for vulnerable adults and the SOVA teams are working well, the agreements made in regards to what constitutes a referral and or an investigation has allowed for the investigation to be referred in a more timely fashion, with officers in the Public Protection Referral Team risk assessing and prioritising the police investigations referring directly to the Safeguarding Sgts for allocation. See the graph below for the numbers of referrals over the past year and subsequent investigations.

Prosecutions/Investigations (Countywide Cover)

Between 01/04/14- 31/03/15 Police received 793 Social Care referrals from all 3 Authorities.

Police completed a significant number of F750s most of which were forwarded on to Adult Social Care. The contrasting figures from 2013-2014 are included for reference and comparison.

Referrals per agency

| | |
|------------------|------------------|
| 2013-2014 | 2014-2015 |
| Police 891 | Police 1435 |
| Sova 1027 | Sova 793 |
| Other 113 | Other 70 |

From the data collated you can see there is a very marked increase in the amount of Form 750s police forms, submitted to Social Services (SSD) in 14/15. This is in contrast to Sova referrals which have seen a marked decrease in the same period.

Staff who regularly deal with VA have also noted this change which is supported by the annual figures.

Break down of VA incidents investigated by SIU

| | Physical | Sexual | Financial | Welfare/Neglect |
|--------------------|----------|--------|-----------|-----------------|
| Safeguarding North | 14 | 14 | 4 | 14 |
| Safeguarding South | 11 | 10 | 11 | 8 |

Auditing

Qualitative auditing of cases continues to be undertaken by Senior Managers in the PPU on a monthly basis in addition to the Detective Sergeants supervisory responsibility for paperwork checks and auditing of ABE and Suspect interviews.

Weekly crime management/ investigation reviews are being completed by the detective Inspectors. Ensuring our victims and suspects are being kept up to date and the investigations are progressing. This will assist with the implementation of Athena as officers are going to have to use new systems to record their investigations.

Training

The specialist staff, within the Public Protection Unit has continued to receive on-going training on current themes, learning from SCR's and legislative updates at the regular Continuous Professionalism Development days (CPD) including updates in the new legislative changes arising from the Care Act.

NCALT training is also being used to train officers within the service along with access being given by the local authorities to their on line training to support and develop officers within the PPU.

DCI Liz Mead PPU has continued to present at the Crime Seminars with the presentation providing an overview of PPU including vulnerable adult investigations .These presentations are on- going with crime updates being completed on rotation.

Forced Marriage & Force Marriage Protection Orders (FMPO)

These remain static

Missing Persons Unit

The MPU practices have been updated to ensure the correct definition is used, regardless of if the person reached Compact or not, which may have impacted the data if it was broken down into missing compared to absent reports. MPU have will also increase their focus on the appropriate recording of reports relating to MH patients, i.e. absconders are no longer recorded as absent / missing (however this data is retained for the working group so they can review and address any issues).

Improvements planned in adult safeguarding during 2014/15 addressing the priorities

Future development

The implementation of a Serious Sexual Offences Investigation Team remains on hold. However, longer term the creation of this Team to investigate all serious sexual offences, will enhance the current Rape Investigation Unit.

CSE

The CSE Team continues to gather significant intelligence around young People (YP) who may be CSE victims and also gathering intelligence on possible perpetrators. With the support of partners and the extra training awareness raising we have seen reporting increase with a number of Young people being referred to the CSE Panel. We are continuing to develop processes within the Team to provide a more effective service to the public our partners and internally.

It has been well documented that there are links between the LSCBs and the LSABs relating to CSE and learning and training are to be shared. Bedfordshire Police positively utilised 'The more you see, the more you know' communication poster campaign and opportunities to promote CSE awareness was undertaken on National CSE Action Day on 18th March.

Bedfordshire Police was the subject of a College of Policing Peer Review for CSE over a 3 day period in March 2015. The results of this review were encouraging and the Report will be published early Summer 2015. Comment has been made on the strengths of the clear vision for the Force in relation to tackling CSE and that the vision had been communicated very effectively to police officers and police staff at all levels and across all teams. There was learning identified around effective communication with external partners but recognised the establishment of the Pan Bedfordshire CSE and Missing Panels and CSE/Missing Strategic Group to illustrate the close working relationship that currently exist.

All occurrences of missing and absent are now referred by Bedfordshire Police to each relevant Local Authority. This extensive sharing of information assists in the decision making process around courses of action to be taken such as Strategy Meetings, referrals

to the MCYPP or the Child Sexual Exploitation Panel. A CSE co-ordinator for all agencies has been recruited and is due to start in June 2015 providing a county-wide function in developing CSE understanding and practice.

MASH

The development of joint working within a MASH will not only support all agencies allowing for a joint assessment, it will ensure that investigations have a clear lead agency, in regards to Vulnerable adult assessments / investigations this should speed the process and give clear parameters in order for the victim and their families to be up to date with an immediate point of contact.

Domestic Violence End To End Processes.

This is an on-going piece of work which is aimed at having one officer to investigate the crime and support the victim, completing safety planning with them. These investigations will be managed as the safeguarding and Rape investigations are. Allowing for the OIC who is aware of all the facts & risk factors to support the victim and process the crime.

ATHENA

Athena the new investigation tool is due to be implemented in January 2016 which will allow for the crossover of police data. This is likely to affect our data records/ figures for 15/16 they will change.

Bedfordshire Fire and Rescue Service

Highlight report of key issues arising during 2014-15

During 2014 -15 Bedfordshire Fire and Rescue Service made 4 Adult Safeguarding Referrals to the Luton Adult Safeguarding Team as follows:

- 3 for Neglect
- 1 Neglect and Emotional Abuse

86 BFRS Managers received Safeguarding Training by attending a new bespoke classroom based training course.

Improvements made in adult safeguarding during 2014-15

Prevention and raising awareness

Bedfordshire Fire and Rescue Service (BFRS) continues to deliver a programme of Home Fire Safety Checks (HFSC's). The checks are delivered by Specialist Community Safety Staff, Operational Fire Crews and partner agencies. During 2014/15 4501 HFSC's were completed across the County by BFRS. A further 807 were completed by our partner agencies. The board should note, that whilst vulnerable adults form part of the target audience not all HFSC's are delivered to vulnerable adults.

BFRS is the enforcing authority of the Regulatory Reform (Fire Safety) Order 2005 on the majority of premises covered by the order in Bedfordshire. The Service conducts a risk based audit programme, this includes auditing Residential Care Homes. The number completed and the frequency of audits completed on Care Homes is determined by the risk associated with each Care Home.

Workforce Development

The Service has completed the initial delivery phase of its Safeguarding training package with the majority of Managers completing the course. We have identified staff that did not receive during the first phase of delivery and have arranged additional training courses for these staff members during the first half of 2015/16. Once this process has been completed we will roll out the e-learning package for staff that do not require the classroom based sessions.

Partnership working

Bedfordshire Fire and Rescue Service continues to refer cases that have been highlighted as a safeguarding concern using relevant processes and procedures laid out in the Services Safeguarding Policy. The Service's safeguarding policies have been drafted to compliment that of the SOVA Board.

Quality assurance

Bedfordshire Fire and Rescue Service will continue to monitor the number of referrals received each quarter to ensure the correct procedures are followed.

Improvements planned in adult safeguarding during 2015-16

Extra classroom based Safeguarding training courses will be delivered for managers who did not complete the training with aim for all relevant staff to have received this training by September 2015. In addition a bespoke e-learning package will be delivered to all staff (including Firefighters) who do not require the more in-depth classroom package.

POhWER

Highlight report of key issues arising during 2014-15

- (1) Preparation for the implementation of the Care Act on 1st April 2015. This has involved preparatory work as a partner member of the Luton Adult Safeguarding Board and internal POhWER preparation. This has involved the Luton Community Manager acting as project lead for the safeguarding element of the Act and a member of her team revising POhWER's internal safeguarding training with a focus on Making Safeguarding Personal.
- (2) Response to the influx of Deprivation of Liberty Safeguards referrals, following Cheshire West ruling (256 referrals for advocacy received in Luton by POhWER) Additional funds allocated by Luton Borough Council to enable the appointment of an additional 0.5 IMCA.

Improvements made in adult safeguarding during 2014-15

Prevention and raising awareness

POhWER advocates, through community engagement activities, have focussed on hate crime and keeping safe, particularly with groups of people with learning disabilities and those with autism.

POhWER advocates continue to be vigilant and raise safeguarding alerts in respect of individuals and are reminded of this through monthly team meetings.

Workforce Development

- (1) Retraining of staff has commenced, following revision of POhWER's internal training.
- (2) Some community advocates retrained to take on an additional IMCA role.
- (3) Advocates currently working on the IMCA/DoLS module of the National Independent Advocacy Qualification.

Partnership working

As well as working in partnership with LSAB, POhWER also is a member of the PAN Bedfordshire Safeguarding group and has been involved in case study examination. POhWER is also a member of the Luton and Dunstable Hospital Board and attends Luton Healthwatch meetings. The community manager has begun visits to local teams within Luton Borough Council, Luton and Dunstable Hospital and ELFT to confirm the link between advocacy and safeguarding referrals under the Care Act.

Quality assurance

- (1) Revised safeguarding training quality assured by POhWER Senior Executive Team.
- (2) Information sharing protocol reviewed and endorsed by POhWER Care Act Project Group.

- (3) Individual safeguarding alerts logged by community manager and reviewed for consistency of approach by Regional Manager.

Improvements planned in adult safeguarding during 2015-16

- (1) POhWER will be hosting a conference on MCA/Deprivation of Liberty to consider the implications of current practice and to consider the Law Commission consultation paper on the future of Deprivation of Liberty Safeguards (*n.b. conference held on 17th July*).
- (2) The Community Manager will be further consulting with teams to confirm the link between advocacy and safeguarding referrals under the Care Act.
- (3) POhWER will be working in partnership with Luton Borough Council social work teams to confirm procedures for referrals for advocacy in respect of applications to the Court of Protection for DoLS in respect of people with learning disabilities who are in supported living accommodation.
- (4) All newly recruited staff will be required to take the revised safeguarding training as part of their induction.



Providing Partnership Services in Bedfordshire,
Essex and Luton

Luton and Dunstable Hospital 
NHS Foundation Trust



Luton Clinical Commissioning Group



East London 
NHS Foundation Trust




Bedfordshire